MEDICAID POLICY & PROCEDURE MANUAL

FOR SERVICES DELIVERED through the IEP/IFSP

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Maryland Department of Health
Division of Children's Services
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PURPOSE AND OVERVIEW

These instructions are to be used by school health-related and health-related early intervention service providers.

The Maryland State Department of Education and the Maryland Department of Health (the Department) established an Interagency Medicaid Monitoring Team (IMMT) in 2000 to provide technical assistance and monitor the delivery of Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) services provided by local school systems (LSS), local lead agencies (LLA), and non-public schools. The goal of the IMMT is to facilitate and monitor compliance with COMAR 10.09.25, COMAR 10.09.36, COMAR 10.09.40, COMAR 10.09.50, COMAR 10.09.52 and COMAR 10.09.56

COMAR References

COMAR 10.09.25	*Transportation Services Under the IDEA*
COMAR 10.09.36	*General Medical Assistance Provider Participation Criteria*
COMAR 10.09.40	*Early Intervention Services Case Management*
COMAR 10.09.50	*EPSDT School and Health-Related Early Intervention Services*
COMAR 10.09.52	*Service Coordination for Children with Disabilities*
COMAR 10.09.56	*Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder*

DEFINITIONS

1) **Autism Waiver:** Autism Waiver means the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder.

2) **Autism Waiver Service Coordination:** Case management services that assist participants and their families in gaining access to AW services as well as other needed in-home, community-based, medical, social, and/or educational services. Includes ongoing communication regarding the child's plan of care (POC), level of care (LOC), AW services and progress.

3) **Department** – The Maryland Department of Health, which is the single State agency designated to administer the Maryland Medical Assistance Program pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

4) **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -** Comprehensive and preventive health care, and other diagnostic and treatment services that are necessary to correct or ameliorate defects and physical and mental illnesses in children younger than 21 years old, pursuant to 42 CFR §441.50 et seq., as amended.

5) **Eligibility Verification System (EVS)** – A web and telephone inquiry system that enables providers to verify Medicaid eligibility.

6) **Health Insurance Portability and Accountability Act (HIPAA)** – the Health Insurance Portability and Accountability Act, a federal law enacted on August 21, 1996, whose purpose is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of administrative and financial data, provide security requirements for transmitted information, and protect the privacy of identifiable health information.

7) **Individuals with Disabilities Education Act (IDEA) –** The Individuals with Disabilities Act was passed by Congress in 1990 and ensures that all children with disabilities are entitled to a free appropriate public education to meet their unique needs and prepare them for further education, employment, and independent living**.**

8) **Individualized Education Program (IEP)** – A written description of special education and related services developed by the IEP team to meet the individual needs of a child.

9) **Individualized Education Program (IEP) Team** – A group convened and conducted by a provider to develop a participant's IEP, which is composed of a child's parent or parents, the child's teacher, and relevant service providers.

10) **Individualized Family Services Plan (IFSP)** – A written plan for providing early intervention and other services to an eligible child and his/her family.

11) **Individualized Family Services Plan (IFSP) Team** – A group convened and conducted by a provider to develop a participant's IFSP, which is composed of a child's parent or parents, the child's service coordinator, and relevant service providers.

12) **Local Health Department (LHD)** – A public health services agency in each county and Baltimore City, which receives State and local government funding to ensure that basic public health services in the areas of personal and environmental health are available in each jurisdiction.

13) **Local Lead Agency (LLA)** – An agency designated by the local governing authority in each county and Baltimore City to administer the interagency system of early intervention services under the direction of the Maryland State Department of Education in accordance with Education Article, §8-416, Annotated Code of Maryland.

14) **Local School System (LSS) –** Any of the 24 public school systems in Maryland responsible for providing public elementary or secondary education.

15) **Managed Care Organization (MCO)** – A healthcare organization that provides services to Medicaid participants in Maryland. The organization contracts with a network of providers to provide covered services to its enrollees. Each MCO is responsible to provide or arrange for the full range of health care services.

16) **Maryland State Department of Education (MSDE)** – The State agency responsible for ensuring that all children with disabilities residing in the State are identified, assessed, and provided with a free, appropriate public education consistent with State and federal laws.

17) **Medically necessary** - A service or benefit that is:
    a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
    b) Consistent with currently accepted standards of good medical practice; the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
    c) Not primarily for the convenience of the consumer, the consumer's family, or provider.

18) **Nursing Care Plan –** A plan developed by a registered nurse, prescribed by the child's primary care provider (physician or nurse practitioner), that identifies the child's diagnosis and needs, the goals to be achieved, and the interventions required to treat the child's medical condition. The Nursing Care Plan **must be reviewed every 60 days**.

19) **Participant** – A Medical Assistance participant who is eligible for and receives health related services in an IEP or health related early intervention services in an IFSP and is under 21 years of age (eligibility ends on the 21st birthday).

20) **Program -** The Medical Assistance Program as defined in COMAR 10.09.36.01.

21) **Provider** – A local school system, local lead agency, State-operated education agency, or State-supported education agency, which meets the conditions for participation as defined in COMAR 10.09.50 to provide health related services in an IEP or health related early intervention services in an IFSP.

22) **Service Coordinator** – An individual who assists participants in gaining access to needed medical, social, educational, and other services as indicated in the child's IEP/IFSP by providing service coordination. The service coordinator must meet the requirements outlined in COMAR 10.09.52.03C and 10.09.40.03C.

