MARYLAND MEDICAL ASSISTANCE

EARLY & PERIODIC SCREENING, DIAGNOSIS & TREATMENT (EPSDT)

SCHOOL HEALTH-RELATED
&
HEALTH-RELATED EARLY INTERVENTION SERVICES (IEP/IFSP SERVICES)

SERVICE COORDINATION & TRANSPORTATION SERVICES

POLICY & PROCEDURE MANUAL
&
BILLING INSTRUCTIONS

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Maryland Department of Health
Division of Children's Services
201 W. Preston Street, Room 210
Baltimore, MD 21201

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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, and COMAR 10.09.52.

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*

DEFINITIONS

1) **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.

2) **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.

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

4) **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.

5) **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**.**

6) **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.

7) **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.

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

9) **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.

10) **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.

11) **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.

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

13) **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.

14) **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.

15) **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;

c. The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
d. Not primarily for the convenience of the consumer, the consumer's family, or provider.

16) **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**.

17) **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).

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

19) **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.

20) **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.

21) **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.

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 the AW Service Coordination handbook and training materials. Please contact the Autism Waiver Liaison at 410-767-0046 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 on the day a service was rendered. An eligibility check should be completed to verify the child is eligible 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 verify quickly and efficiently 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 to your advantage to do so 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 provider number as well as pertinent participant information 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 HIPPA can be found at:
https://health.maryland.gov/hipaa/Pages/Home.aspx.

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.

SERVICE DESCRIPTIONS AND PROCEDURE CODES

Service Coordination

IFSP COMAR 10.09.40 & IEP COMAR 10.09.52

See the Fee Schedule on pages 20-25 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 to develop an initial IEP/IFSP for a participant. The IEP 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 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 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, 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**

(2) 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/IFSP Review.

IEP/IFSP Ongoing Service Coordination

A provider may bill one unit per month for the ongoing service coordination for IEP or IFSP services. The initial IEP or 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 or 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, 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, or by telephone, with the participant's family, on the participant's behalf. For any changes to service coordination, the parent must be notified in writing. Billing for new service coordination cannot be submitted until this is complete. Please note that a new consent form is **not** necessary for this process.

It is recommended that service coordination **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.

HEALTH-RELATED 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 on pages 20-25 of this manual for specific health-related service codes.

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 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.

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;
- 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.

Occupational therapy services require supervision for lesser-qualified professionals. See page 9 of this manual for documentation requirements.

Physical Therapy Services

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

Physical therapy services require supervision for lesser-qualified professionals. See page 9 of this manual for documentation requirements.

Speech Language Pathology Services

Speech language pathology services include evaluations, diagnosis, or treatments delivered by a licensed speech language pathologist, or treatments delivered by a licensed speech language pathology assistant. A speech language pathologist with a limited license who is completing his/her clinical fellowship year can bill for both evaluations and treatment. Documentation of supervision is not required for the purpose of IMMT review; however, other lesser- qualified professionals do require this documentation to be on file. See page 9 of this manual for documentation requirements.

Therapeutic Behavior Services

Therapeutic behavior services are one-to-one rehabilitative services, delivered by a therapeutic behavior aide, using appropriate methods of preventing or decreasing maladaptive behaviors for a Medicaid participant. The therapeutic behavior 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.

Therapeutic behavior services require supervision for lesser-qualified professionals. See page 9 of this manual for documentation requirements.

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 for Medicaid covered services is a requirement for Medicaid reimbursement. Medicaid covered services are defined by the following COMAR regulations: 10.09.50 EPSDT School Health-Related Services or Health-Related Early Intervention Services, 10.09.52 Service Coordination for Children with Disabilities, 10.09.40 Early Intervention Services Case Management, and 10.09.25 Transportation Services Under the Individuals with Disabilities Education Act (IDEA).

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 and Date of Birth***
- ***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***
- ***Activity/Procedure Note*:** A written description of the intervention provided to the student. The note should clearly describe the 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 should 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; and

- The printed name and legible signature of the therapist, and initials in each section they have written.

Multidisciplinary assessment reports require all of the above elements in addition to the signatures and initials of each therapist involved.

- ***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. They 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 never acceptable.
- ***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, TBS, LMSW, etc.).

