

**MEDICAID
DIRECT SERVICES GUIDEBOOK
FOR
LOCAL EDUCATION AGENCIES**

MAY 2004

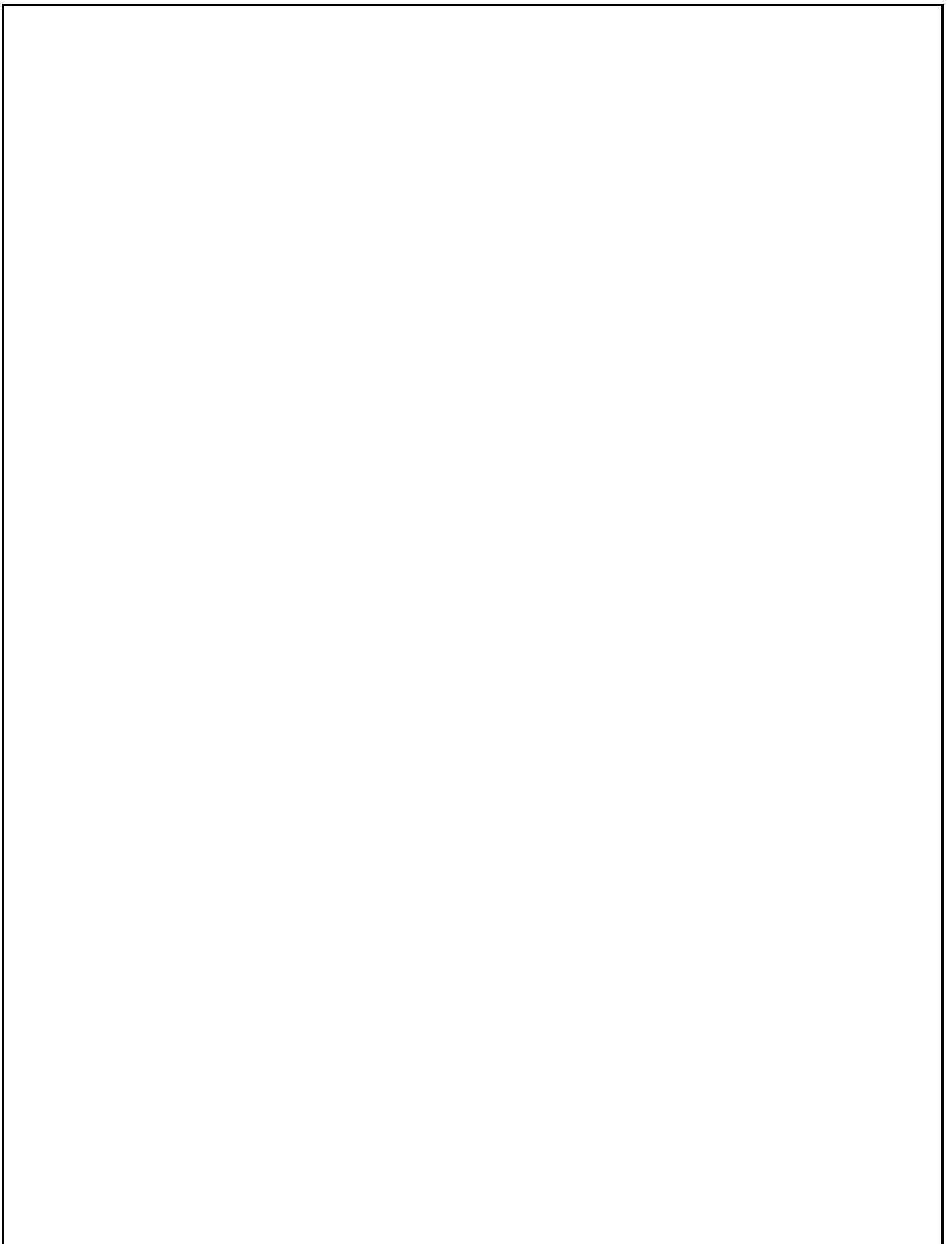


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I. INTRODUCTION

INTRODUCTION

This Guidebook contains information to assist Local Education Agencies (LEAs) in Rhode Island with Medicaid direct services claiming.

The purpose of this guide is to assist LEA personnel in implementing and maintaining a Medicaid reimbursement program for services provided by or for a Local Education Agency. The intent is to clarify the roles and responsibilities of the various school personnel involved in the direct services reimbursement program. This personnel includes administrators, direct service providers and support staff. These responsibilities include submitting the Certification of Local Funds on a quarterly basis, signing provider agreements, completing provider logs, formatting and submitting claims, reconciling claims, and maintaining provider logs and other records used to support a claim.

The scope of information includes: provider enrollment, service definitions, provider qualifications, documentation guidelines, claim submittal information (including diagnosis and procedure codes), claim reconciliation information, eligibility verification, and other policies and procedures effecting the program e.g., the federal Individuals with Disabilities Education Act (IDEA) Part B, the Rhode Island State Regulations Governing the Education of Children with Disabilities, as well as the federal Health Insurance Portability and Accountability Act (HIPAA).

ACKNOWLEDGEMENTS

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II. BACKGROUND

A. Rhode Island General Law 40-8-18

Congress has allowed schools and school districts to submit claims for reimbursement from state Medicaid programs for certain services since 1989. The State of Rhode Island enacted Rhode Island General Law (RIGL) 40-8-18 in 1992 (see Addendum A). Amended in 2000, this general law enables LEAs to enroll as Early and Periodic Screening Diagnosis and Treatment (EPSDT) Providers with the Rhode Island Medical Assistance Program. Enrolling as a provider allows an LEA to submit claims for services provided within its programs. This means that the Medicaid program may reimburse an LEA for certain services provided to a child who is Medicaid eligible and most of the services reimbursable are identified through the special education process by the development and implementation of Individualized Education Programs (IEPs).

Local Education Agencies in Rhode Island started enrolling as EPSDT providers in 1992. As of February 2004, 41 LEAs representing 38 communities, 5 Public Charter Schools, a Regional Educational Collaborative, and the Metropolitan Career and Technical Center were enrolled as EPSDT Providers.

Key Provisions of RIGL 40-8-18 include:

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

In addition to these highlights, the following must be considered by LEAs when determining which services are to be submitted for reimbursement:

- Services provided through funding from federal grants are not reimbursable through Medicaid. For example, if the salary for a Speech and Language Pathologist is supported by IDEA funds, then the services provided by this pathologist shall not be submitted for Medicaid reimbursement.

B. Medicaid

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

Medicaid programs pay for services identified in a plan, called the State Plan, some of which are mandated by the Federal government and others that are optional and determined to be covered by each state. Within the Medicaid statute is a program for children birth to 21 years of age called the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. Under EPSDT, children must receive not only screening and diagnostic services, but also any medically necessary treatments that may not otherwise be available under a state's Medicaid plan but are allowable under Federal Medicaid law.²

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

- Children;
- Pregnant Women;
- Adults in Families with Dependent children;
- Individuals with disabilities;
- Individuals 65 or over.³

Medicaid should not be confused with **Medicare**, which is a Federal insurance program. Medicare primarily serves people over 65, whatever their income; and serves some categories of younger people who are disabled and dialysis patients. Medicare is also administered by the Centers for Medicare and Medicaid Services (CMS).⁴

For more information on Medicaid, please refer to www.cms.hhs.gov/medicaid
For more information regarding Medicare, please refer to www.medicare.gov

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

² Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An examination of Federal Policies, U.S Department of Health and Human Services 1991, p. 5

³ <http://questions.cms.hhs.gov/>

⁴ Ibid

C: Medical Assistance in Rhode Island

Families and children in Rhode Island may become eligible for Medicaid by applying for coverage through the following: RItE Care, RItE Share, Supplemental Security Income (SSI), Katie Beckett, Adoption Subsidy and the Mental Retardation/Developmental Disability (MR/DD) Waiver. The majority of children covered by Medicaid are enrolled in a Managed Care Program through RItE Care or RItE Share. Most children with special health care needs (CSHCN) receive their coverage through eligibility from SSI, Katie Beckett, Adoption Subsidy or the Mental Retardation/Developmental Disability (MR/DD) Waiver.

Starting in September 2003, families whose children are eligible for Medicaid through SSI, Katie Beckett or Adoption Subsidy *and* who do not have other insurance coverage are being given the choice of staying in fee-for-service Medicaid or enrolling in a RItE Care managed care program, Neighborhood Health Plan of Rhode Island. Those children who are eligible through SSI, Katie Beckett or Adoption Subsidy and who do have other insurance coverage will continue to remain in fee-for-service Medicaid.

Since services provided by LEAs through their special education program are carved out of the RItE Care benefit package, LEAs can submit claims for reimbursement for children who receive services through a managed care program or through the fee-for-service delivery system. It is hoped that there is coordination between a child's primary care physician/provider and the services provided by the LEA. It is also important to note, that the reimbursement accessed by the LEAs *does not affect the family* because there is no additional cost to any family in terms of co-pays, premiums or lifetime service caps when LEAs submit claims to the Medical Assistance Program for services provided to eligible children.

LEA staff may assist families with applications for Medical Assistance (MA). These activities can be documented for those districts participating in the time studies used for Medicaid Administrative Claiming. As Medicaid benefits for children under the Early and Periodic Screening Diagnosis and Treatment Program are identical regardless of the basis for their Medicaid eligibility, the following are broad guidelines for school district staff to use when helping a family apply for MA:

- (1) **RItE Care:** Eligibility is based on family income. Refer by calling 462-5300 or by calling the local DHS offices (see Addendum **B**) or download an application for RItE Care from the DHS web site at www.dhs.ri.gov
- (2) **RItE Share:** Families, whose income falls within certain federal guidelines that have access to employer-sponsored insurance, may be eligible for RItE Share. For more information call the RItE Share line at 462-0311.
- (3) **SSI:** Eligibility is based on the child's disability *and* the family's income. Refer to the Social Security Administration (SSA), by calling 1-800-772-1213, by contacting a local SSA office (See Addendum **C**) or by accessing the Social Security web site at www.socialsecurity.gov
- (4) **Katie Beckett:** Three elements are considered when determining if a child aged birth to 18 years old is eligible for Katie Beckett. These are (1) a disability determination

- (2) a level of care determination and (3) the child's income and resources. Refer to the DHS long term care offices for application. (See Addendum D)
- (5) **Adoption Subsidy:** Children in Adoption Subsidy may qualify for RIte Care or RIte Share. The adoption subsidy program is administered through the Department of Children Youth and Families. For more information, please contact: (401) 254-7020

D: The Role of Special Education

a. IDEA Part B

IDEA Part B authorizes Federal funding to states in order to ensure that children eligible for special education and related services receive a free appropriate public education (FAPE). FAPE is defined to include special education and related services at no cost to the parents. The provision of FAPE however, does not relieve "an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a child with a disability."⁵

- Special Education is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability." It can include classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions to ensure that children with disabilities receive a free appropriate public education.⁶
- Related services are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools and parent counseling and training."⁷

Under the law, LEAs must prepare an Individualized Education Program (IEP) for each child eligible, specifying all special education and related services needed by the child. For children transitioning from Early Intervention, through age 5, an Individualized Family Service Plan (IFSP) that meets IEP requirements may be used to meet these requirements (Section 300.342(c) of the IDEA/Rhode Island Special Education Regulations) The IEP must be developed cooperatively by the parent and school personnel including: at least one regular education teacher of the child, at least one special education teacher *or* special education provider of the child, the child's parent or guardian, a person designated as the LEA representative, an

⁵ Individuals with Disabilities Education Act 1997 300.301 (b)

⁶ Rhode Island Board of Regents for Elementary and Secondary Education: Regulations Governing the Education of Children with Disabilities, December 14, 2000, Section 300.26

⁷ Ibid, Section 300.24

individual who can interpret evaluation results and others at the discretion of the parent or LEA.⁸ Developed and reviewed (and if appropriate revised) at least annually, the IEP must detail specific special education and related services that are to be provided to the child. The LEA is responsible for assuring that all services included in the IEP are provided to the child.⁹

A state Medicaid program can pay for those related services that are specified in the Federal Medicaid statute and determined to be medically necessary by the state Medicaid agency.¹⁰ Within Federal and state Medicaid program requirements regarding allowable services and providers, LEAs can seek reimbursement from the Medicaid program for these health-related services when provided to children enrolled in Medicaid.¹¹ This is important because of the additional funding it offers LEAs.

For the provision of special education and related services, LEAs must adhere to the requirements of the IDEA Part B and the Rhode Island State Regulations Governing the Education of Children with Disabilities. The following provides information regarding the role of special education and the IEP in relation to the Medicaid Reimbursement program.

b. Individualized Education Program (IEP)

The Purpose of the Individualized Education Program

It must be noted that while documentation of services in the IEP is an important component of Federal Medicaid requirements, the development of the IEP and the provision of special education and related services are guided by the application of the following Federal and State Laws: The Individuals with Disabilities Education Act (IDEA) Part B and the Rhode Island Board of Regents for Elementary and Secondary Education Regulations Governing the Education of Children with Disabilities. To provide a better understanding of the purpose of the IEP, the following was taken from the Introduction of IEP: Purpose, Process and Product, Second Edition 2002 by the Rhode Island Department of Education, Office of Special Needs, with support from the Rhode Island Technical Assistance Project:

The Individual with Disabilities Education Act (I.D.E.A.), formerly known as PL 94-142, requires that all students with disabilities in need of special education services be provided with free appropriate public education designed to meet their unique needs. The cornerstone of this provision is the development and implementation of the Individualized Education Program (IEP). The IEP serves as a written agreement between the parents and the school system. According to the regulations, the IEP must be developed at a meeting at which parent and school personnel *jointly* make decisions about the student's program, and must be reviewed and revised at least annually.