23) **Service Coordination** – Case management services that assist participants in gaining access to needed medical, social, educational, and other services as indicated on the child's IEP/IFSP. It includes communication with the family on the child's progress towards the IEP/IFSP goals.

24) **Telehealth** – The delivery of medically necessary services to a patient at an originating site by distant site provider, through the use of technology-assisted communication.

PROGRAM SUPPORTS

Autism Waiver Service Coordination Services

Autism Waiver (AW) Service Coordination is covered under EPSDT and is billed the same as typical ongoing service coordination at rates identified on the attached Provider's Fee Schedule. Specific requirements pertinent to the AW are found in COMAR 10.09.52. Please contact the Autism Waiver Liaison at 410-767-7497 or 410-767-0258 for more information.

Data Match

The Maryland Department of Health's (the Department) Medical Assistance Program and the Maryland State Department of Education (MSDE) have a special agreement to exchange information for the purpose of identifying Medical Assistance participants who received health-related services identified on the child's IEP/IFSP. The school system receives the list of students to determine who is covered and bills the Department for the services rendered to the Medicaid participant. The data match is a quick and easy way to determine the participant's eligibility status. However, there is no guarantee that the individual is eligible for Medicaid on the day a service was rendered. An eligibility check should be completed to verify the child is eligible for Medicaid on the date of service.

Eligibility Verification System (EVS)

The Eligibility Verification System (EVS) is a web and telephone inquiry system that enables health care providers to quickly verify a Medicaid participant's current eligibility status. Medicaid eligibility should be verified on EACH DATE OF SERVICE prior to rendering services. If the MA number is not available on the date of service, EVS can identify the number by using the participant's social security number and the first two letters of the last name. Although Medicaid eligibility validation via the Program's EVS system is not required, it is recommended in order to prevent the rejection of claims for services rendered to a canceled/non-eligible participant. Before rendering a Medicaid service, verify the participant's eligibility on the date of service via the Program's Eligibility Verification System (EVS) at **1- 866-710-1447**. The provider must be enrolled in *eMedicaid* in order to access the web EVS system.

For additional information view the EVS website at https://encrypt.emdhealthchoice.org/emedicaid/ or contact 410-767-5340 for provider support. If you need additional EVS information, please contact the Provider Relations Unit at 410-767-5503 or 800-445-1159. Additionally, Provider Relations may be able to assist you in acquiring eligibility information. **You must have your Maryland Medicaid provider number as well as pertinent participant information (e.g. Student Name, Medical Assistance Number, and Date of Service) in order to obtain assistance from Provider Relations.**

A participant who is enrolled with an MCO under HealthChoice is eligible for school health-related or health-related early intervention services that are documented on an IEP/IFSP. **These services are billed directly to Medicaid and not to the MCO.**

Health Insurance Portability Accountability Act of 1996 (HIPAA)

HIPAA requires that standard electronic health transactions be used by health plans, including private, commercial, Medicaid and Medicare, healthcare clearinghouses and health care providers.

The intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using health care industry standard sets of data and codes. More information on HIPAA can be found at: https://www.hhs.gov/hipaa/for-professionals/index.html

National Provider Identifier (NPI)

Since July 30, 2007, all health care providers who perform medical services have been required to have an NPI. It is a unique 10 digit, numerical identifier that does not expire or change. It is administered by CMS and is required by HIPAA.

Apply for an NPI by using the web-based application process via the National Plan and Provider Enumeration System (NPPES) at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. You should use the NPI as the primary identifier and your Medicaid Provider number as the secondary identifier on all paper and electronic claims.

Provider Enrollment

Any providers delivering services through the IEP/IFSP to Medicaid participants must be enrolled and in an active status as a Maryland Medicaid provider prior to rendering services. If you are not currently enrolled as a Maryland Medicaid provider and wish to do so, please utilize the Department's electronic Provider Revalidation and Enrollment Portal (ePREP).

Provider Revalidation

All Medicaid providers must revalidate (submit a new MA application and supporting documentation) with Maryland Medicaid at least every five years.

Maryland Medicaid will send a notice via ePREP notifications if the provider already has an account in ePREP to prompt the provider to enter ePREP and submit a revalidation application. Providers will not be notified by mail for revalidation unless the provider has never created an ePREP account.

For detailed instructions on the provider enrollment and revalidation process, please refer to https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx

SERVICE DESCRIPTIONS AND PROCEDURE CODES

SERVICE COORDINATION
IFSP COMAR 10.09.40 & IEP COMAR 10.09.52

See the Fee Schedule at the back of this manual for specific service coordination codes.

Initial IEP or IFSP

For the initial IEP or IFSP, providers may bill one unit of service per lifetime for IEP and one unit of service per lifetime for IFSP. The code used for the initial IEP or IFSP is T1023- TG.

The initial IEP/IFSP consists of convening and conducting an IEP/IFSP team meeting to perform an assessment, and review outcomes to determine eligibility for specialized instruction and the need to develop an initial IEP/IFSP.

The IEP/IFSP identifies the participant's needs for early intervention, medical, mental health, social, educational, financial assistance, counseling, and other support services; responsibilities and rights of the participant and the family; provider's responsibilities, and resources available to provide the needed services. Parents must be invited, in writing, 10 days in advance of the meeting, unless it is an expedited meeting.

