MEDICAID POLICY & PROCEDURE MANUAL

FOR NON IEP Mental Health Services

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

In May 2023, the Center for Medicare and Medicaid Services (CMS), the federal agency overseeing Medicaid, released state guidance on new increased flexibilities for Medicaid reimbursement of school-based services (SBS), including the related administrative activities.

The Maryland Department of Health, in collaboration with the Maryland State Department of Education (MSDE), has used these new flexibilities to **1) enable school psychologists to bill for IEP/IFSP services** and **2) expand Medicaid reimbursement for certain behavioral health services provided by school psychologists and school social workers to non-IEP/IFSP students.**

The instructions in this manual are to be used by school mental health providers (School Psychologists and School Social Workers (LCSW-C).)

COMAR References

COMAR 10.09.36	*General Medical Assistance Provider Participation Criteria*
COMAR 10.09.50	*EPSDT School and Health-Related Early Intervention Services*
COMAR 10.09.59	*Specialty Mental Health Services*

DEFINITIONS

1) **Behavioral Health Administrative Services Organization –** The contactor procured by the State to provide the Department with administrative support services to operate the Maryland Public Behavioral Health System.

2) **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.

3) **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.

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

5) **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.

6) **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**.**

7) **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.

8) **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.

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

10) **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.

11) **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.

12) **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.

13) **Participant** – A Medical Assistance participant who is eligible for and receives school-based mental health related services and is under 21 years of age (eligibility ends on the 21st birthday).

14) **Plan Of Care** – A medical document developed after an assessment by a qualified health

professional acting within their scope of practice. Serves as documentation of medical necessity for all services being provided to the student.

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

16) **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.

17) **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

Carelon Provider Portals (ProviderConnect and Availity)

Carelon is the Department's behavioral health administrative services organization. The LEAs will register for Carelon's provider portals, ProviderConnect and Availity, to request authorizations, submit claims, check on claim status, and other administrative tasks. LEAs will register with the provider portals after enrolling in Medicaid via ePrep.

- Register with ProviderConnect here.
- Register with Availity here.

Please see Carelon's Behavioral Health Provider Orientation training for full instructions on how to register for ProviderConnect and Availity (pages 1-16), and guidelines for submitting authorization requests (pages 28-36).

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. 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 through the Eligibility Verification System (EVS) 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.**

These services are billed to the behavioral health administrative services organization (Carelon). Services provided to participants enrolled with an MCO under HealthChoice should be billed to Carelon 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 non-IEP behavioral health services 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

PSYCHOLOGICAL SERVICES

COMAR 10.09.50 and COMAR 10.09.59

Psychological, counseling, and social work services must be delivered by a licensed mental health professional, including licensed school psychologists or a LCSW-C. 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 established goals. Please see the Documentation Requirement section of this manual for more guidance on the documentation required.

The following professionals will **not** be eligible to bill Medicaid for services provided to non-IEP students: LCSWs, LMSWs, LGPCs, Nurse Practitioners.

These services must be provided according to the requirements detailed below when the service is addressed in a plan of care. See the Fee Schedule at the end of this manual for specific service codes.

Billing reimbursement requests (codes) for services must match the child's Plan of Care (COMAR l0.09.50.05; COMAR 10.09.36.03) and must clearly specify the frequency and duration of the service.

DOCUMENTATION REQUIREMENTS

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

A Plan of Care is required to establish the medical necessity for the frequency and intensity of services.

A record is considered complete, if it contains sufficient information to identify the student, document the behavioral health diagnosis, 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 of Authorization***
- ***Behavioral Health Diagnosis***
- ***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***
- ***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.
- ***Provider name, location, and provider number***
- ***Signatures*****:** The printed name, legible signature, and credentials (School Social Worker, School Psychologist) 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. If the signature is not recognizable, an attestation confirming that the signature in the record belongs to the provider will be accepted.
- ***Location: School:*** The location of treatment will be in the school setting.
- ***Licenses/Certification*****:** Previous and current licenses/certifications 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.
- ***Record Retention*****:** Providers are required to maintain all records related to Medicaid for six (6) years.