⁸ Ibid, Section 300.344

⁹ Ibid, Section 300.350

¹⁰ "Opdt Medicaid Coverage, November 1991, p. 1

¹¹ Ibid

The IEP serves a number of purposes, such as providing a vehicle for communication, problem resolution, and compliance. It also provides goals and objectives based on the general curriculum to guide the special education services to be provided in the least restrictive environment and outline the type and amount of such services.

The development and implementation of an Individualized Education Program pursuant to IDEA and Rhode Island Regulations must take precedence over any other requirement by any entity for its own purposes. The Centers for Medicare and Medicaid Services (CMS) requires that services submitted for reimbursement from Medicaid must be documented in the IEP. CMS does not dictate where or how these services need to be documented in the IEP, so for purposes of claiming services for reimbursement, the state of Rhode Island requires that LEAs follow the IEP guidance provided by the RIDE.

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

A. Local Governing Authority Approval

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

B. Department of Human Services/Local Education Agency Interagency Provider Agreement

In order to enroll as a Medical Assistance provider, an LEA must complete, sign and return an interagency provider agreement with the Department of Human Services (DHS). The Interagency Provider Agreement between the DHS and LEAs is currently valid for 2 years and newly signed agreements must be completed once the current agreement term expires. Copies of the Provider Agreement are available from the DHS by contacting Sharon Reniere at (401) 462-2187 or sreniere@dhs.ri.gov

C. Certification of Funds Requirement

According to the DHS/LEA Interagency Provider Agreement, “The LEA will certify matching funds on a quarterly basis, effective with the first day of the calendar quarter in which the Agreement becomes effective.” The Certification of Funds letter must state that the LEA certifies that there are sufficient state/local and/or private money being used as a match for the Federal Medicaid reimbursements. Please refer to Addendum G for a sample Certification of Funds letter. Each LEA is required to submit a Certification of Funds letter quarterly for the following dates:

March 31	September 30
June 30	December 31

LEAs receive the Federal share of each Medicaid claim approved for payment because they provide the state match for the Federal reimbursement. This is known as the Federal financial participation (FFP), which varies each federal fiscal year and is currently 56.03% for Federal Fiscal Year 2004.

D. Electronic Data System (EDS) Provider Enrollment Process

a. Provider Enrollment Packet

EDS is the fiscal agent for the DHS and its Medical Assistance Program. As the fiscal agent for the DHS, EDS assigns provider numbers to eligible providers, provides billing

software, provides technical assistance and support, verifies recipient eligibility, processes claims, provides remittance advices on claims reconciliation and provides training for billing activities. After an LEA completes the interagency provider agreement with DHS and its application is approved, it must enroll as a provider with EDS by requesting a Provider Enrollment packet from EDS. Provider Enrollment packets can also be accessed on the DHS website at: www.dhs.ri.gov/secure/logon/do

Providers can contact EDS for the following information by calling 784-8100 for local and long distance calls or by calling 1-800-964-6211 for in-state toll calls or border community calls:

- Provider Enrollment Packet (including LEA Linkage Form)
 - Provider enrollment form
 - W-9 Form
 - Electronic Data Interchange Agreement (TPA)
 - Provider Agreement Form: Addendum 1 and Addendum 2
 - Electronic Funds Transfer (EFT) Form.
- Electronic Data Interchange Trading Partner Agreement (TPA)
- A copy of the HIPAA compliant Provider Electronic Solutions Software (PES)
- A copy of the Recipient Eligibility Verification System (REVS) User Guide
- The Rehabilitation Provider Manual (this is available on the DHS web site at www.dhs.ri.gov/dhs/heacre/provsvcs/manuals/rehab/rehabtoc.htm)

The provider enrollment packet must be submitted to EDS and approved by DHS *before* an LEA submits claims for reimbursement. EDS will enroll each LEA and assign two billing provider numbers to be used when submitting claims:

- **Individual Provider Number** is used to claim services provided by individuals employed by the LEA.
- **Group Provider Number** is used to claim services provided by individuals contracted by the LEA.

An LEA uses its individual provider number as the billing provider number and leaves the “performing provider” field blank when submitting claims for services provided by its personnel. An LEA uses its group provider number as the billing provider number *and* uses the performing provider number assigned to the contracted provider in the “performing provider” field when submitting claims for services provided by contracted providers.

b. Electronic Data Interchange Trading Partner Agreement (TPA)

Effective October 16, 2003, all Medicaid providers, including LEAs, must utilize HIPAA compliant software. Providers may use EDS’ free software, Provider Electronic Solutions (PES), or another software that has completed testing with EDS. Another component for HIPAA compliance is the completion of an Electronic Data Interchange (EDI) Trading Partner Agreement.

Each billing provider, clearinghouse, or billing service who will directly exchange electronic data with EDS **must** complete and sign the Trading Partner Agreement (TPA). Once an LEA forwards a TPA to EDS, EDS will then forward an ID and a password for usage to access information on the DHS web portal. The web portal can be utilized to send claims, receive remittance advices, verify recipient eligibility verification, check on claims status, or to check a message center and to verify remittance payment.

An LEA must list its Individual *and* Group Billing Provider numbers on its TPA. RI Medicaid providers who utilize a Third Party to exchange data with EDS, must identify the transactions that the Third Party is authorized to perform on their behalf, and indicate consent by an authorized signature on the TPA. Providers who do not exchange electronic data directly with EDS are not required to complete a TPA.

If an LEA contracts with a billing company that will share or receive information electronically with EDS, then the billing company needs to complete a TPA and the LEA needs to sign it in the appropriate place. It is possible that an LEA, a billing company or both will have a signed TPA on file with EDS. If you have any questions about completing the TPA, please contact the EDI HIPAA Coordinator at (401) 784-3817.

1. LEA Instructions for Completing a Trading Partner Agreement

Original signatures are required on any TPA sent to EDS. Photo copied or faxed agreements *will not* be accepted. Information for completing the TPA (See Attachment E for a TPA form):

- Page 1 (Provider’s Full Name): fill in the name of the LEA (trading partner).
- Page 2 (2.2): fill in the LEA’s (trading partner’s) information
- Page 4 (6.1): Please check one if the LEA will be submitting claims or leave blank if the LEA is just signing up for eligibility verification.
- Page 5 (Check off all that apply): LEAs or their billing companies can check off the following:

Yes	837 Professional	Yes*	277 Unsolicited Claim Status
N/A	837 Institutional	Yes	997 Functional Acknowledgement
Maybe	837 Dental	Yes*	835 Remittance Advice
Yes	270 Eligibility Inquiry	Yes	271 Eligibility response
Yes	276 Claim Status Inquiry	N/A	NCPDP 1.1 Batch Pharmacy Claim response
N/A	NCPDP 5.1 Batch		

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

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

claims reports. If the billing company will have access to this information, then the TPA filled out by the billing company will have these items checked off. EDS will continue to generate paper versions of the Remittance Advice.

LEAs utilizing billing companies, may want to execute a TPA for eligibility verification capabilities. If an LEA fits in this category, please complete the TPA and check off 270 Eligibility Inquiry and 271 Eligibility Response.

- Page 5: Specify software: Unless the LEA or its billing company has created or purchased new HIPAA compliant software, the Provider Electronic Solutions should be checked.
- Page 5: Method of transmission: The LEA needs to list any and all methods of transmission for the activities, e.g., Internet, website, modem, or DSL
- Page 6: list the person who should be contacted if there is a problem with an electronic claim being transmitted.
- Page 6: for LEAs with two billing numbers, please list the assigned group provider number and the assigned individual provider number separately. An LEA must sign the authorized signatures in the section, *even if* the LEA contracts with a billing company to submit its claims.
- Page 7: the trading partner (the LEA or its billing company) must sign here.

c. LEA Linkage Process

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

Local Education Agency Linkage Form

If an LEA contracts with a psychologist, physical therapist or day or residential program etc. and wants to seek reimbursement for these or any contracted services, then the LEA needs to initiate the enrollment and/or linkage of the contracted provider. To accomplish this, both the LEA and the contracted provider need to complete the LEA Linkage Form (see Addendum F).

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

While it is permissible to photocopy the form and fill in standard information, the signatures must be original and the form must be dated. Any forms submitted without original signatures or improperly dated will not be processed.

E. Eligibility Verification

There are two processes for Medicaid Providers to verify recipient Medicaid eligibility. These include: (a) the Recipient Eligibility Verification System (REVS) maintained by EDS; and (b) the eligibility verification available through the DHS web portal.

a. REVS

To verify eligibility through the REVS, an LEA needs its provider number, the dates of service being verified, (up to 365 days from date of service), and the student's Medical Assistance Identification (MID) number, which is usually the recipient's social security number.

The REVS User Guide developed by EDS is available to assist providers in using the REVS using a touch-tone phone to verify eligibility. The following key points about using REVS have been taken from The REVS User Guide and should provide the basic information needed to verify eligibility for Medical Assistance through the REVS.

How to access REVS via a Touch-Tone Phone:

- REVS phone allows providers 5 transaction per phone call
 - Call or 1-401-784-8100 for local or long-distance calls
 - Call 1-800-964-6211 for in-state toll or border state community calls

Entering and Receiving Information:

- Security access is provided by the provider's 7 digit provider number
- To enter letters in a provider number-
 - Press the asterisk key followed by two numbers representing the placement and position of letters on the touch-tone keypad.
 - For example, A is entered by pressing *21, B is entered by pressing *22, C is entered by pressing *23, D is entered by pressing *31...
 - Q is assigned *11
 - Z is assigned *12
- To enter a 7 digit provider number containing letters and numbers-
 - Enter each digit, ending with the pound key (#)
 - Provider number CF00001 is entered as: *23 *33 00001#
 - Provider number EG00002 is entered as: *32 *41 00002#
 - Provider number WD00003 is entered as: *91 *31 00003#
- To enter dates of service
 - MMDDYY format used followed by a pound key (#) e.g. March 31, 2004 is entered as 033104#
 - # Key is used to enter current date as date of service

- Use of pound (#) key
 - Used to mark end of data just entered, e.g. provider number or date of service
 - Used to tell system to reuse data previously entered for a specific prompt, e.g. recipient MID number
 - Used to repeat a prompt
- Use of asterisk (*) key
 - Used to repeat a prompt at an options menu or main menu prompt
 - Used to enter letters into the system
 - Double asterisk (**) used to erase information entered incorrectly and to replace it with the correct information

b. DHS Web Portal Eligibility Verification System

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

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

- Complete a TPA and select 270 Eligibility Request and 271 Eligibility Response
- Receive a Trading Partner ID and password from EDS
- Access the DHS web site at: www.dhs.ri.gov
- Select "MMIS Web Transactions"
- Enter their Trading Partner ID and password
- Choose from the list of options that appear (these will vary and depend on those selected on the TPA)
- Select "Eligibility"

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

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

F. Medicaid Matching System

In March 2004, EDS began a process that provides LEAs (or their billing agencies) the Medical Assistance Identification Number of identified students. This process will be executed 3 times per year in March, July, and November. All LEA's interested in participating in the data match for a period will be required to submit files prior to a pre-defined deadline. The LEA will submit their request by the 15th of the month and EDS will process and return the information to the LEA by the end of the same month. If the requested submission date was missed one month, then the LEA would need to wait until the next request date to submit information to EDS.

Below is a summary of the process for LEA Data Match. In order to access information from EDS to provide a Medicaid match for eligible students, an LEA needs to have a signed provider agreement on file with DHS as well as having up to date certification of funds letters on file with DHS. The Data Match will be used to provide LEAs with the Medical Assistance Identification Number of clients; however this will not be a guarantee of eligibility. It is still the provider's responsibility to ensure their students are eligible for services rendered. Eligibility can be verified using either the Recipient Eligibility Verification System (REVS) or through the new Web Eligibility Inquiry System processes described in section E-"Eligibility Verification".

On a CD or diskette please send the following information in a comma or tab-delimited text file:

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

Below are some notes about the file you should send:

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

EDS will process the file against the MMIS Recipient Data evaluating each record for an exact match based on recipient first name, last name, and date of birth. For each record with a match, the following information will be written to a text file and returned to the submitter on CD:

- Recipient Last Name
- Recipient First Name

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

For more information about this process, please contact Karen Richard at EDS by calling at (401) 784-3888 or by e-mailing at: Karen.Richard.eds.com

G. Rehabilitation Provider Manual

The Department of Human Services has provider manuals designed for all Medical Assistance Providers. The manual that should be referenced for LEAs is the Rehabilitation Provider Reference Manual. The section on special education can be found in pages 300-70-14 through 300-70-19. Copies of this manual are available from the DHS web site at www.dhs.ri.gov/heacre/provsvcs/manuals/rehab/rehabtoc.htm

Highlights of the information in the provider manual include:

- **Preface Information:** This section contains the general Table of Contents, a Desk Reference Guide of DHS and EDS addresses and telephone numbers, and a list of acronyms and abbreviations used in the Medical Assistance Program.
- **Program Information:** This section contains general information about the Medical Assistance Program, including provider and recipient information.
- **General Billing Information:** This section explains the basic standards required for EDS' processing of billing forms.
- **Claim Preparation Instructions:** This section contains claim form completion instructions for specific provider types.
- **Remittance Advice Reconciliation:** This section contains information about claims reconciliation.