A Medicaid consent form for service coordination, which includes the name of the service coordinator **must be signed** by the participant's parent (or by the student if 18 years or older and competent) and must be on file prior to billing for this service. It is suggested that a signed Medicaid consent be on file for all participants (Non-Medical Assistance & Medical Assistance covered) receiving service coordination so that if a non-Medical Assistance covered participant gains Medical Assistance eligibility, back billing would be able to take place for services rendered during the eligibility certification period (up to the previous 12 months). It is also suggested that a backup case manager be identified on the consent form.

IEP/IFSP Review

A unit of service is defined as an interim or annual IEP/IFSP review, as evidenced by a signed, revised IEP/IFSP. The code used for the interim or annual IEP or IFSP is T1023.

The IEP/IFSP Annual Review consists of a completed annual IEP/IFSP review and at least one contact with the participant or the participant's family, on the participant's behalf. The covered services include convening and conducting an IEP/IFSP team meeting to perform a reassessment of the participant's status and service needs, and review and revise, as necessary, the participant's IEP/IFSP.

If during the interim review it is determined that a revised IEP/IFSP was not required, then the IEP/IFSP team meeting’s records must include documentation that a meeting took place in which there was participation by at least two different disciplines and at least one contact by the service coordinator or IEP/IFSP team in person, face-to-face, by telephone, or by written progress notes or log with the participant or the participant's parent, on the participant's behalf.

The interim review for an IEP cannot be billed more than **three (3) times** in a calendar year (including emergency reviews). The interim review for an IFSP cannot be billed more than **two times** in a calendar year. The interim review cannot be billed more than once in any given month. **Additionally, it cannot be billed in conjunction with ongoing service coordination (both cannot be billed for the same month) unless a subsequent review is documented as an emergency.** If an IEP/IFSP review takes more than one meeting to complete, the Program will only make payment for the meeting during which the IEP/IFSP was signed. The covered services include convening and conducting an IEP/IFSP team meeting to perform a reassessment of the participant's status and service needs and to review and revise, as necessary, the participant's IEP/IFSP.

If a subsequent review is required after ongoing service coordination has already been provided to the participant, there must be documentation on file to reflect each emergency review.

NOTE: Parents must receive a written request to attend the Initial and the Interim/Annual IEP Review.

IEP/IFSP Ongoing Service Coordination

A provider may bill one unit per month for the ongoing service coordination for IEP/IFSP services. The initial IEP/IFSP (T1023-TG) and the interim or annual review (T1023) cannot be billed in the same month as the IEP/IFSP ongoing service coordination. The code used for the ongoing service coordination for the IEP/IFSP is T2022.

Service Coordination is a continuum of services provided during the month. To bill MA for service coordination, at least one (l) contact per month must be conducted and sufficiently documented by the service coordinator. The contact may be in person, face-to-face, by telephone or in writing, with participant or parent/guardian, on the participant's behalf, related to the child's IEP. For IFSP the contact may be in person, face-to-face, or by telephone, with the participant's family, on the participant's behalf. If there is a change of service coordination provider, the parent must be notified in writing. Billing for new service coordination cannot be submitted until this is complete. Please note that a new Medicaid consent form is **not** necessary for this process.

Service coordination **may not be provided** directly to children under 6 years old without a parent present, since it is uncertain if the child would benefit from the service.

NOTE: The parents must be notified in writing when there is a change in the Service Coordinator.
NOTE: Text messaging does not meet the requirements for delivery and reimbursement of IEP/IFSP Service Coordination.

HEALTH RELATED SERVICES

EPSDT School Health-Related or Early Intervention Services

COMAR 10.09.50

The following services must be provided according to the requirements detailed below when the service is addressed in an IEP/IFSP. See the Fee Schedule at the end of this manual for specific health-related service codes.

Billing reimbursement requests (codes) for services must match the child's IFSP or IEP (COMAR l 0.09.50.05; COMAR 10.09.36.03). Reimbursement for services on the IEP/IFSP must clearly specify the frequency and duration of the service. Quantifying the provision of occupational therapy, physical therapy, speech/language therapy, nursing, or mental health as "quarterly," "semi-annually," or "yearly" is not acceptable for reimbursement by Medicaid.

Audiology Services

Audiology services must be delivered by a licensed audiologist. These services may include an evaluation, identification of auditory impairments and treatment.

Psychological Services

Psychological, counseling, and social work services must be delivered by a licensed mental health professional. These services consist of the evaluation, diagnosis, and treatment of emotional and behavioral problems, including counseling of parents and parent training when the participant is present, as necessary to achieve an IEP/IFSP goal.

Licensed lesser qualified professionals (i.e. LMSWs, LGPCs) who provide psychological services require supervision. Please see the Documentation Requirement section of this manual for more guidance on the documentation required for services rendered by a licensed lesser qualified professional.

Nursing Services

Nursing services, which are determined to be medically necessary in order for the participant to benefit from educational or early intervention services, must be performed by a licensed nurse (RN or LPN). In order for these services to be covered, they must:

- Be related to an identified health problem;
- Be ordered by a licensed prescriber (physician, certified nurse practitioner, or physician assistant);
- Be indicated in the nursing care plan, which is reviewed at least every 60 days or more frequently when the child's medical condition changes;
- Require the judgment, knowledge, and skills of a licensed nurse; and
- Include the NPI of the referring prescriber on the claim.