AUDIT REQUIREMENTS

Monitoring of delivery of non-IEP services will be conducted on a regular basis by the Audit Team. Reimbursement for services that do not meet the requirements described in this manual will be recovered (see Recovery/Refund Process). The timeline for audits will be established in mid-2025.

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):

- MA Consent for treatment
- Evidence of annual written notification of MA rights given to parents;

> **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.

- All clinical and supporting documentation for each service;
- Provider's active certification or active license at the time of treatment;
- Official school attendance record for each student.

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

After the audit, schools and mental health 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 timeline for recovery of funds will be established in mid-2025.

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 Audit Team'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 audit. 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: Linda Rittelmann, Deputy Director, Acute Care Administration, Maryland Department of Health, 201 W. Preston St., Rm. 208, Baltimore, MD 21201, Linda.Rittelmann@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: MSDE Staff, 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 write "CORRECTED CLAIM" at the top of the CMS-1500 or UB-04 form. Please include the original Carelon Behavioral Health of Maryland claim number on the corrected claim.

To electronically submit corrected claims, please refer to the 837 Companion Guide.

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. The services must be medically necessary for evaluating the need. The child's record must document an eligible behavioral health diagnosis, as listed in COMAR 10.67.08.02. Health-related services must be listed in the child's Plan of Care. Expansion services must be billed using the provider's Maryland Medicaid provider type 91 provider number. All services require the referring provider's NPI.

The provider shall submit requests for payment for school mental health-related services to Carelon. 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 rendered by telephone to the participant (or participant's parent/guardian on the participant's behalf), unless telehealth standards are met;
- Completion of notes, forms or reports;
- 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;
- 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.

Third Party Insurance

If the Medicaid participant has other insurance in addition to Medicaid, do not bill Medicaid for these services.

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. A copy of the annual written notification of MA rights must be distributed to the participant's parent annually.

Claims Submission

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

Referring Provider

Claims for all 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, please contact Carelon's Customer Service phone number at 1-900-888-1965.

Non-IEP MENTAL HEALTH PROCEDURE CODES & FEE SCHEDULE EFFECTIVE 1/1/25

As a Maryland Medicaid provider, it is your responsibility to bill the Program appropriately for all school health-related services.

Procedure Code	Procedure Description	Modifier	Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
Psychological Services						
90791**	Psychiatric Diag. Interview	AH	Licensed Psychologist, School Psychologist	1	$191.89	One time a year, (in twelve months). Cannot bill on day with other psych treatment or psych testing; Time minimum 16 min. to 60 min.
		AJ	LCSW-C		$168.02	
90832**	Individual psychotherapy	AH	Licensed Psychologist, School Psychologist	20-30 min	$63.53	One per day; cannot bill 90834 on the same day
		AJ	LCSW-C		$55.43	
90834**	Individual psychotherapy	AH	Licensed Psychologist, School Psychologist	45-50 min	$115.12	One per day; cannot bill 90832 on the same day
		AJ	LCSW-C		$101.07	
90847**	Family psychotherapy 45-60 minutes	AH	Licensed Psychologist, School Psychologist	1	$121.10	Can be billed on same date as 908342, 90834, 90853
		AJ	LCSW-C		$104.04	
90853	Group psychotherapy		Licensed Psychologist, School Psychologist, LCSW-C	1	$39.25	Can be billed on the same date as 90847, 90832, 90834

** Indicates that the service may be delivered via telehealth. **Services billed via telehealth require the GT modifier.**

PLEASE NOTE: Monitoring of the delivery of these services is conducted on a regular basis by the Audit Team. Reimbursement for services that do not meet the requirements described in this manual and/or the appropriate COMAR regulation chapter(s) will be recovered.