IV. DIRECT SERVICES CLAIMING

A: Free Care Principle

An important requirement within Medicaid is the issue of “free care.” Under the free care principle, Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. An important exception to the free care requirements are services provided through IDEA. Section 1903 (c) of the Social Security Act prohibits the Department of Health and Human Services from refusing to pay or otherwise limiting payment for services provided to children with disabilities that are funded under the IDEA through an IEP or IFSP.¹² LEAs are able to submit claims for reimbursement from Medical Assistance for Medicaid beneficiaries even though they do not charge children/families for services provided through Special Education. Although services are exempt from the free care rule, LEAs still need to pursue any liable third party insurers.¹³

B. Third Party Liability (TPL)

Under Medicaid law and regulations, Medicaid is generally the payer of last resort. A third party is any individual, entity or program that is or may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services. Congress intended that Medicaid pay for health care only after a beneficiary’s other health care resources were accessed.¹⁴ Even though services provided through IDEA are exempt from the free care principle, LEAs must comply with TPL policies. What this means for LEAs in Rhode Island, is that districts or their billing companies must submit a claim to a third party insurer. If the district receives a denial of payment from the third party insurer for the claim, then the district or its billing company can submit the claim to EDS for payment. There are exceptions to the provisions of Medicaid as the payer of last resort that allows Medicaid to be the primary payer to another Federal or Federally funded program and these include Medicaid-covered services listed on a Medicaid eligible child’s IEP/IFSP. Medicaid will pay primary to IDEA.¹⁵

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

¹² OpCit, Medicaid and School Health, 1997 Free Care

¹³ Ibid, TPL

¹⁴ Ibid

¹⁵ Ibid, Exceptions to Medicaid as Payer of Last Resort

C. Claims Preparation Activities

a. Pre-Claiming Activities

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

- Designate a person responsible for Medicaid activities
- Medicaid activities include
 - Creating provider log forms
 - Providing staff training
 - Completing LEA/DHS Provider Linkage Forms and returning to EDS for processing
 - Verifying student Medicaid eligibility (through REVS or Web Portal)
 - Creating a system for filing and securing records
 - Identifying reimbursable services through IEP reviews
 - Establishing a system for log collection (usually on a monthly basis)
 - Requesting tuition breakdown from day and residential program providers of educational costs, treatment costs and room & board costs, if appropriate, (refer to pages 49-52 for more detailed information about tuition breakdown)
 - Requesting monthly attendance reports from day and residential program providers
- LEAs may choose to contract with a billing company that will provide some or all of these activities

b. Use of Billing Companies

LEAs that contract with billing companies to submit claims on their behalf should be aware that the LEA is liable for those claims submitted by the billing company. Please note the following taken from page 200-10-2 of the Rehabilitation Provider Manual:

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

c. Record keeping Requirements

LEAs must adhere to record keeping requirements prescribed by the Department of Human Services in conjunction with the Centers for Medicare and Medicaid Services (CMS) for records used to support a Medicaid claim.

The following items are required by DHS and CMS of LEAs for records that support Medicaid claims:

- LEAs must maintain any records used to support a Medicaid claim for *at least 7 years* from date of service
- The records to be maintained include:
 - Copies of Individualized Education Programs (IEPs)
 - Student attendance records (students must be marked present for dates of service that a claim is being submitted)
 - Signed Provider logs or contact sheets
 - Providers must sign their logs
 - Supervisors of paraprofessionals *and* the paraprofessional must sign a paraprofessional's log
 - Completed evaluations
 - Yearly tuition breakdown for day and residential programs
 - Invoices
 - Treatment or care plans
 - Progress notes
- Auditors will verify any records used to support a claim and they could recommend a disallowance of a claim if any piece of information is missing e.g. attendance records, provider logs, IEP in effect for date of service

d. Provider Log Guidelines

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

Provider Log Recommendations:

- Create user-friendly log sheets (including color-coding by month)
- Include staff in the design process
- Use duplicate forms
- Establish cycle for logs returned to central office (monthly, quarterly...)

- Provide staff training for completing logs
- Decide how to file the logs e.g., by service provider, by service, by student records
- It is recommended that logs be created for individual students in adherence to confidentiality requirements of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA)
- If a log contains information about more than one confidentiality, student's identifiable information must be whited out if the log is accessed by someone who does not have the right to view that student's information without an appropriate signed release form.

Minimum information required by DHS and CMS:

- Service Provider
- Type of service
- Length of encounter (e.g. minutes, day)
- Student's name
- Date of service
- Provider signature
 - Includes supervisor signature for paraprofessional logs
- Progress notes (these may be included on the log or as part of a separate record)
 - Progress toward annual goals of the IEP will be created as often as parents are regularly informed (through such means as periodic report cards), at least as often as parents are informed of their non-disabled children's progress.

e. Claiming Activities

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

- Verify student Medicaid eligibility
 - Staff can verify eligibility through the REVS via telephone
 - Staff can verify eligibility through the DHS Web Portal via computer
- Transfer log information to claim form
- Submit claims within 365 days of the date of service (EDS processes claims approximately every two weeks)
- Develop a system for the dissemination and collection of logs to and from school staff and/or contracted providers
- Ensure contracted providers are enrolled and linked to the LEA's group number (please refer to Section III (D) (c) LEA Linkage Process, p. 12)
- Provide training to staff on how to complete service logs
- A system for submitting claims to EDS should be established
- Claims can be submitted daily, weekly or monthly basis
- Processing timeline is determined by when claims are received by EDS

- Services supported through other federal funds, e.g. IDEA cannot be submitted for reimbursement
- The LEA needs to identify services provided through federal grants and ensure that these are not submitted for reimbursement. For example, if IDEA Part B funds are used to support the salary of a Speech-Language Pathologist (SLP), then a district cannot submit claims for services provided by this SLP.
- LEAs should submit claims for services actually provided to the child. (Although it is possible that the LEA may pay for services not provided to the child through a contract with e.g. a nursing agency or a day or residential treatment, claims may be submitted for only those services received by the child.)

f. Span Date Policy

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

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

Span Date Policy for Day or Residential Services: To span date within a calendar month for services where units are based on days in attendance, list the first day of the month as the “from” date of service and the last day of the month as the “through” date of service e.g., 03012004 through 03312004. For the number of units, fill in the number of days the child was **in attendance** for that program for that calendar month. Even though a district may pay the full tuition *regardless* of days in attendance for 180-day, 230-day or 365-day programs, Medicaid will reimburse only for those services *provided* to the eligible student. If a child is absent from a day, or residential program for even one day, the district cannot submit for the entire month, it can only submit for the actual days the child was in attendance.

Span Date Policy for Distinct services: To span date within a calendar month for services whose units are based on 15 minute units, half-hour units, hour units, or completed service units, the “from” and “through” date of service must be for consecutive days for the same procedure code. These services include case management, nursing, therapy services, assistive technology services, personal care services, child outreach services and counseling services.

D. Claims Reconciliation Activities

An important element in maintaining a Medicaid billing system is the reconciliation of claims submitted for payment. Claims submitted for payment to the Medicaid Management Information System (MMIS) are paid, denied or suspended. All providers *should* reconcile their claims to the claims reconciliation information contained in their Remittance Advices (RAs),, which is processed twice a month.

RAs are generated for every provider that has claims processed in a cycle. Active providers will receive an RA in each claims cycle. Paper RAs are mailed to providers. RAs can be accessed on the DHS web site for those providers **OR** their billing companies as authorized through an Electronic Data Interchange Trading Partner Agreement. (Please refer to Section III, D b on page 10.)

Claims Reconciliation Guidance:

- Paid claims *should not* be resubmitted (the system will deny payment as a “duplicate claim”)
- Denied claims *may be* resubmitted with the corrected information and will be considered a new claim
- If an LEA determines that a claim has been paid incorrectly, then it must complete and submit either a *Single or a Multiple Claims Adjustment Form* (see Addendum I)
- LEAs should monitor any suspended claims, waiting for them to pay or deny before reconciling or resubmitting with corrected information. If claims suspend for several months, then the LEA should contact a provider representative at EDS.

More detailed information about claims reconciliation can be referenced in the Rehabilitation Provider Manual. EDS also mails Provider Updates monthly, typically with the first RA of the month. Provider Updates can be accessed on the DHS web site at: www.dhs.ri.gov/dhs/heacre/provsvcs/mprvlib.htm. These updates include important information for providers that can include billing and reconciliation policy as well as provider training opportunities.

**V.
SERVICES:
DEFINITIONS
AND
RECORD KEEPING GUIDELINES**

Special Education Medicaid Reimbursable Services

LEAs may submit claims for certain services as authorized by the DHS. The Individual Education Program (IEP) Team identifies the need for most of these services. The exceptions include the following: an evaluation identified as reimbursable by DHS that is used to determine initial eligibility for special education is an allowable claim; certain expanded behavioral health services identified outside the IEP process are reimbursable. These behavioral health services include individual and group counseling sessions provided by a psychologist, social worker or a guidance counselor. The following is a list of services that can be submitted for reimbursement. The section following this list covers qualified personnel, service definitions and record keeping requirements for all reimbursable services.

<p>Physical Therapy: Physical Therapy Evaluation Individual therapy w/Licensed Therapist Program (individual) Program-Group</p> <p>Occupational Therapy: Occupational Therapy Evaluation Individual therapy w/Licensed Therapist Program (individual) Program-Group</p> <p>Speech, Hearing and Language Therapy: Speech, Hearing, Language Evaluation Individual w/Licensed Therapist Program (individual) Program-Group</p> <p>Psychological Evaluations: Psychiatric Evaluation Psychological Evaluation Social Worker Evaluation</p>	<p>Psychological Counseling: Psychiatric Individual Counseling Psychological Individual Counseling Social Worker Individual Counseling Guidance Counselor Individual Counseling Counseling Services-Group</p> <p>Expanded Behavioral Health Psychiatric Individual Counseling Psychological Individual Counseling Social Worker Individual Counseling Guidance Counselor Individual Counseling Counseling Services-Group</p> <p>Nursing Services</p> <p>Day Program Treatment</p> <p>Residential Treatment Program</p> <p>Transportation</p> <p>Non-Medical Case Management</p> <p>Medical Case Management</p> <p>Personal Care Attendant</p> <p>Assistive Technology Device</p> <p>Assistive Technology Service</p> <p>Child Outreach Screening</p> <p>Child Outreach Re-screening</p>
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Physical Therapy Service Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Physical Therapy Service Definitions:

Physical Therapy

Physical Therapy means services provided by a licensed Physical Therapist or by a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.¹⁶

[Rhode Island Board of Regents for Elementary and Secondary Education Regulations Governing the Education of Children with Disabilities, Section 300.24 (b) (8)]

Physical Therapy Evaluation

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

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

Individual Physical Therapy w/Licensed Physical Therapist

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

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

Individual Physical Therapy Program

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

- A Physical Therapy Assistant (PTA) working under the supervision of the licensed Physical Therapist provides individual therapy to a student.
- The individual therapy needs to last the minimum time required by DHS for this service.

¹⁶ OP Cit, RI Regulations §300 24 (b)

- The child is Medicaid eligible.
- The need for services is documented in the child's IEP.

Physical Therapy Program-Group

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

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

Physical Therapy Record Keeping Requirements:

Evaluations

- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations.
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- A log indicating the time the therapist spent with the student (time to write the evaluation report is calculated in the rate) needs to be maintained.
- Copies of staff licensure are maintained.
- All records used to support a claim must be maintained not less than 7 years.

Individual *or* Small Group Services Provided by the Therapist

- The need for Physical Therapy must be documented in the child's Individualized Education Program (IEP).
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (evaluation, individual session, small group therapy, case management)
 - Length of service in minutes
 - Provider signature
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA.
- Student attendance records
- Copies of staff licensure are maintained.
- All records used to support a claim must be maintained not less than 7 years.

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

- The need for Physical Therapy services must be documented in the child's Individualized Education Program (IEP).
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of service in minutes (or unit)
 - Provider signature *and* the provider logs must be signed by the supervising licensed Physical Therapist
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- Student attendance records
- Copies of staff licensure are maintained, where appropriate.
- All records used to support a claim must be maintained not less than 7 years.

Occupational Therapy Service Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Occupational Therapy Service Definitions:

Occupational Therapy

Occupational Therapy are services provided by a licensed Occupational Therapist or by a Certified Occupational Therapy Assistant (COTA) under supervision of a licensed Occupational Therapist and includes: improving, developing or restoring functions impaired or lost through illness, injury or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; and preventing, through early intervention, initial or further impairment or loss of function.¹⁷

Occupational Therapy Evaluation

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

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

Individual Occupational Therapy w/Licensed Occupational Therapist

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

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

Individual Occupational Therapy Program

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

- A Certified Occupational Therapy Assistant (COTA) working under the supervision of

¹⁷ Ibid §300.24(b) (5)

- the licensed Occupational Therapist provides individual therapy to a student.
- The individual therapy lasts the minimum time required by DHS for this service.
 - The child is Medicaid eligible.
 - The need for services is documented in the child's IEP.