Nursing Services Do Not Include:

- Routine assessments of participants whose medical condition is stable, unless the

assessment is ordered and listed in the IEP/IFSP and leads to an intervention or change in the nursing care plan;
- Administration of medications;
- Supervision of interventions that the child is able to perform independently;
- Health screens;
- Health education, except one-on-one training regarding self-management of the child's medical condition;
- First aid interventions;
- Services not deemed medically necessary at the time of the initial assessment or the most recent nursing care plan review; or
- Delegation of any services.

Nutrition Services

Nutrition services must be delivered by a licensed nutritionist or dietitian. Nutrition services include nutrition assessments and evaluations, the development and monitoring of appropriate plans to address the nutritional needs of the participant and making referrals to appropriate community resources to achieve the nutrition goals identified in the IEP/IFSP.

Occupational Therapy Services

Occupational therapy services include any screenings, evaluations or treatments delivered by a licensed occupational therapist, or treatments delivered by licensed occupational therapy assistant. Licensed lesser qualified professionals (i.e. COTAs) who provide OT services require supervision. Please see the Documentation Requirement section of this manual for more guidance on the documentation required for services rendered by a licensed lesser qualified professional.

Physical Therapy Services

Physical therapy services include evaluations or treatments delivered by a licensed physical therapist, or treatments delivered by a physical therapy assistant.

Licensed lesser qualified professionals (i.e. PTAs) who provide PT services require supervision. Please see the Documentation Requirement section of this manual for more guidance on the documentation required for services rendered by a licensed lesser qualified professional.

Speech Language Pathology Services

Speech language pathology services include evaluations, diagnosis, or treatments delivered by a licensed speech language pathologist (SLP), or treatments delivered by a licensed speech language pathology assistant (SLP-A). A speech language pathologist with a limited license who is completing his/her clinical fellowship year (CF) can provide evaluations and treatment; however, these services must be billed under the NPI of the fully licensed supervising SLP who is enrolled with Maryland Medicaid. SLP Clinical Fellows are not eligible to enroll with Maryland Medicaid.

Licensed lesser qualified professionals (i.e. SLP-As) who provide SLP services require direct supervision. Services provided by a SLP-A must be billed under the NPI of the supervising SLP who is enrolled with Maryland Medicaid. Please see the Documentation Requirement section of this manual for more guidance on the documentation required for services rendered by a licensed

lesser qualified professional.

Therapeutic Behavior Services

Therapeutic behavior services are one-to-one rehabilitative services, delivered by a therapeutic behavioral aide, using appropriate methods of preventing or decreasing maladaptive behaviors for a Medicaid participant. The therapeutic behavioral aide must be supervised by a licensed physician or licensed mental health professional and receive annual training in the principles of behavioral management and appropriate methods of preventing or decreasing maladaptive behaviors.

Lesser qualified professionals (i.e. TBAs) who provide therapeutic behavioral aide services require supervision. Please see the Documentation Requirement section of this manual for more guidance on the documentation required for services rendered by a lesser qualified professional.

Transportation Services

The following are covered transportation services:

- Transportation to or from a school where a Medicaid covered IDEA service is provided;
- Transportation to or from a site where a Medicaid Early Intervention covered IDEA service is provided; and
- Transportation between a school and a Medicaid IDEA covered service.

Specialized transportation services are covered when provided to a child:

- Who is an eligible Medicaid participant requiring special transportation;
- Who was transported to and/or from a Medicaid covered service under IDEA; and
- Whose transportation and Medicaid covered services are included on the child's IEP/IFSP.

DOCUMENTATION REQUIREMENTS

Documentation is required for every Medicaid service delivered to a student.

A record is considered complete, if it contains sufficient information to identify the student, document the intervention, treatment, and/or service provided as well as the student’s response to the intervention, treatment, and/or service(s). All entries in the record must be **legible**, complete with date and time noted, and printed name and signature of the person providing the intervention, treatment, or service.

The provider **must** maintain documentation for all of the following data elements:

- ***Student Name***
- ***Medical Assistance Number***
- ***Date and Duration of Service*****:** The date, start and stop time the Medicaid service is provided to a student.
- ***Nature, Unit or Units, and Procedure Codes***
- ***Mode of Service Delivery: Was the service provided in person or via telehealth***

> **NOTE:** IEP Service Coordination may be rendered in person, in writing, by telephone or via telehealth.
> **NOTE:** IFSP Service Coordination may be rendered in person, by telephone or via telehealth.

- ***Activity/Procedure Note***: A written description of the intervention provided to the student. The note should clearly describe the therapist intervention/activity that was provided, and the student's response to it.
- ***Individual/Group***: Document whether the student received services on an individual (I) basis or in a group (G) setting. When delivering therapies in a group setting, the group size should be two or more students. If individual therapy occurs while a provider works with a student during a class setting, the note needs to clearly specify and describe the individual treatment provided to the student.
- ***Co-treatment***: The simultaneous treatment by two providers of different therapy disciplines during the same time period may be provided in circumstances where it is medically necessary to optimize the student's rehabilitation. The billing time for these combined services must be prorated. In order to receive prorated reimbursement, the session must be at least 30 minutes. There should be separate session notes for each of the two disciplines providing services during co-treatment.
- ***Assessment/Reassessment:*** The needs of the student may at times require assessments and reassessments. The assessment and reassessment reports must include the following elements:
    - The date and name of the assessment tool;
    - The behavioral responses and raw scores of the child;
    - The professional analysis of the data;
    - The recommendations for treatment;
    - The validity statement;
    - The printed name and legible signature of the therapist;
    - Start and stop times; and
    - Permission to test, signed and dated by parent

> **NOTE:** Multidisciplinary assessment reports require all of the above elements in addition to the signatures and initials of each therapist involved, for each section completed by that therapist.

- ***Make-up Session***: If the service is a make-up session, this must clearly be documented in the service note, which should also include the date when the original session was scheduled. The make-up session must be made up within 3 months from the date the session was originally scheduled.
- ***Provider name, location, and provider number***
- ***Signatures***: The printed name, legible signature, and credentials (RN, PT, LCSW-C, etc.) of the professional who provided the services. Signatures can be handwritten or in an electronic form (there needs to be an established protocol for electronic signatures). Insertions of signature or rubber stamps are not acceptable, unless medically documented with a prescription.
- ***Transportation:*** Transportation services can only be billed to Medicaid on days when the student received a school health- related service. A signed bus log documenting the trip to and from school is required. The bus log becomes a Medical Assistance record and must be retained as such.
- ***Supervision***: Documentation of monthly supervision must be maintained for lesser qualified

licensed professionals (SLPA, COTA, PTA, LGPC, LMSW, and TBA).
This documentation must include:

- The printed names and signatures of both the lesser qualified professional and supervisor;
- Date of monthly supervision, completed in the same month of discussion of supervision activities, detailing monthly supervision (i.e. a supervision date in April, discussed supervision activities for the month of April);
- The participant's full name and progress towards goals; and
- Changes to the participant's treatment plan if indicated, as a result of review;

Notes that are co-signed by the supervisor but do not include the documentation described above **DO NOT** meet the documentation requirement for supervision.

- ***Location: Home, School, and Community:*** The location of treatment needs to be identified on the IEP/IFSP in the description of the service section, and in the documentation of the treatment or contact with family for service coordination.
- ***Licenses*****:** Previous and current licenses must be maintained in a retrievable format to verify the provider's credentials for all dates of services provided to Medicaid participants. Previous and current licenses for anyone providing supervision must also be maintained.
- ***Certifications:*** Previous and current certifications must be maintained in a retrievable format to verify the provider's credentials for all dates of services provided to Medicaid participants.
- ***Record Retention*****:** Providers are required to maintain all records related to Medicaid for six (6) years.

AUDIT REQUIREMENTS

Monitoring of delivery of IEP/IFSP services will be conducted on a regular basis by the Interagency Medicaid Monitoring Team (IMMT). Reimbursement for services that do not meet the requirements described in this manual will be recovered (see Recovery/Refund Process).

Copies of the following records must be maintained for six years for auditing purposes (even if the student is no longer living in the jurisdiction):

- A one-time Initial MA Parental Consent, signed by the parent on or after March 18, 2013;
- Evidence of annual written notification of MA rights given to parents;
- When testing, signed permission to test is required.

> **NOTE**: The language included in the initial MA Parental Consent and Annual Written Notification must be consistent with the language utilized by the Maryland Online IEP/IFSP at the time the signature was obtained or the notification was provided.

- Documentation of parental notification of name of current Service Coordinator;
- All IEP/IFSPs that were in effect during the month being reviewed;
- Notes of an IEP/IFSP team meeting and copies of all evaluation reports, if a child is not

found to be eligible under IDEA;

- All evaluation reports, if an evaluation occurred for the month of review;
- Notes of an emergency meeting when billing for an emergency IEP review;
- All clinical and supporting documentation for each service as prescribed on the IEP/IFSP;
- Provider’s active certification or active license at the time of treatment;
- Supervisor’s license and documentation of supervision for lesser-qualified providers;
- Annual training is required for therapeutic behavior aides and non-professional service coordinators. Evidence of this annual training must include:
    - The name of the training course;
    - The date(s) of the training course;
    - The course description;
    - The name and credentials of the instructor; and
    - The attendance sheet verifying trainee participation, which must detail the printed name and signature of each trainee;
- Transportation attendance logs signed; and
- Official school attendance record for each student.

INSTRUCTIONS ON RECOVERY/REFUND PROCESS (RETURNING FUNDS TO MEDICAID)

After the audit, schools and ITP providers will be notified verbally and in writing of findings regarding services that were not delivered in accordance with terms of applicable federal regulations and State Medicaid rules. The Department will seek reimbursement for any identified overpayment.

The funds will be deducted from future MA payments, thirty (30) days from the date of the notice. Schools have thirty (30) days from the date of the notice of a proposed action to appeal the decision in writing and request a hearing with the Department in accordance with COMAR 10.09.36.09.

CORRECTIVE ACTION PLAN

The Corrective Action Plan (CAP) addresses the actions taken by the provider to correct the findings identified (if any) in the IMMT's report. Use the provided CAP paperwork to document all CAP activities. The CAP must be submitted within eight (8) weeks following the receipt of the report. A second CAP, or CAP Part II is required approximately eight (8) weeks prior to the date of the next IMMT review. This portion of the CAP addresses the efficacy of the first portion of the CAP. Use the CAP paperwork provided by MSDE to document all CAP activities.

For the Department, a copy of the CAP should be sent to: Lori Proctor, Division Chief, Division of Children's Services, Maryland Department of Health, 201 W. Preston St., Rm. 208, Baltimore, MD 21201, Lori.proctor@maryland.gov, and Stanlee Lipkin, Program Specialist, 201 W. Preston St., Rm. 210, Baltimore, MD 21201, Stanlee.lipkin@maryland.gov.