Occupational Therapy Program-Group

This service is reimbursable when *either* a licensed Occupational Therapist *or* Certified Occupational Therapy Assistant (COTA) provides therapy in a small group setting. A claim for group therapy can be made for each Medicaid eligible student in the group. A claim for reimbursement from Medicaid can be made when the following criteria are met:

- The group therapy lasts the minimum time required by DHS for this service.
- The child is Medicaid eligible.
- The need for services is documented in the child's Individualized Education Program (IEP).

Occupational Therapy Record Keeping Requirements:

Evaluations

- A log indicating the time the therapist spent with the student (time to write the evaluation report is calculated in the rate)
- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations.
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained
- Copies of staff licensure are maintained.
- All records used to support a claim must be maintained not less than 7 years.

Individual *or* Small Group Services Provided by the Therapist

- The need for Occupational Therapy services must be documented in the child's Individualized Education Program (IEP).
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (evaluation, individual session, small group therapy, case management)
 - Length of service in minutes (or unit)
 - Provider signature
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA.
- Student attendance records
- Copies of staff licensure are maintained.
- All records used to support a claim must be maintained not less than 7 years.

Individual *or* Small Group Services Provided by an Appropriately Credentialed Paraprofessional Working Under the Supervision of the Therapist (e.g. Certified Occupational Therapy Assistant (COTA))

- The need for Occupational therapy services must be documented in the child's Individualized Education Program (IEP).
 - Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (evaluation, individual session, small group therapy, case management)
 - Length of service in minutes (or unit)
 - Provider signature *and* the provider logs must also be signed by the supervising licensed Occupation Therapist
 - Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA.
 - Student attendance records
 - Copies of staff licensure are maintained, where appropriate.
 - All records used to support a claim must be maintained not less than 7 years
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Speech And Hearing And Language (SHL) Therapy Service Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Speech Hearing and Language (SHL) Therapy Service Definitions:

Speech Hearing and Language Services

Includes: identification of children with speech or language impairments; diagnosis and appraisal of specific speech or language impairments; referral for medical or other professional attention necessary for the habilitation of speech or language impairments; provision of speech and language services for the habilitation or prevention of communicative impairments; and counseling and guidance of parents, children and teachers regarding speech and language impairments.¹⁸

Speech Hearing and Language Evaluation

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

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

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

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

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

Individual Speech Hearing and Language Program

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

¹⁸ Ibid §300.24 (b) (14)

- A paraprofessional working under the supervision of a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education, or a Speech-Language Pathologist licensed by the Rhode Island Department of Health provides an individual speech or hearing session to a student. This includes individuals who have received emergency certification as a school Speech-Language Pathologist from RIDE per RIGL 16-25.3-2
- The individual therapy needs to last the minimum time required by DHS for this service.
 - The child is Medicaid eligible.
 - The need for service is documented in the child's Individualized Education Program (IEP).

Speech Hearing and Language Therapy Program/Group

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

- Speech Hearing and Language therapy is provided in a small group setting by a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education, or a Speech-Language Pathologist licensed by the Rhode Island Department of Health *or*
- Speech Hearing and Language therapy is provided in a small group therapy by a paraprofessional working under the supervision of a Speech-Language Pathologist certified by the Rhode Island Department of Elementary and Secondary Education, or under the supervision of a Speech-Language Pathologist licensed by the Rhode Island Department of Health. This includes individuals who have received emergency certification as a school Speech-Language Pathologist from RIDE per RIGL 16-25.3-2.
 - The group therapy needs to last the minimum time required by DHS for this service.
 - The child is Medicaid eligible
 - The need for service is documented in the child's Individualized Education Program (IEP).

Speech and Language Therapy Record Keeping Requirements:

Evaluations

- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations.
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- A log indicating the time the therapist spent with the student (time to write the evaluation report is calculated in the rate).
- Copies of staff licensure or certification are maintained.
- All records used to support a claim must be maintained not less than 7 years.

Individual *or* Small Group Services Provided by the Therapist

- The need for Speech Hearing and Language services must be documented in the child's IEP.
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (evaluation, individual session, small group therapy, case management)
 - Length of service in minutes (or unit)
 - Provider signature
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA.
- Student attendance records
- Copies of staff licensure or certification are maintained.
- All records used to support a claim must be maintained not less than 7 years.

Individual *or* Small Group Services Provided by an Appropriately Credentialed Paraprofessional Working Under the Supervision of the Speech Language Pathologist

- The need for Speech Hearing and Language services must be documented in the child's Individualized Education Program (IEP).
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (evaluation, individual session, small group therapy, case management)
 - Length of service in minutes (or unit)
 - Provider signature *and* the provider logs must also be signed by an appropriately credentialed Speech-Language Pathologist
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA.
- Student attendance records
- All records used to support a claim must be maintained not less than 7 years.

Evaluations Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Definition of Evaluation Services:

Evaluation services include administering psychological and educational tests, interpreting assessment results; obtaining, integrating, and interpreting information about child behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies as they relate to the child's learning.¹⁹

Psychiatric Evaluation by an MD

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

- A board certified MD provides a psychological evaluation.
- It is an individual service.
- The evaluation needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- The evaluation is used to determine eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services.

Record keeping requirements:

- Child's Individualized Education Program (IEP)
- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- Copies of staff licensure or certification are maintained
- Child's attendance records
- Provider signature

Psychological Evaluation by a Clinical Psychologist or a Certified School Psychologist

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

- A Clinical Psychologist or a Certified School Psychologist provides a psychological evaluation.
- It is an individual service.
- The evaluation needs to last the minimum time required by DHS
- The child is Medicaid eligible.

¹⁹ Rhode Island Board of Regents for Elementary and Secondary Education Regulations Governing the Education of Children with Disabilities, Section 300.24 (b) (9)

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

Record keeping requirements:

- Child's Individualized Education Program (IEP)
- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations.
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- Copies of staff licensure or certification are maintained
- Child's attendance records
- Provider signature
- All records used to support a claim must be maintained not less than 7 years

Social Worker Evaluation by a Social Worker

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

- A LICSW or a Certified School Social Worker provides a clinical assessment or Mental Health evaluation..
- It is an individual service.
- The evaluation needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- The evaluation is used to determine eligibility for special education or related services or
- The evaluation is a re-evaluation to determine continued eligibility for special education or related services.

Record keeping requirements:

- Child's Individualized Education Program (IEP)
- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- Copies of staff licensure or certification are maintained
- Child's attendance records
- Provider signature
- All records used to support a claim must be maintained not less than 7 years

Counseling Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Definition of Counseling Services:

Counseling services include administering psychological and educational tests, interpreting assessment results; obtaining, integrating, and interpreting information about child behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies as they relate to the child's learning.²⁰

A psychiatric; certified school psychologist, licensed clinical psychologist, a certified school social worker, a licensed social worker or a certified school guidance counselor may provide counseling as identified through the IEP process in individual or small group sessions.

Individual Psychiatric Counseling by a Psychiatrist

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

- A Psychiatrist provides an individual psychiatric counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service

Record Keeping Requirements:

- Child's Individualize Education Program (IEP)
- Child's attendance records
- Provider's logs must be maintained and included the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
- Provider signature
- Copies of staff licensure is maintained
- Progress toward annual goals of the IEP will be created as often as parents are regularly informed (through such means as periodic report cards), at least as often as parents are informed of their non-disabled children's progress

²⁰ Ibid

Individual Psychological Counseling by a Clinical Psychologist or Certified School Psychologist

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

- A Clinical Psychologist or a Certified School Psychologist provides an individual psychological counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individualized Education Program (IEP)
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA

Individual Social Worker Counseling by a Licensed Social Worker or Certified School Social Worker

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

- A LICSW or a Certified School Social Worker provides an individual counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individualized Education Program (IEP)
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- All records used to support a claim must be maintained not less than 7 years

Individual Guidance Counselor Counseling

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

- A Certified School Guidance Counselor provides an individual counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individualized Education Program (IEP)
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- All records used to support a claim must be maintained not less than 7 years

Small Group Counseling

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

- A Psychiatrist, Clinical Psychologist, Certified School Psychologist, Licensed Social Worker, Certified School Social Worker, or Certified School Guidance Counselor provides a group counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- A claim for group therapy can be made for each Medicaid eligible student in the group.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements

- Child's Individualized Education Program (IEP)
- Child's attendance records
- Provider logs must be maintained and include the following information:

- Student's name
- Date of service
- Type of service (individual session, group therapy, case management)
- Length of encounter in minutes (or unit)
- Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- All records used to support a claim must be maintained not less than 7 years

Expanded Behavioral Health Counseling Services and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Definition of Expanded Behavioral Health Services:

Expanded Behavioral Health Counseling includes administering psychological and educational tests, and other assessment procedures; interpreting assessment results; obtaining, integrating, and interpreting information about child behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies.²¹

A Psychiatrist, Certified School Psychologist, Clinical Psychologist, a Certified School Social Worker, a LICSW or a Certified School Guidance Counselor may provide individual or small group counseling as identified through a Treatment Plan. (Refer to Addendum K for a sample Treatment Plan)

Expanded Behavioral Health Individual Psychiatric Counseling by a Psychiatrist

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

- A Psychologist provides an individual psychiatric counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individual Education Program (IEP)
- Child's Individual Treatment Plan
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes are maintained
- All records used to support a claim must be maintained not less than 7 years

Expanded Behavioral Health Individual Psychological Counseling by a Clinical Psychologist or Certified School Psychologist

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

²¹ Ibid

- A Clinical Psychologist or a Certified School Psychologist provides an individual

psychological counseling session.

- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the services.

Record Keeping Requirements:

- The Child's Individual Education Program (IEP)
- The Child's Individual Treatment Plan
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group counseling, case management)
 - Length of encounter in minutes (or unit)
- Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes are maintained
- All records used to support a claim must be maintained not less than 7 years

Expanded Behavioral Health Individual Social Worker Counseling by a LICSW or Certified School Social Worker

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

- A LICSW or a Certified School Social Worker provides an individual counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.
- A Treatment Plan is maintained.

Record Keeping Requirements:

- The Child's Individual Education Program (IEP)
- The Child's Individual Treatment Plan
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group counseling, case management)
 - Length of encounter in minutes (or unit)
- Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes are maintained

Expanded Behavioral Health Individual Guidance Counseling by a Certified School Guidance Counselor

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

- A Certified School Guidance Counselor provides an individual counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- Provider logs are maintained supporting the delivery of the service.
- A Treatment Plan is maintained.

Record Keeping Requirements:

- Child's Individual Education Program (IEP)
- Child's Individual Treatment Plan
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group counseling, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes are maintained
- All records used to support a claim must be maintained not less than 7 years

Expanded Behavioral Health Small Group Counseling

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

- A Psychiatrist, Clinical Psychologist, Certified School Psychologist, Licensed Social Worker, Certified School Social Worker, or Certified School Guidance Counselor provides a group counseling session.
- The counseling session needs to last the minimum time required by DHS.
- The child is Medicaid eligible.
- A claim for group therapy can be made for each Medicaid eligible student in the group.
- Provider logs are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individual Education Program (IEP)
- Child's Individual Treatment Plan
- Child's attendance records
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service

- Type of service (individual session, small group therapy, case management)
- Length of encounter in minutes (or unit)
- Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes are maintained
- All records used to support a claim must be maintained not less than 7 years

Nursing Services Definitions and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Nursing Services Definitions:

LEAs may submit claims for individual nursing services. Claims are for individual skilled provided to eligible students for *non-routine* services. Non-routine services include the special needs of children enrolled in special education who require tracheotomies, catheters, ventilators and medically necessary services for the medically fragile. This can include the one-to-one nursing services provided during transportation to and from school as well as the one-to-one services provided during the school day.

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

- A certified School Nurse Teacher or a registered nurse provides individual nursing services.
- The session needs to last the minimum time required by DHS.
- LEA's can bill only for the time that the nurse is providing nursing care to the child.
- The child is Medicaid eligible.
- Provider logs including physician's orders are maintained supporting the delivery of the service.

Record Keeping Requirements:

- Child's Individualized Education Program (IEP) and/or Individual Health Plan (per RI School Health Regulations)
- Child's attendance records
- Physician's Orders
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of RN licensure are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- All records used to support a claim must be maintained not less than 7 years

Day Program Treatment Definition and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Day Program Treatment Definition:

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

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

- The yearly tuition for the program *and*
- A breakdown of the daily cost of the program (known as tuition) into daily educational costs *and* into daily treatment costs

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

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days or 230 days, this amount equals the daily rate.
- The daily rate then needs to be broken down into “daily treatment costs” and “daily educational costs”.
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following activities:
 - Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services
- This daily treatment rate is the rate used for reimbursement of this service.
- Educational costs, *which are not reimbursable*, include the cost for the following activities:
 - Cost related to the development of the content, methodology or the delivery of specially designed instruction, including materials, staff salaries and benefits.