For MSDE, a copy of the CAP should be sent to: Kathi McConnell, Lead Medicaid Monitoring Specialist, Maryland State Department of Education, Division of Special Education/Early Intervention Services, 200 E. Baltimore St., Baltimore, MD 21201.

SELF-MONITORING PROCESS

Providers are strongly encouraged to conduct self-monitoring activities related to the delivery and billing for Medicaid services.

When a provider needs to submit an adjustment, the provider should complete the MDH 4518A Adjustment Request Form, found on the Provider Information page.

BILLING GUIDELINES

The following guidelines are to be used for Medical Assistance (MA) reimbursement for children enrolled in the Medical Assistance Program who receive health-related services identified in an IEP/IFSP. The services must be medically necessary for evaluating the need for and implementation of a child's IEP/IFSP, pursuant to COMAR 10.09.50.04A (1)-(5). The child's record must document a disability or disorder. Health-related services or health-related early intervention services (including transportation) must be listed in the child's IEP/IFSP, and must be approved by the IEP/IFSP team. IEP and IFSP services must be billed using the provider's Maryland Medicaid provider type 91 provider number. All services with the exception of service coordination and transportation require the referring provider's NPI.

The provider shall submit requests for payment for school health-related services, health-related early intervention services, service coordination, and transportation services as stated in COMAR 10.09.36. Providers will accept payment in full for covered services rendered and make no additional charge to any person for covered services. Providers are reimbursed according to the Fee Schedule found at the end of this manual.

Billing Limitations

The Provider may not bill the Program for:

- Services not listed on the child's IEP/IFSP;
- Services provided in excess of the IEP/IFSP;
- Services rendered by mail with the exception of IEP/IFSP service coordination;
- Services with the exception of IEP/IFSP service coordination and Counseling rendered by telephone to the participant (or participant's parent/guardian on the participant's behalf);
- Completion of notes, forms or reports with the exception of 96136 and 96137;
- Broken or missed appointments;
- Services that do not meet the standards set forth in the Documentation Requirements section noted above;
- Consultation with other staff;
- Services provided by unlicensed student interns or any other unqualified provider;
- Make-up services provided on the same day as regular services were delivered, or more than 90 days before or after original date of service; and
- Services limited to coaching; no direct therapeutic interventions provided to the child/student.

The Department may not reimburse for claims received for services provided more than 12 months after the date of service. The claim is considered to have been received when the claim is reported on the provider's remittance advice statement.

The provider may not bill the Program for evaluations/re-evaluations and therapy provided on the same day for the same service type (e.g., PT evaluation or reevaluation and PT services on the same date of service).

When co-treatment has taken place, the billing time for these combined services must be prorated and

have separate session notes for each of the two disciplines. If the two therapy providers were present for 30 minutes, (e.g., OT and PT), the following services should be billed: 1 unit (15 minutes) of OT services and 1 unit (15 minutes) of PT services. If the co- treatment of a 30 minute service involves a speech therapist, the speech therapy provider should bill for 1 unit of service (92507, one time per day) and the second therapy provider (OT and/or PT) should bill for 1 unit of service (15 minutes).

Third Party Insurance

If the Medicaid participant has other insurance in addition to Medicaid, do not bill Medicaid for these services**. IEP and IFSP service coordination and transportation services are an exception to this requirement.**

Parental Consent

An initial consent form must be signed by the participant's parent (or by the participant if 18 years or older and competent) and must be on file prior to billing for medical assistance. The language included in the initial MA Parental Consent must be consistent with the language utilized by the Maryland Online IEP/IFSP at the time the signature was obtained. A Medical Assistance service coordinator must be identified by name on the consent form in order to bill service coordination. A backup service coordinator may be identified as well.

A signed consent should be on file for all participants so that if a non-Medical Assistance covered participant gains Medical Assistance eligibility, back billing would be able to take place for services rendered during the eligibility certification period, up to the previous 12 months.

A copy of the annual written notification of MA rights must be distributed to the participant’s parent annually. The language included in the Annual Written Notification must be consistent with the language utilized by the Maryland Online IEP/IFSP at the time the notification was provided.

For any changes to the service coordinator, the parent must be notified in writing. Billing for new service coordination cannot be submitted until this is complete. Please note that while a new consent form is not necessary for this process, it may be utilized to make this process easier and will fulfill the annual notification requirement as well.

NOTE: The parents must be notified in writing when there is a change in the Service Coordinator.

Claims Submission

For information on claims submission, please refer to the CMS-1500 Billing Instructions on the Provider Information page.

Referring Provider

Claims for all services except service coordination and transportation services must include the name and NPI for the Referring Provider (RP) in Box 17 of the CMS 1500. The RP must be a licensed fully qualified enrolled Medicaid provider. If you have a provider enrollment question, please contact our ePREP Helpline at 1.844.4MD.PROV (1.844.463.7768). You may also visit the Provider Enrollment website for helpful enrollment resources.

Denial Claims

If a claim is denied there will be a code at the bottom of the remittance advice. If you have questions about your billing or payment questions please contact our Provider Relations Helpline at 410-767-5503 (Professional/CMS 1500 Claims - Select Option 2; Institutional/UB04 - Select Option 3).

IEP/IFSP HEALTH-RELATED SERVICE PROCEDURE CODES & FEE SCHEDULE EFFECTIVE 7/1/24

As a Maryland Medicaid provider, it is your responsibility to bill the Program appropriately for all school health-related and early intervention health-related services including service coordination and transportation services.

NOTE: Bolded procedure codes indicate a rate increase for dates of service on or after 7/1/2024.

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
Psychological Services					
90791**	**Psychiatric Diag. Interview** — Modifier: AF	**Licensed Psychiatrist**	**1**	**$235.66**	**One time a year, (in twelve months). Cannot bill on day with other psych treatment; Time minimum 16 min. to 60 min.**
	AH	**Licensed Psychologist**	**1**	**$191.89**	
	AJ	**LCSW-C**	**1**	**$168.02**	
	AJ	**LCPC**	**1**	**$168.02**	
	AJ	**Licensed Nurse Psychotherapist**	**1**	**$168.02**	
90832**	**Individual psychotherapy**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LMSW, LCPC, LGPC, Licensed Nurse Psychotherapist**	**20-30 min**	**$63.53**	**One per day; cannot bill 90834 on the same day**
90834**	**Individual psychotherapy**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LMSW, LCPC, LGPC, Licensed Nurse Psychotherapist**	**45-50 min**	**$115.12**	**One per day; cannot bill 90832 on the same day**
90847**	**Family psychotherapy 45-60 minutes**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LMSW, LCPC, LGPC, Licensed Nurse Psychotherapist**	**1**	**$121.10**	

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
90853	**Group psychotherapy**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LMSW, LCPC, LGPC, Licensed Nurse Psychotherapist**	**1**	**$39.25**	
96130	**Psychological Testing, Evaluation, Treatment Planning and Report, and Interactive feedback to the student, family members, and caregivers.**	**Licensed Psychologist**	**First hour**	**$179.37**	**One per 12 months**
96131	**Psychological Testing, Evaluation, Treatment Planning and Report, and Interactive feedback to the student, family members, and caregivers.**	**Licensed Psychologist**	**Each additional hour**	**$136.31**	**Billed with 96130, for each additional half hour.**
96136	**Psychological Test Administration and Scoring**	**Licensed Psychologist**	**First 30 minutes**	**$73.96**	**One per 12 months**
96137	**Psychological Test Administration and Scoring**	**Licensed Psychologist**	**Each additional 30 minutes**	**$68.96**	**Three units per day, Nine units per 12 months**
Speech Language Pathology					
92521**	Evaluation of speech fluency	Licensed Speech Pathologist	1	$91.35	One time per 12 months; cannot bill 92507 or 92508 on the same day
92522**	Evaluation of speech sound production	Licensed Speech Pathologist	1	$74.00	One time per 12 months; cannot bill 920507, 92508 or 92523 on the same day

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
92523**	Evaluation of speech sound production with evaluation of language comprehension & expression	Licensed Speech Pathologist	1	$153.97	One time per 12 months; cannot bill 92507, 92508 or 92522 on the same day
92523** with 52 Modifier	Evaluation of language comprehension & expression	Licensed Speech Pathologist	1	$79.97	One time per 12 months; cannot bill 92507, 92508 or 92522 on the same day
92524**	Behavioral & qualitative analysis of voice & resonance	Licensed Speech Pathologist	1	$77.40	One time per 12 months; cannot bill 92507, 92508 or 92522 on the same day
92507**	Individual speech therapy	Licensed Speech Pathologist or Licensed Speech Pathology Assistant	1	$63.99	One time per day; cannot bill 92508 on the same day
92508**	Group speech therapy	Licensed Speech Pathologist or Licensed Speech Pathology Assistant	1	$25.68	One time per day; cannot bill 92507 on the same day
Audiology					
92551	Screening Test Pure Tone, Air Only	Licensed Audiologist	1	$9.72	One time per day
92552	Pure Tone Audiometry	Licensed Audiologist	1	$25.40	One time per day; cannot bill 92557 on the same day
92553	Audiometry, Air & Bone	Licensed Audiologist	1	$30.25	One time per day; cannot bill 92557 on the same day
92555	Hearing Test	Licensed Audiologist	1	$18.85	One time per day
92556	Speech Audiometry, with speech recognition	Licensed Audiologist	1	$30.53	One time per day; cannot bill 92557 on the same day

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
92557	Comprehensive audiology evaluation	Licensed Audiologist	1	$36.60	One time per day; cannot bill 92552 on the same day
92567	Tympanometry	Licensed Audiologist	1	$17.36	One time per day
92568	Acoustic Reflex Testing	Licensed Audiologist	1	$16.22	One time per day
92570	Acoustic Immittance Testing	Licensed Audiologist	1	$36.00	One time per day
92579	Visual Reinforcement Audiometry	Licensed Audiologist	1	$35.55	One time per day
92582	Conditioning Play Audiometry	Licensed Audiologist	1	$53.94	One time per day
92587	Distortion product evoked otoacoustic emissions; limited evaluation	Licensed Audiologist	1	$24.18	One per year
92588	Evoked otoacoustic emissions; comprehensive evaluation	Licensed Audiologist	1	$36.71	One time per day
92592	Hearing Aid Check, Monaural	Licensed Audiologist	1	$42.00	One time per day
92593	Hearing Aid Check, Binaural	Licensed Audiologist	1	$42.00	One time per day
92626	Evaluation of auditory rehab status; first hour (can be used pre-op and post-op)	Licensed Audiologist	1	$70.21	One time per day
92627	Evaluation of auditory rehab status; each additional 15 min.	Licensed Audiologist	15 mins.	$17.37	Three units per day
Therapeutic Behavioral Services					
96158	**Therapeutic Behavior Services**	**Therapeutic Behavior Aide**	**First 30 minutes**	**$36.26**	**One time per day**
96159	**Therapeutic Behavior Services**	**Therapeutic Behavior Aide**	**Each additional 15 minutes**	**$18.12**	**Unlimited**