The school district must also request from the Day Program Provider monthly attendance reports for each calendar month a student attends the Day Program. The district may only submit claims for the number of days within each calendar month that a child attends the Day Program. The district may span date for the entire calendar month and use for units the total number of days the child attends the program that month.

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

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

- A certified day program provide services as identified by the child's IEP.
- The child is Medicaid eligible.
- Invoices describing the tuition break down are maintained.
- Child's attendance records are maintained.

Day Program Record keeping Requirements:

- Child's Individualized Education Program (IEP)
- Daily tuition rates (broken down by treatment and educational costs)
- Monthly attendance reports
- Purchasing orders or invoices
- Provider Logs for documentation when services are provided in addition to those as part of the regular day program e.g. nursing, personal care services or additional therapies
 - Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
 - Copies of staff licensure or certification are maintained
 - Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA

Residential Treatment Definition and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Residential Treatment Definition:

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

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

- The yearly tuition for the program *and*
- A breakdown of the daily cost of the program (known as tuition) into daily educational costs *and* into daily treatment costs *and* into daily room and board costs

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

- Divide the total yearly tuition amount by the total number of days of the program e.g. 180 days, 230 days or 365 days; this amount equals the daily rate.
- The daily rate then needs to be broken down into “daily treatment costs”, “daily educational costs” and “daily room and board costs”.
- Treatment costs to be taken into consideration when assigning a daily treatment rate include the cost of the following activities:
 - Physical therapy, occupational therapy, speech-language pathology, psychological counseling services, case management and any other services included in the basic tuition costs, e.g. nursing services, personal care services, assistive technology services
- This daily treatment rate is the rate used for reimbursement of this service.
- Educational costs, *which are not reimbursable*, include the cost for the following activities:
 - Cost related to the development of the content, methodology or the delivery of specially designed instruction, including materials, staff salaries and benefits.
- Room and board costs are those costs for providing food and shelter for the child in this program. *If* the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits a Residential Facility, *then* the costs for room and board are also reimbursable.

The school district must also request from the Residential Program Provider monthly attendance reports for each calendar month a student attends at the Program. The district may only submit claims for the number of days within each calendar month that a child attends the Program. The district may span date for the entire calendar month and use for units the total number of days the child attends the program that month. To calculate the total rate, multiply the number of days in

attendance that calendar month by the daily treatment rate. *If* the facility is JCAHO accredited, *add* the treatment rate and the room and board rate then multiply this combined rate by the number of days in attendance for that calendar month.

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

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

- A residential treatment program provides the services as identified by the child's IEP.
- The child is Medicaid eligible.
- Invoices describing the tuition break down are maintained.
- Child's attendance records are maintained.

Residential Program Record Keeping Requirements:

- Child's Individualized Education Program (IEP)
- Daily tuition rates (broken down by treatment, educational and room & board costs)
- Monthly attendance reports
- Purchasing orders or invoices
- Provider Logs for documentation when additional services are provided e.g. nursing, personal care services or additional therapies containing the following information:
 - Student's name
 - Date of service
 - Type of service (individual session, small group therapy, case management)
 - Length of encounter in minutes (or unit)
 - Provider signature
- Copies of staff licensure or certification are maintained
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA

Transportation Definition and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Transportation Definition:

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

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

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

If a child receives a Medicaid-covered IDEA service at an off-site facility during the school day, the cost of transportation from the school to the facility and back to the school would be reimbursable.²²

Record Keeping Requirements:

Documentation includes:

- The child's Individualized Education Program (IEP)
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service
 - Provider signature
 - Roundtrip transportation was provided
- Student attendance records
- All records used to support a claim must be maintained not less than 7 years

²² Op Cit. Medicaid and School Health, 1997, Transportation

Case Management Definition and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Case Management Definition:

Care coordination, including aspects of case management, has always been an integral component of the EPSDT program. The purpose of case management in the EPSDT program is to assist children in arranging and obtaining health and related services in their communities. Since EPSDT screening, diagnosis, and treatment activities are frequently not conducted at one time or in one place, case management is critical to ensure that a child receives appropriate services on a timely basis.

The Rhode Island Medical Assistance Program can reimburse LEAs for case management provided to students receiving special education and related services. Case Management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and other services appropriate to the needs of the individual. For children enrolled in RIte Care who have special health care needs, active case management of the child's medical needs and health services is provided directly by the Health Plan case management unit. In such cases, the school should not duplicate the medical case management role of the plan, but instead, the school's case manager can complement the role of the health plan case manager by providing "non-medical" case management for these children, that is, reaching beyond medical care coordination to coordinate access to/arrange a broad range of services. Schools are well situated to reach beyond the coordination of medical care, since they have access to the majority of children and adolescents on a daily basis, and can coordinate important linkages for the child and family with vocational, social, and other supportive services. Such coordination of services is essential to maximize a child's access to an array of coordinated, needed services, while preventing duplication. Among other activities, case management can be used to assist families in identifying and choosing providers, scheduling appointments, accessing transportation, maintaining records (including up-to-date assessments and evaluations), and helping families to maintain contact with providers.

Case management may be used to reach out beyond the bounds of the Medicaid program to coordinate access to a broad range of services. The following are examples of appropriate case management services:

- Assisting an adolescent whose parent is an abusive alcoholic to gain access to Alateen.
- Assisting the parents of a child who is developmentally disabled in accessing needed services.
- Providing assistance to parents in scheduling appointments for a child with a severe health problem.
- Assisting in coordinating and arranging for services for an adolescent whose parent has experienced domestic violence.

Claims should be fully documented and should include date of service, name of recipient, nature, extent or units of service and place of service.²³

²³ Ibid Case Management

The following is a list of frequently misunderstood services that are **not** acceptable Case Management Services:

- Assessment costs for determining the individual's need for a physical or psychological examination or evaluation;
- The provision of any medical treatment or service;
- Discharge planning from an institution (this is already required as a condition of payment of a hospital, NF and ICF/MR);
- Administrative activities such as eligibility determination, screening, intake, outreach and utilization review;
- Formal advocacy and developing new provider resources;
- Payment for the cost of the administration of other services or programs to which a recipient is referred;
- General administrative expenses of the Medicaid program; and
- Prior authorization of services²⁴

²³ Ibid Case Management

²⁴ Ibid

Case Management Record Keeping Requirements:

Case management may be submitted for reimbursement from Medicaid when the following criteria are met:

- A case manager, assigned to a student, provides the allowable activities described above in accordance with the student's IEP.
- The activities provided need to last the minimum time required by DHS for this service.
- The child is Medicaid eligible.
- The child's IEP includes case management as a service the child will receive.
- Child's Individualized Education Program (IEP) must stipulate that case management services will be provided.
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service
 - Place of service
 - Length of encounter in minutes (or unit)
 - Provider signature
- All records used to support a claim must be maintained not less than 7 years.

²⁴ Ibid

Personal Care Definition and Record Keeping Requirements

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Personal Care Definition:

Services provided by a Personal Care Attendant in the school setting and identified in a child's Individualized Education Program (IEP) include assistance with eating, personal hygiene, and other activities of daily living (including assistance provided to support the child in his/her educational setting).

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

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

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

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

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

The need for personal care services must be identified in the student's IEP. Some students may require assistance for transitioning from one area of the school to another, others may require assistance with toileting or feeding and others may require these services for the entire school day. The personal care attendant may be assigned to the student for the entire school day or may be assigned for portions of the school day, depending on the needs of the child.

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

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

Record Keeping Requirements:

- The child's Individualized Education Program (IEP)
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service
 - Length of encounter in minutes (or unit)
 - Provider signature
 - The provider logs must be signed by the person who supervises the PCA
- Progress notes for services submitted for reimbursement, when appropriate, must be maintained as often as required by IDEA
- Student attendance records
- All records used to support a claim must be maintained not less than 7 years.

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

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

a. Assistive Technology Service

Definition:

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

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

Record Keeping Requirements:

- The activities provided need to last the minimum time required by DHS for this service.
- The child is Medicaid eligible.
- The need for services is documented appropriately in the child's Individualized Education Program (IEP).
- The completed evaluation and log of the Evaluation Team must be maintained for initial evaluations.
- The completed evaluation and documentation of the IEP Team evaluation decisions must be maintained.
- Provider logs must be maintained and include the following information:
 - Student's name
 - Date of service
 - Type of service

²⁵ Op Cit, IDEA §300.6

- Describing what kind of service e.g., evaluation, repair, training...
 - Length of service in minutes (or unit)
 - Provider signature
- Progress notes for services submitted for reimbursement must be maintained as often as required by IDEA
- Student attendance records, when appropriate, for example a child does not need to be in attendance the day a device is being serviced or repaired.
- All records used to support a claim must be maintained not less than 7 years.

b. Assistive Technology Device

Definition:

An Assistive Technology Device is any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified, or customized, that is medically necessary and is used to increase, maintain, or improve the functional capabilities of children with disabilities.²⁶

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

Record Keeping Requirements:

- The child is Medicaid eligible.
- The child's Individualized Education Program (IEP) stating the need for an Assistive Technology device
- Invoice for the device must be maintained and include the following information:
 - Date of invoice
 - Type of device
 - Cost of the device
- All records used to support a claim must be maintained not less than 7 years.

²⁶ Ibid, §300.5

Child Outreach: Screening and Re-Screening

(Please refer to Addendum J for procedure code, rate and diagnosis code list.)

Service definition:

- a. Screening: All school departments in Rhode Island provide Child Outreach Screening services for children aged 3-5 years old. Trained staff provides these screenings and they assess a child's development. Screening components include hearing, vision, speech and developmental skills.
- b. Re-screening: Children are asked back for a re-screening if an area of concerns arises after the initial screening. The re-screening includes any areas of concern and is provided by trained staff.

Record Keeping Requirements:

- The activities provided need to last the minimum time required by DHS for this service.
- The child is Medicaid eligible.
- A copy of the completed screening or re-screening
- All records used to support a claim must be maintained not less than 7 years.

VI.
ROLES AND RESPONSIBILITIES
FOR
SCHOOL ADMINISTRATORS

Responsibilities for school administrators, including Superintendents, Business Managers, and Directors of Special Education may include:

- Signing the Interagency provider agreement with the Department of Human Services
- Certifying Local Funds quarterly
- Creating or selecting log forms for service providers
- Organizing/providing staff training for completion of logs
- Overseeing a system for log distribution, collection and maintenance
- Providing or arranging for IEP training to document services appropriately
- Overseeing remittance advice reconciliation
- District administrators should be aware that Medicaid revenues and expenses must be reported to the RIDE as part of district fiscal reporting requirements (e.g. In\$ite)

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

Background:

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

HIPAA

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

Electronic Transactions and Code Sets

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

Privacy Requirements

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

Security Requirements

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

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

National Identifier requirements

July 30, 2004 is the deadline for most providers and small providers have until August 1, 2005 to become compliant with this requirement. HIPAA requires that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The remaining identifiers are expected to be determined in 2003.

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

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

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

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

Specifically, Section 164.501 of the HIPAA Privacy Regulations defines *Protected Health Information* as: **need to format as a quote**

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

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

“Educational Records” FERPA 34 CFR sec. 99.3

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

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

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

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

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

LEAs that electronically transmit records that are not subject to FERPA because they do not become educational records will be subject to the Privacy Regulations and Security Regulations of HIPAA. These requirements will be explained as more information becomes available.

HIPAA DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA) of 1996: A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, K2 or Public Law 104-191.

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

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

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

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

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

**VIII.
REFERENCES
AND
KEY TECHNICAL ASSISTANCE CONTACTS**

References:

- EDS: Rehabilitation Provider Manual
- EDS: Recipient Eligibility Verification System (REVS) User Guide
- Medicaid and School Health: A Technical Assistance Guide, U.S. Department of Health and Human Services Health Care Financing Administration, 1997, Available on CMS Website at:
www.cms.hhs.gov/medicaid/schools/scbintro.asp
- Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An examination of Federal Policies, U.S Department of Health and Human Services 1991
- IEP Manual
- IEP: Process, Product and Purpose
- Rhode Island Board of Regents for Elementary and Secondary Education: Regulations Governing the Education of Children with Disabilities, December 14, 2000
- Individuals with Disabilities Education Act, as amended June 1997

Resources:

www.dhs.ri.gov
www.ritap.org
www.ridoe.net
www.ssa.gov
www.cms.hhs.gov/medicaid
www.cms.hhs.gov/hipaa/
www.medicare.gov
www.cms.hhs.gov/medicaid/schools/macguide.pdf (CMS Administrative Claiming Guide, May 2003)

Key Technical Assistance Contacts:

- Rhode Island Technical Assistance Project (RITAP):
Denise Achin, (401) 222-4600 ext. 2306, dachin@ride.ri.net
- Rhode Island Department of Human Services (DHS):
Sharon Reniere, (401) 462-2187, sreniere@dhs.ri.gov
- Electronic Data System (EDS):
Karen Richard, (401) 784-3888, Karen.Richard@eds.com

SECTION IX: ADDENDA

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

Addendum B: Department of Human Services Local Offices

Addendum C: Social Security Administration Contact Information

Addendum D: Department of Human Services Long Term Care Offices (for Katie Beckett applications)

Addendum E: Trading Partner Agreement Form

Addendum F: LEA Provider Linkage Form

Addendum G: Sample Certification of Funds Letter

Addendum H: Sample Log

Addendum I: Single Claim Adjustment form *and* Multiple Claims Adjustment Form

Addendum J: Procedure Codes, Rates and Diagnosis Codes

Addendum K: Sample Expanded Behavioral Health Care Plan and Progress Notes

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

Addendum M: Frequently use Acronyms

ADDENDUM A

Rhode Island General Law 40-8-18

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

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

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

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

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

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

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

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

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

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

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

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

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

ADDENDUM B

RI Department of Human Services (DHS) Offices

If you live in...	Local DHS Office Location	Phone Number
Coventry Cranston West Greenwich West Warwick	Cranston DHS Forand Building 600 New London Ave. Cranston, RI 02920	462-6500 Fax # 462-6504
Foster Scituate Johnston North Providence	Johnston DHS 1514 Atwood Ave Johnston, RI 02919	222-5666 Fax # 222-5684
Jamestown Newport Middletown Little Compton Portsmouth Tiverton	DHS Family Center 110 Enterprise Drive Middletown, RI 02842	849-6000 800-675-9397 Fax # 849-9066
East Greenwich North Kingstown Narragansett South Kingstown Exeter Charlestown Hopkinton Richmond Westerly New Shoreham	North Kingstown DHS 7734 Post Road North Kingstown, RI 02852	267-1030 800-862-0222 Fax # 267-1040
Central Falls Barrington Bristol East Providence Pawtucket Warren	Pawtucket DHS 24 Commerce Street Pawtucket, RI 02860	729-5400 Fax # 729-8756
Providence	Providence DHS 206 Elmwood Avenue Providence, RI 02907	222-7000 TTY 222-7032 Fax # 521-4875
Warwick	Warwick DHS 100 Meadow Street	736-6511 Fax # 737-6557

ADDENDUM B

If you live in...	Local DHS Office Location	Phone Number
	Warwick, RI 02888	
Burrillville	Woonsocket DHS	235-6300
Glocester	450 Clinton Street	800-510-6988
Smithfield	Woonsocket, RI 02895	TTY 235-6490
North Smithfield		Fax # 235-6303
Woonsocket		
Cumberland		
Lincoln		

ADDENDUM C

Social Security Administration Contact Information

Regional Social Security Offices process claims for Supplemental Security Income (SSI). SSI is a program that entitles eligible recipients for medical assistance benefits and a monthly cash benefit. There are income as well as disability criteria that an individual needs to meet in order to be determined eligible for these benefits. To find out more information about the Social Security Administration or to start an application for SSI, contact the following:

- Web site: www.ssa.gov
- Telephone
 - Toll free number 1-800-772-1213: to start an application
 - Toll-free TTY number, 1-800-325-0778: to start an application
 - Local Offices: to start an application

Social Security operates its toll-free telephone listed above from 7:00AM to 7:00PM, Monday through Friday. If you have touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. A service option includes identifying and receiving directions to your local SSA office by entering your zip code. People who are deaf or hard of hearing may call the toll-free TTY number listed above between 7:00AM and 7:00PM on Monday through Friday. It is recommended that you have your social security number handy when you call.

Local Offices:

You may call the 1-800-772-1213 toll free number or you may contact the local Social Security Office representing your town. All of the offices listed below are open for business Monday-Friday from 9:00 AM-4:00 PM.

130 Bellevue Avenue
Newport RI 02840
(401) 849-3487

380 Westminster Street
Room 318
Providence RI 02903
(401) 528-4501

55 Broad Street
Pawtucket RI 02860
(401) 724-9611

30 Quaker Lane
1st Floor
Warwick RI 02886-0111
(401) 822-1463

2168 Diamond Hill Road
Woonsocket RI 02895
(401) 766-8423

2 Shaws Cove
Room 203
New London CT 06320
(860) 443-8455

RIDE/RITAP

ADDENDUM D

DHS Offices for Katie Becket Applicants

When applying for Katie Beckett/Medicaid Assistance applicants should call their local DHS Office for their town (See list below)

If you live in...	DHS Office for Long Term Care	Phone Number
Providence North Providence	Providence Regional Family Center 206 Elmwood Ave. Providence, RI	Phone: 222-7371 Fax: 222-7333
East Providence Central Falls Pawtucket Barrington		Phone: 222-7000 Fax: 222-7333
Burrillville Clumberland Glocester Lincoln N. Smithfield Smithfield Woonsocket	Woonsocket Family Center 450 Clinton Street Woonsocket	Phone: 235-6300 Fax: 235-6479
Bristol Jamestown Little Compton Middletown Newport Portsmouth Tiverton	DHS Family Center 110 Enterprise Drive Middletown, RI 02895	Phone: 849-6000 Fax: 849-9066
Charlestown Coventry Cranston East Greenwich Exeter Foster Hopkinton Johnston Narragansett New Shoreham Richmond Scituate South Kingstown Warren Westerly West Warwick	DHS Long Term Care Benjamin Rush Bldg. #55 Howard avenue Cranston, RI 02920	Phone: 462-5182 Fax: 462-3034

If you live in...

**DHS Office for Long Term
Care**

Phone Number

Warwick

West Greenwich

ADDENDUM E

ELECTRONIC DATA INTERCHANGE TRADING PARTNER AGREEMENT

Based on the following recitals. The Rhode Island Department of Human Services (hereinafter referred to as “DHS”) it’s fiscal agent, Electronic Data Systems (hereinafter referred to as “EDS”), and

(Provider’s Full Name)

(hereinafter referred to as “the Trading Partner”), enter into this Agreement to facilitate business transactions (“Transactions”) by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents and to assure that such Transactions are not legally invalid or unenforceable as result of this use of available electronic technologies for the mutual benefit of the Trading partners.

ARTICLE I. PURPOSE

- 1.0 EDS has developed, under the state of Rhode Island Medical Assistance Program, a paperless transaction system that will process Rhode Island Medical Assistance Program electronic transactions submitted through the designated electronic media.
- 1.2 EDS is the fiscal agent for DHS and the State of Rhode island Medical Assistance Program. Although EDS operates the computer systems through which electronic transactions flow, DHS retains ownership of the data itself. Trading Partners access the pipeline network over which the transmission electronic data occurs. Accordingly, providers are required to transport data to and from EDS. Additionally, contracted vendors and/or billing services must identify the providers they represent so that proper reporting of claims processing may occur.
- 1.3 This agreement delineates the responsibilities of EDS and its Trading partners in regard to the Rhode Island Medical Assistance Program.

ARTICLE II. PARTIES

- 2.0 **STATE OF RHODE ISLAND DEPARTMENT OF HUMAN SERVICES**
600 New London Avenue
Cranston, RI 02920
- 2.1 **ELECTRONIC DATA SYSTEMS CORPORATION**
1471 Elmwood Avenue
Cranston, RI 02910

2.2 **TRADING PARTNER**

Name: _____

Address: _____

Contact Name: _____

Phone Number: _____

Email address: _____

Provider Number: _____

ARTICLE III. GENERAL PROVISIONS

3.0 **Prerequisites**

Document Standards. Each party may electronically transmit to or receive from the other party any of the transaction sets listed in this Electronic Trading Partner Agreement (TPA), and transaction sets which the parties, by written amendment agree to add to this TPA. Electronic transmission of all data (“Documents”) shall be in strict accordance with the standards set forth in this TPA and as defined by the Health Insurance Portability and Accountability Act (HIPAA)

3.1 **Third Party Service Providers**

3.1.1 Documents will be transmitted electronically to each party either directly or through a contracted third-party service provider. Either party may modify its election to use, not use or change a third-party service provider upon prior written notice to the other party to this TPA.

3.1.2 Each party shall be responsible for the costs of any third party service provider with which it contracts, unless otherwise set forth in this TPA.

3.2 **Security Procedures**

Each party shall properly institute and adhere to those security procedures including any special security procedures specified in this TPA, which are reasonably calculated to provide appropriate levels of security for the authorized transmission of documents and to protect its business records and data from improper access.

3.3 Termination

This TPA shall remain in effect until terminated by either by DHS or the Trading Partner with not less than thirty(30) days prior written notice to the other party. Such notice shall specify the effective date of termination and shall not affect the respective obligations or rights of the parties arising prior to the effective date of termination. If EDS determines that the submission of documents fails to conform to the paperless transactions specifications agreed to within thus TPA or relevant guidelines governing the submission of electronic transactions then EDS may, with the approval of DHS, terminate this TPA five (5) business days after the Trading partner has received a written termination notice for EDS. Additionally, the TPA will be terminated, with the approval of the State of Rhode Island, if any of the following events occur:

- a. The State of Rhode Island requests EDS to stop processing claims for the Trading Partner or its agent.
- b. The contract between EDS and the State of Rhode Island expires or terminates.

3.4 Modifications

This TPA constitutes the entire agreement of the parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information and or documents, all of which are hereby incorporated by reference. Any change to this Agreement will be effective only when set forth in writing and executed by all parties.

ARTICLE IV. CONFIDENTIALITY, PRIVACY AND SECURITY

- 4.0 EDS and the Trading Partner will conform with all appropriate federal and state laws and regulations pertaining the confidentiality, privacy, and security applicable to each party.
- 4.1 The Trading Partner agrees to safeguard all DHS information within its possession, whether verbal, written, or otherwise, received from EDS, or acquired by the Trading partner in performance of this TAP, recognizing all such information as privileged. The use or disclosure of information concerning Rhode Island Medicaid beneficiaries shall be limited to purposes directly connected with the administration of the Rhode Island Medical Assistance Program.

ARICLE V. SUBMITTED CHARGES

- 5.0 The Trading Partner attests that all services for which payment will be claimed shall be provided in accordance with all federal and state laws pertaining to the Rhode Island Medical Assistance Program.
- 5.1 The Trading partner agrees that any payments made in satisfaction of claims submitted electronically will be delivered from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution applicable under federal and state law.
- 5.2 The Trading partner shall allow EDS access to its claims data and shall make all reasonable efforts to ensure that authorized personnel will submit claims data. The Trading Partner also agrees to promptly notify DHS, through its agent EDS, any and all

erroneous payments received by the Trading partner regardless of the reason for such erroneous payments, and to promptly refund the subject erroneous payments to EDS.

- 5.3 The Trading Partner understands that all other terms and conditions of participation as set forth in the Provider Agreement Form with the Rhode Island Medical Assistance program remain in effect and unchanged by this TPA.
- 5.4 EDS, as the DHS Fiscal Agent for the Rhode island Medical Assistance Program, has been granted the authority to approve and enroll Trading partners participating in the electronic transmission of documents.

ARTICLE VI TESTING

- 6.1 Proof that transactions meet X12N4010A standards is required prior to testing. Please submit documentation with this completed TPA.

Please check one:

Pre-Certification	Agency or Product Name:
Using Provider Electronic Solutions	EDS
Certified by Independent Agency	
Translator Compliance Check	
Utilizing Certified Vendor/Clearing House	
Other (Describe)	

ARTICLE VII. MEDICAL TRANSACTION STANDARDS

Rhode Island Medical Assistance Program Transaction Standards

Selected **ASC X 12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below. The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading partner for claims submission and another for downloads each party must complete a separate TPA.

Check all that apply:

<input type="checkbox"/>	837 Professional	<input type="checkbox"/>	277 Unsolicited Claim Status
<input type="checkbox"/>	837 Institutional	<input type="checkbox"/>	997 Functional Acknowledgement
<input type="checkbox"/>	837 Dental	<input type="checkbox"/>	835 Remittance Advice
<input type="checkbox"/>	270 Eligibility Inquiry	<input type="checkbox"/>	271 Eligibility Response
<input type="checkbox"/>	276 Claim Status Inquiry	<input type="checkbox"/>	NCPDP 1.1 Batch pharmacy Claim Response
<input type="checkbox"/>	NCPDP 5.1 Batch		

Specific Software:

Software	Vendor
Provider Electronic Solutions	EDS
Other	

Method of Transmission: _____

Guidelines

HIPAA—Health Insurance Portability and accountability Act. In the event of any conflict, HIPAA standards and implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

Name Phone Number

Name Phone Number

e-mail address

ARTICLE VIII. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider please make copies of Article VIII.

1. _____
Medical Assistance Provider Number
Provider Name: _____
Authorized Signature: _____
Date: _____

2. _____
Medical Assistance Provider Number
Provider Name: _____
Authorized Signature: _____
Date: _____

3. _____
Medical Assistance Provider Number
Provider Name: _____
Authorized Signature: _____
Date: _____

**Trading partner Execution:
TRADING PARTNER**

Signed

Name

Title

DON NOT FAX

**Please mail this certification to the
Following Address:**

**EDS
Attn: EDI Coordinator
P.O. BOX 2010
Warwick, RI 02997-2010**

ADDENDUM F



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Dear Provider,

Thank you for your participation in the Rhode Island Medical Assistance Program. Enclosed is the Local Education Agency Provider Linkage Form to enroll as a provider within a School Department.