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
Physical Therapy					
97161**	Physical therapy evaluation, Low complexity, 20 min	Licensed Physical Therapist	20 mins.	$69.20	One time per 12 months; cannot bill with 97110, 97162 or 97163, on the same day
97162**	Physical therapy evaluation, Moderate complexity, 30 min	Licensed Physical Therapist	30 mins.	$69.20	One time per 12 months; cannot bill with 97110, 97161, 97163 on the same day
97163**	Physical therapy evaluation, High complexity, 45 min	Licensed Physical Therapist	45 mins.	$69.20	One time per 12 months; cannot bill with 97110, 97161, 97162, on the same day
97164**	Physical therapy re-evaluation, Established plan of care	Licensed Physical Therapist	1	$47.19	Cannot bill 97161, 97162, 97163, or 97110 on the same day
97110**	Physical therapy service	Licensed Physical Therapist, or Licensed Physical Therapy Assistant	15 mins.	$29.03	4 units per day; cannot bill 97161, 97162, 97163, or 97164 on the same day
Occupational Therapy					
97165**	Occupational therapy evaluation, low intensity, 30 min	Licensed Occupational Therapist	30 mins.	$67.01	One time per 12 months; cannot bill 97530, or 97150, 97166, 97167 on the same day
97166**	Occupational therapy evaluation, Moderate intensity 45 min	Licensed Occupational Therapist	45 mins.	$67.01	One time per 12 months; cannot bill 97530, or 97150, 97165, 97167 on the same day
97167**	Occupational therapy evaluation, High intensity 60 min	Licensed Occupational Therapist	60 mins.	$67.01	One time per 12 months; cannot bill 97530, or 97150, 97165, 97166 on the same day
97168**	Occupational Therapy re-evaluation	Licensed Occupational Therapist	1	$44.34	Cannot bill 97165, 97166, 97167, 97150, or 97530 on the same day

Procedure Code	Procedure Description	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
97150**	Group occupational therapy service	Licensed Occupational Therapist or Licensed Occupational Therapy Assistant	1	$18.25	Cannot bill 97165, 97166, 97167, 97168, or 97530 on the same day
97530**	Occupational therapy service	Licensed Occupational Therapist or Licensed Occupational Therapy Assistant	15 min	$30.56	4 units per day; cannot bill 97165, 97166, 97167, 97168, or 97150 on the same day
Nursing Services					
T1000	**Nursing services**	**Registered Nurse**	**15 min**	**$19.87**	**8 units per day**
T1000 with 52 Modifier* **	**Nursing Services**	**Licensed Practical Nurse**	**15 min**	**$12.88**	**8 units per day**
Nutrition Services					
97802**	Nutrition assessment & intervention	Licensed Dietitian/Nutritionist	15 min	$30.03	Once per year; 4 units per day
97803**	Nutrition re-assessment & intervention	Licensed Dietitian/Nutritionist	15 min	$26.35	2 units per day; cannot bill 97802 on the same day
Service Coordination					
T1023-TG	Initial IEP or IFSP	Qualified Service Coordinator per COMAR 10.09.40 or COMAR 10.09.52	1	$500.00	Once per lifetime, age 0-2; once per lifetime, age 3-20
T1023**	Periodic IEP/IFSP Review	Qualified Service Coordinator per COMAR 10.09.40. or COMAR 10.09.52	1	$275.00	3 per calendar year

T2022**	Ongoing Service Coordination	Qualified Service Coordinator per COMAR 10.09.40 or COMAR 10.09.52	1	$150.00	Once a month; cannot bill T1023 or T1023-TG in the same month

Procedure Code	**Procedure Description**	**Qualified Provider**	**Unit of Service**	**Rate per Unit**	**Maximum Units of Service**
W9322**	Initial Autism Waiver Plan of Care	Qualified Service Coordinator per COMAR 10.09.52	1	$500.00	Student must be enrolled in the Autism Waiver
W9323**	Ongoing Autism Waiver Service Coordination	Qualified Service Coordinator per COMAR 10.09.52	1	$150.00	Student must be enrolled in the Autism Waiver
W9324**	Autism Waiver Plan of Care Reassessment; Risk Assessment	Qualified Service Coordinator per COMAR 10.09.52	1	$275.00	Student must be enrolled in the Autism Waiver
Transportation Services					
T2003	Non-Emergency Transportation Services		1	$12.50	2 units per day

** Indicates that the service may be delivered via telehealth. **Services billed via telehealth require the GT modifier.**
***The 52 modifier is used to indicate a reduced service.

PLEASE NOTE: Monitoring of the delivery of IEP/IFSP Services is conducted on a regular basis by the IMMT. Reimbursement for services that do not meet the requirements described in the IEP/IFSP Manual and/or the appropriate COMAR regulation chapter will be recovered.