Please return the completed **LEA Provider Linkage Form** and a **current copy of individual's form of licensure** to:

EDS
Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 0287-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at (401) 784-8100 or 1-800-964-6211 for in-state long distance and border communities.

Sincerely,

Provider Services

Attachments

ADDENDUM F

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
LOCAL EDUCATION AGENCY PROVIDER LINKAGE FORM

Provider Name: _____

School Dept Name: _____

Service Location Address: _____

School Dept Group Provider Number: _____

School Dept Tax Identification Number: _____

Provider Phone Number: _____

School Dept Pay to Address: _____

License #: _____

Effective Date: * _____

School Dept Mail to Address: _____

Provider Type: _____

Provider Signature

Date

Authorized Signature of School Department Representative

Title

Date

For EDS Use Only

Census Track: _____

County Code: _____

Town Code: _____

Location Code: _____

***Indicate the effective date the Provider began providing services for the School Department**

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE FOR PROVIDER MEMBER LISTED*****

**RETURN FORM TO: EDS, PO BOX 2010, WARWICK, RI 02887-2010, ATTN: PROVIDER
ENROLLMENT UNIT**



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Dear School Department,

Thank you for your participation in the Rhode Island Medical Assistance Program. Enclosed is the Local Education Agency Provider Linkage Form to enroll as a provider within a School Department.

Please return the completed **LEA Provider Linkage Form** and a **current copy of individual's form of licensure** to:

EDS
Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 0287-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at (401) 784-8100 or 1-800-964-6211 for in-state long distance and border communities.

Sincerely,

Provider Services

Attachments

ADDENDUM G
Sample Certification of Funds Letter

Date

Ms. Sharon Reniere
Chief Medical Care Specialist
Department of Human Services,
Center for Child and Family Health
600 New London Avenue
Cranston, RI 02920

Dear Ms. Reniere,

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

Sincerely,

Superintendent's signature
Superintendent's printed name
Address
School Department

Date

ADDENDUM H

Fully Documented Record for Medicaid Claiming Purposes Documents listed must be retained for 7 (seven) years According to State Medicaid law

- 1) **IEP indicating the need for a Medicaid covered service as described in the Social Security Act section 1903(c)**
- 2) **Copy of the appropriate provider licensure, certification, etc. as required by state and federal law**—as described, by service/provider type, in CFR and state regs.
- 3) **Referral/prescription, as required by state and federal law (in some states an IEP signed by an appropriate medical professional may suffice)--** as described, by service/provider type, in CFR and state regs
- 4) **Service Log:**
 - a) **Child’s Name**—State Medicaid Manual 2500-2
 - b) **Provider’s Name**—State Medicaid Manual 2500-2
 - c) **Date of Service**—State Medicaid Manual 2500-2
 - d) **Type of Service Provided**—State Medicaid Manual 2500-2
 - e) **Number of Service Units/Cumulative Time**—State Medicaid Manual 2500-2
 - f) **Group or Individual Setting**—when needed for reimbursement purposes
 - g) **Place of service**—State Medicaid Manual 2500-2
 - h) **Brief Description of Service (supplemented by quarterly progress note, or as often as otherwise indicated educationally/medically)**

Section 1901 of the Social Security Act is appropriated specifically to allow States to “furnish medical assistance on behalf of families with dependent children...whose income and resources are insufficient to meet the costs of *necessary medical services*” (emphasis added). States are also required in Section 1902@ to “provide for agreements with every person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving medical assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.” This requirement is also reiterated in CFR Section 431.107, which describes “Required provider agreement.”

- 5) **Documentation that services are being appropriately provided, as applicable,” under the supervision/guidance of” and meeting all federal and state oversight requirements**
- 6) **Other appropriate documents kept by schools, such as: child attendance records, school operating calendars (including snow days and other unscheduled school closings), or employee attendance record, etc. when available.**
- 7) **Other state specific or professional association requirements, as applicable.**

School Based Medicaid Service Description Slip
DIRECTIONS

School/Billing Unit

This line should capture both the name of the school and the Medicaid ID number that the school or administrative unity uses to bill the Medicaid program.

Service Period, Year:

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

Student Name:

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

Date of Birth

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

Provider Name:

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

Provider Type:

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

Diagnosis:

A medical diagnosis is necessary for billing the Medicaid program. The child's primary special education disability will suffice. This is true even if the diagnosis on the claim form does not seem directly related to the service being provided so long as the service being provided is clearly articulated in the child's Individualized Education Program.

Date:

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

Activity/Procedure Note or Code:

In this area, the provider should write a short description of the service provided to the child on that date. Providers should use their professional judgment to create a brief note that adequately documents the nature/extent of the service provided.

Small Group/Large Group/Individual

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

Time or Number of Service Units (Cumulative):

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

Quarterly Progress Note (or as otherwise medically or educationally indicated):

The inclusion of a progress note is imperative to document the medical necessity of the service provided and billed to Medicaid. The state Medicaid agency is only permitted to pay for services that are medically necessary. If the progress note required by the Department of Education captures the medical necessity and progress of this child, it may be used for Medicaid service description purposes. If not it is essential that the provider compose a separate progress note valuation the child's medical progress and need for continual care. This evaluation can, to minimize administrative burden, be completed in coordination with other evaluations as required by IDEA. In such cases, it should be completed quarterly or as often as the child's non-disabled peers are evaluated academically. There should also be a mechanism for more frequent evaluations if there are significant changes in the child's condition..

Signatures:

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

When applicable, services may be provided "under the direction of" a certified licensed health care professional. In such situations, each patient's care must be under the supervision of a

qualified professional (as indicated by federal/state law) who is directly affiliated with the entity providing the billed medical services. To meet this requirement the supervising certified/licensed professional must see the patient at least once, prescribe the type of care provided, and periodically review the need for continued services. He/she must assume professional responsibility for the services provided and assure that such services are medically necessary. The concept of professional responsibility implicitly supports face-to-face contact by the supervising certified/licensed at least at the beginning of the treatment and, in addition, during the delivery of services. By signing this form, the supervising medical professional is assuring that the above conditions have been met and are, in fact, assuming responsibility for the child's care.

ADDENDUM H

**RI DEPARTMENT OF EDUCATION
School Year 2004-2005**

SPECIAL EDUCATION CENSUS

SERVICE LOG

TEACHER:

SERVICE:

MONTH:

Last	First	D.O.B	Time/unitsService	Date of Service	Time in Minutes
-------------	--------------	--------------	--------------------------	------------------------	------------------------

DIRECTIONS: ENTER THE DATE(S) YOU SAW THIS STUDENT AND
THE TYPE OF SERVICE THAT YOU PROVIDED

KEY FOR

G = GROUP THERAPY

I = INDIVIDUAL THERAPY

E = EVALUATION

C = CASE MANAGEMENT

=====

COMMENTS/PROGRESS NOTES

SIGNATURE:

DATE:

ADDENDUM I

Single Claim Adjustment Form
&
Multiple Claims Adjustment Form

ADDENDUM I

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
SINGLE ADJUSTMENT REQUEST FORM**

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

ADDENDUM I

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
MULTIPLE ADJUSTMENT REQUEST FORM**

1. PROVIDER NAME: _____

2. PROVIDER NUMBER: _____

3. REASON FOR ADJUSTMENT (MUST BE SAME FOR ALL ATTACHED):

EDS USE ONLY	4. CLAIM INTERNAL CONTROL NUMBER	5. MEDICAL ASSISTANCE RA DATE	6. RECIPIENT NAME FIRST/LAST	7. RECIPIENT MEDICAL ASSISTANCE NO.
0.				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED AND THE APPROPRIATE REMITTANCE ADVICE IS ATTACHED.

SIGNATURE	CONTACT NUMBER	DATE
-----------	----------------	------

******EDS USE ONLY******

EXAMINER	DATE	ACTION TAKEN
----------	------	--------------

REMARKS:

MAIL TO:
EDS
ADJUSTMENTS
P.O. BOX 2010
WARWICK, RI 02887-2010

MULTIPLE ADJUST FORM

ADDENDUM J

**SPECIAL EDUCATION PROGRAM
MMIS CODES, UNITS, RATES
April 2004**

<u>HCPCs</u>	<u>SERVICES</u>	<u>Unit</u>	<u>Rate</u>
X0201	Physical Therapy Evaluation	1 Hour (min. 31min.)	\$ 85.00
X0202	Ind. P.T. W/Licensed PT	1/2 Hour (min. 20 min.)	\$ 29.00
X0203	Ind. P.T. Program	1/2 Hour (min. 20 min.)	\$ 24.00
X0204	P.T. Program-Group	1/2 Hour (min. 20 min.)	\$ 19.00
X0205	Occupational Therapy Evaluation	1 Hour (min. 31min.)	\$ 85.00
X0206	Ind.O.T. W/Licensed OT.	1/2 Hour (min. 20 min.)	\$ 29.00
X0207	Ind. O.T. Program	1/2 Hour (min. 20 min.)	\$ 24.00
X0208	O.T. Program-Group	1/2 Hour (min. 20 min.)	\$ 19.00
X0209	Speech, Hearing, Lang. Evaluation	1 Hour (min. 31min.)	\$ 85.00
X0210	Ind. S.H.L. w/Speech Lang. Pathologist	1/2 Hour (min. 20 min.)	\$ 29.00
X0211	Ind. S.H.L. Program	1/2 Hour (min. 20 min.)	\$ 24.00
X0212	S.H.L. Program/Group	1/2 Hour (min. 20 min.)	\$ 19.00
X0521	Psychiatric Evaluation	Completed Evaluation	\$135.00
X0525	Psychological Evaluation	Completed Evaluation	\$120.00
X0529	Social Worker Evaluation	Completed Evaluation	\$ 85.00
X0523	Psychiatric Counseling	1/2 Hour (min. 20 min.)	\$ 45.00
X0527	Psychological Counseling	1/2 Hour (min. 20 min.)	\$ 40.00
X0531	Social Worker Counseling	1/2 Hour (min. 20 min.)	\$ 30.00
X0222	Guidance Counselor Counseling	1/2 Hour (min. 20 min.)	\$ 29.00
X0223	Counseling Services-Group	1/2 Hour (min. 20 min.)	\$ 20.00
X0221	Nursing Services	1/2 Hour (min. 20 min.)	\$ 25.00
X0213	Residential Placement Less Education & R. & B.	1 unit equals 1 day	M.A. Approved Cost
X0220	Transportation	Individual For A Round Trip	\$ 10.00
X0215	Non-Medical Case Mgt	1/2 hour (min. 15 min.)	\$ 35.00
X0650	Medical Case Mgt	1/2 hour (min. 15 min.)	\$ 35.00
X0216	Personal Care	1/2 hour (min. 20 min.)	\$ 10.00
X0217	Day Program Services	1 unit equals 1 day	M.A. Approved Cost Less Education
X0226	Assistive Technology Device	1 unit equals 1 device	Variable Rate
X0227	Assistive Technology Service	1/2 hour (min. 20 min.)	\$ 25.00
X0229	Child Outreach Screening	Completed screening	\$ 60.00
X0239	Child Outreach Rescreening	Completed screening	\$ 25.00

ADDENDUM J

Primary Special Education Diagnoses and Codes

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

Claiming Hints

- **Use whole units: do not use fractions**
 - **Minimum length of time for case management half hour unit is 15 minutes**
 - **Minimum length of time for all other services half hour units is 20 minutes**
 - **Minimum length of time for hour evaluations (PT, OT, SLP) is 31 minutes**
- **Complete each unit and fee entered with a number-do not use dittos**
- **Use complete from and to date of service in 6-digit MMDDYY format**

ADDENDUM J**PHYSICAL THERAPY SERVICES**

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0201	Physical Therapy Evaluation	1 unit equals 1 hour (Minimum time to qualify is 31 minutes per session)	\$85.00 per hour	Physical Therapist licensed by the Department of Health
X0202	Individual physical therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$29.00 per ½ hour	Physical Therapist licensed by the Department of Health
X0203	Individual physical therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$24.00 per ½ hour	Physical Therapy Assistant (PTA) licensed by the Department of Health working under the supervision of a Licensed Physical Therapist
X0204	Small Group physical therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$19.00 per ½ hour	Physical Therapist licensed by the Department of Health Or Physical Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Physical Therapist

ADDENDUM J**OCUPATIONAL THERAPY SERVICES**

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0205	Occupational Therapy Evaluation	1 unit equals 1 hour (Minimum time to qualify is 31 minutes per session)	\$85.00 per hour	Occupational Therapist licensed by the Department of Health
X0206	Individual occupational therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$29.00 per ½ hour	Occupational Therapist licensed by the Department of Health
X0207	Individual occupational therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$24.00 per ½ hour	Certified Occupational Therapy Assistant (COTA) licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist
X0208	Small Group occupational therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$19.00 per ½ hour	Occupational Therapist licensed by the Department of Health Or Certified Occupational Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist

ADDENDUM J

SPEECH AND LANGUAGE THERAPY SERVICES

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0209	Speech and Language Therapy Evaluation	1 unit equals 1 hour (Minimum time to qualify is 31 minutes per session)	\$85.00 per hour	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE
X0210	Individual speech and language therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$29.00 per ½ hour	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE
X0211	Individual speech and language therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$24.00 per ½ hour	A paraprofessional working under the supervision of a A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE
X0212	Small Group speech and language therapy session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$19.00 per ½ hour	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE Or A paraprofessional working under the supervision of a SLP licensed by the Department of Health Or A SLP certified by the RIDE

ADDENDUM J**PSYCHOLOGICAL EVALUATIONS**

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0521	Psychiatric Evaluation	1 Unit equals the completed evaluation, including the report writing	\$135.00 per completed evaluation	Board Certified Psychiatrist (appropriate for age of student)
X0525	Psychological Evaluation	1 Unit equals the completed evaluation, including the report writing	\$120.00 per completed evaluation	Clinical Psychologist Licensed by the Department of Health or School Psychologist Certified by RIDE and is appropriately credentialed
X0529	Social Work Evaluation	1 Unit equals the completed evaluation, including the report writing	\$85.00 per completed evaluation	LICSW by the DOH or School Social Worker certified by RIDE and is appropriately credentialed

ADDENDUM J

PSYCHOLOGICAL COUNSELING SERVICES

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0523	Psychiatric Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$45.00 per ½ hour session	Board Certified Psychiatrist (appropriate for age of student)
X0527	Psychological Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$40.00 per ½ hour session	Clinical Psychologist Licensed by the Department of Health or School Psychologist Certified by RIDE and is appropriately credentialed
X0531	Social Worker Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$30.00 per ½ hour session	LICSW by the DOH or School Social Worker certified by RIDE and is appropriately credentialed
X0222	Guidance Counselor Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$29.00 per ½ hour session	School Guidance Counselor Certified by RIDE
X0223	Small group counseling session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$20.00 per ½ hour session per Medicaid eligible children	Small group session conducted by any of the above

ADDENDUM J

EXPANDED BEHAVIORAL HEALTH COUNSELING SERVICES

Procedure Code with modifier	Service	Unit	Rate	Provider Qualifications
X0523 JB	Psychiatric Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$45.00 per ½ hour session	Board Certified Psychiatrist (appropriate for age of student)
X0527 JB	Psychological Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$40.00 per ½ hour session	Clinical Psychologist Licensed by the Department of Health or School Psychologist Certified by RIDE and is appropriately credentialed
X0531 JB	Social Worker Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$30.00 per ½ hour session	LICSW by the DOH or School Social Worker certified by RIDE and is appropriately credentialed
X0222 JB	Guidance Counselor Counseling	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$29.00 per ½ hour session	School Guidance Counselor Certified by RIDE
X0223 JB	Small group counseling session	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$20.00 per ½ hour session per Medicaid eligible child(ren)	Small group session conducted by any of the above

ADDENDUM J**OTHER SERVICES**

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0221	Nursing Services	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$25.00 per ½ hour service	Certified School Nurse Teacher or a Registered Nurse
X0216	Personal Care Services	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$10.00 per ½ hour service	Appropriately credentialed paraprofessional working under the supervision of the classroom teacher or other school staff
X0220	Transportation	Round trip transportation	\$10.00 per round trip	Transportation provided in accordance with federal and state law and as defined in Section V
X0215	Non-Medical Case Management	1 unit equals ½ hour (Minimum time to qualify is 15 minutes per session)	\$35.00 per ½ hour service	Designated case manager within school who provides activities described in Section V of the Guidebook
X0650	Medical Case Management	1 unit equals ½ hour (Minimum time to qualify is 15 minutes per session)	\$35.00 per ½ hour service	Designated case manager within school who provides activities described in Section V of the Guidebook

ADDENDUM J

OTHER SERVICES

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0217	Day Program Services	1 unit equals 1 day in attendance in the program	Variable rate determined by the treatment costs of the individual program	Providers can be another Local Education Agency (LEA) or a program approved by the RIDE
X0213	Residential Treatment Program	1 unit equals 1 day in attendance in the program	Variable rate determined by the treatment costs of the individual program and the costs for room and board <i>only</i> in JCAHO accredited facilities	Approved residential treatment programs

ADDENDUM J**OTHER SERVICES**

Procedure Code	Service	Unit	Rate	Provider Qualifications
X0227	Assistive Technology Service	1 unit equals ½ hour (Minimum time to qualify is 20 minutes per session)	\$25.00 per ½ hour	Appropriately credentialed staff provide the service
X0226	Assistive Technology Device	1 unit is equal to the purchase of one device	Variable rate: rate is the cost of the item	Appropriately credentialed staff order the device
X0229	Child Outreach Screening	1 unit equals the completed screening	\$60.00 per completed screening	Appropriately credentialed staff perform the screening
X0239	Child Outreach Re-Screening	1 unit equals the completed re-screening	\$25.00 per completed re- screening	Appropriately credentialed staff perform the re-screening

ADDENDUM K

**CHILDREN'S BEHAVIORAL HEALTH CARE/TREATMENT PLAN
And
PROGRESS NOTES**

Child's Name: _____
Service Provider: _____
Date of Birth: _____
Presenting Problem/Diagnosis: _____
Plan of Treatment: _____

Intervention: _____

Goals and Objectives: _____

Progress Notes:

DATE (Month/Day/Year)	COMMENTS	Recommendations

ADDENDUM L

HIPAA

FREQUENTLY ASKED QUESTIONS

Prepared by

Denise Achin, M.Ed

Medicaid Specialist

R.I. Technical Assistance Project

Rhode Island College

Judith A. Saccardo, Ed.D. Director

Prepared for

R.I. Department of Education

Thomas P. DiPaola, PhD

Director, Office of Special Needs

Acknowledgements

The following persons need to be acknowledged for their input and/or review of this document: Lynne Harrington (Department of Human Services), Aurora Duarte (East Providence School Dept.), Jeanne Begos (Coventry School Dept.), Kathy Magiera (Cranston School Dept.), David Kane (RITAP/RIDE), Pat Beauchamin (Barrington School Dept.), Alice Brady (Rhode Island Association of School Nurse Teachers), and Ruth Schennum (Department of Human Services).

References:

www.cms.hhs.gov/hipaa/

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

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

Disclaimer

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

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Protected Health Information.....Page 12

Key Definitions.....Page 16

BACKGROUND

Q: What is HIPAA?

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

Q: What is the intent of the HIPAA law?

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

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

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

HIPAA:

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

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

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

Privacy Rule

Q: What are the privacy standards?

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

Q: Why is the HIPAA Privacy Rule needed?

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

Q: What does the HIPAA Privacy Rule create?

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

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

Q: What does it mean for patients?

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

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

Security Rule

Q: What are the security standards?

A: The HIPAA Security Standards stipulate that health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule outlines the minimum administrative, physical and technical safeguards to protect electronic protected health information in their care to prevent unauthorized access to protected health care information. The security standards work in concert with the final privacy standards adopted by

HHS in 2002. The privacy standards have been in effect for most covered entities since April 14, 2003 and small providers have an additional year to meet compliance (April 14, 2004). The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Most providers need to be compliant with the security standards by April 21, 2005 and small providers have an additional year to meet compliance (April 21, 2006).

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

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

Transactions and Code Sets

Q: What are the national transactions and code sets?

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

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

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

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

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

A: All covered/hybrid entities must utilize HIPAA compliant software and national code sets by October 16, 2003. LEAs will continue to use their existing MMIS procedure codes

through December 31, 2003 and will utilize new “HIPAA” procedure codes starting January 1, 2004.

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

A: Free Provider Electronic Solutions (PES) software is available from Electronic Data Solutions (EDS) or providers may purchase or have software developed by private entities. This software is available once a covered entity submits an Electronic Data Interchange Trading Partner Agreement with EDS and the Department of Human Services.

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

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

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

Trading Partner Agreement (TPA)

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

A: A Trading Partner (Electronic Data Interchange-EDI) Agreement is an agreement between a provider or a billing company and EDS and the DHS in order to exchange electronic data. A copy of this form and instructions to complete it are available as Addendum A or copies of the TPA can be accessed through the DHS web site at <http://www.dhs.ri.gov/dhs/hipaa/hEDI.htm>

Q: Who needs to complete a TPA?

A: Anyone who performs an electronic transaction with EDS or DHS needs to complete a TPA with the DHS and EDS. This includes:

- Any provider who verifies patient eligibility through the RI Medicaid Portal
- Any provider or billing agent who will check claim status through the RI Medicaid Portal
- Any Clearing House that bills electronically i.e., Web MD
- Any Billing Agent who will exchange data electronically
- Any provider and /or billing agents checking remittance advice payments
- *Remittance advice/files and Pended Claims reports will be available to only one trading partner. (LEAs utilizing a billing company need to decide if they will have access or if their billing agent will have access to the Remittance files and pended claims reports).*

If you have any questions about completing the TPA, call the EDS Electronic Data Interchange help desk at 1-800-399-0835 or contact Denise Achin at 1-401-222-4600 ext. 2306 or dachin@ride.ri.net

Q: Should an LEA complete a TPA?

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

National Identifier

Q: What is the National Identifier?

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

COVERED ENTITIES

Who must comply with HIPAA?

Q: Who must comply with HIPAA regulations?

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

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

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

Q: What is a Hybrid Entity?

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

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

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

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

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

FAMILY EDUCATION RIGHTS AND PRIVACY ACT (FERPA)

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

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

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

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

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

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

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

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

A: The term Educational Records defined by FERPA include:

(a) Those records that are:

- (1) Directly related to a student; and
- (2) Maintained by an educational agency or institution or by a party acting for the agency or institution.

(b) The term does not include:

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

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

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

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

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

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

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

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

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

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

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

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

PROTECTED HEALTH INFORMATION (PHI)

Q: What is protected health information?

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

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

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

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

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

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

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

Q: What is "treatment"?

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

Q: What is "payment"?

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

provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is considered “health care operations”?

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

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

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

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

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

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

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

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

Individual Rights and Disclosure of PHI

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

A: Individuals have the right to:

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

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

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

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

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

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

A. The Privacy Rule does not prohibit the use, disclosure, or request of an entire medical record; and a covered entity may use, disclose, or request an entire medical record without a case-by-case justification, if the covered entity has documented in its policies and procedures that the entire medical record is the amount reasonably necessary for certain identified purposes. No justification is needed in those instances where the minimum necessary standard does not apply, such as disclosures to or requests by a health care provider for treatment purposes or disclosures to the individual who is the subject of the protected health information.

Q: When are authorizations required?

A: Authorizations are required for uses and disclosures not otherwise permitted or required by the Rule. Generally, an entity cannot condition treatment, payment, eligibility, or enrollment on an authorization. However, if eligibility for Federal or State healthcare coverage (Medicare/Medicaid) requires documentation of disability or financial condition and this information is not granted, then coverage *can* be denied because eligibility for

program determination cannot be made. Authorization must contain core elements & required statements, including an expiration date or event and a statement that authorization is revocable.

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

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

Q: Are there exceptions to the Minimum Necessary Standard?

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

KEY DEFINITIONS

Q: What is a Business Associate?

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

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

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

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

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

Q: What is Code Set:

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

Q: What is a Covered Entity?

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

Q: What is a Hybrid Entity?

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

Q: What is a Health Care Provider?

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

Q: What is a Health Care Clearinghouse?

A: A health care clearinghouse is a public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health

management information systems or community health information systems, and “value-added” networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Q: What is considered “health care operations”?

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

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

Q: What is Health Information?

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

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

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

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

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

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

Q: What is “payment”?

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

provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is protected health information (PHI)?

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

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

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

Q: What is Privacy?

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

Q: What is Security?

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

Q: What are the HIPAA Security Standards?

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

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

A: A Trading Partner EDI Agreement is an agreement between a covered/hybrid entity, including billing companies, and EDS and the DHS in order to exchange electronic data. Copies of this form can be accessed through the DHS web site at <http://www.dhs.ri.gov/dhs/hipaa/hEDI.htm>

Q: What is “treatment”?

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

ADDENDUM M:

Acronyms Used

ADL: Activities of Daily Living
AT: Assistive Technology
CEDARR: Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation
CIS: Children's Intensive Services
CMS: Center for Medicare and Medicaid Services
COTA: Certified Occupational Therapy Assistant
CSHCN: Children with Special Health Care Needs
DHS: Department of Human Services
DCYF: Department of Children, Youth & Families
EDI: Electronic Data Interchange
EDS: Electronic Data Systems
EPSDT: Early and Periodic Screening Diagnosis and Treatment
FERPA: Family Educational Rights and Privacy Act
HBTS: Home Based Therapeutic Services
HIPAA: Health Insurance Portability and Accountability Act
IDEA: Individuals with Disabilities Education Act
IEP: Individualized Education Program
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
LEA: Local Education Agency
MA: Medical Assistance
MHRH: Mental Health Retardation and Hospitals
OT: Occupational Therapy
PASS: Personal Assistance Services & Supports
PHI: Protected Health Information
PT: Physical Therapy
PTA: Physical Therapy Assistant
RA: Remittance Advice
REVS: Recipient Eligibility Verification System
RIDE: Rhode Island Department of Elementary and Secondary Education
RIGL: Rhode Island General Law
SHL: Speech, Hearing and Language
SLP: Speech and Language Pathologist
SSA: Social Security Administration
SSI: Supplemental Security Income
TCYC: Therapeutic Child & Youth Care
TPA: Trading Partner Agreement
TPL: Third Party Liability