  This documentation should include:
  - The name of the lesser qualified professional;
  - Dates detailing monthly supervision;
  - The participant's progress towards goals;
  - Changes to the participant's treatment plan as a result of review; and
  - Signature of both the supervisor and lesser qualified professional.

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

- Initial MA Parent Permission, signed by the parent on or after March 18, 2013;
- Evidence of annual written notification of MA rights given to parents;
- 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 a child is found to be eligible under IDEA, and billing if an evaluation occurred for the month of review;
- Notes of an emergency meeting when billing for an emergency IEP review;
- Clinical documentation for each service as prescribed on IEP/IFSP;
- Provider's active licenses at the time of treatment;
- Supervisor's licenses 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;
- School attendance records for each student.

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

After the onsite visit, schools and ITP providers will be notified 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 10.01.03.06.

When findings include a required adjustment, the provider should complete the MDH 4518A - Adjustment Request Form. To request a copy of the form, call 410-767- 6857.

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. The CAP must be submitted within six (6) weeks following the receipt of the report.

For the Department, a copy of the CAP should be sent to: Margaret Berman, Division Chief, Children's Services, Maryland Department of Health, 201 W. Preston St., Rm. 210, Baltimore, MD 21201.

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 required to conduct self-monitoring activities related to the delivery and billing for Medicaid services. A copy of the annual summary report should be sent to the addresses for the Department and MSDE that are listed in the "Corrective Action Plan" section of this manual.

Note that providers are required to return funds to Medicaid if, during their self-monitoring activities, it is found that Medicaid was billed in error (even if the error was more than 12 months ago). Conversely, providers have up to twelve (12) months from the date of service to submit a claim form if it is found that a billing opportunity was missed during the self-monitoring process.

Please contact the staff specialist for School Health Services at the Department at **410-767-1599** if you have any questions

BILLING PROCESS

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 10.9.36. 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 on pages 20-25 of this manual.

Billing Limitations

The following billing instructions 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 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 service coordination;
- Services with the exception of IEP/IFSP service coordination rendered by telephone to the participant (or participant's parent/guardian on the participant's behalf);
- Completion of notes, forms or reports;
- Broken or missed appointments;
- Services that are not sufficiently documented (clinical note, attendance record, license of the provider for the date of service);
- Consultation with other staff;
- Services provided by unlicensed student interns or any other unqualified provider; and
- Make-up services provided on the same day as regular services were delivered.

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 re-evaluation 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.**

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 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. It is recommended that service coordinators utilize the Medical Assistance page of the Maryland Online IEP for this purpose.

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.

INSTRUCTIONS FOR COMPLETING THE BILLING FORM (CMS-1500)

Claims Submission

***Electronic Claims Submission*:** Providers must submit claims in the ANSI ASC X12N 837P format, version 5010A. A signed Submitter Identification Form and Trading Partner Agreement must be submitted, as well as testing before transmitting such claims. Testing information can be found on the Department's web page: *https://health.maryland.gov/hipaa/Pages/testinstruct.aspx*.

Companion guides to assist providers for electronic transactions can be found on the Department's web page: *http://dhmh.maryland.gov/hipaa/pages/transandcodesets.aspx*.

Early intervention and school providers may use one of the HIPAA compliant electronic billing methods with a modified CMS-1500 or the professional electronic claim 837P. Please note that referring providers must be enrolled in Medicaid and include their NPI. When submitting claims electronically, the referring provider NPI can be sent at the claim level (2310B Loop) or the Service Line (2420F Loop). For information about electronic billing, use the following link: https://encrypt.emdhealthchoice.org/emedicaid/ and refer to the 837P HIPAA Implementation Guide.

To test 837P claims, existing providers need to use the correct ISA header information and option on the WebPortal Main Menu page. The user guide and FAQ also on the Main Menu provide further instructions on testing claims. For questions, please contact mdh.hipaaeditest@maryland.gov

***eClaims*:** Direct billing is available through our *eMedicaid* website. This service will enable certain provider types, that bill on the CMS-1500, to submit their single claims electronically. Claims that require attachments cannot be submitted through this feature. Claims will be processed the same week it is keyed and payment will follow the next week.

To become an eClaim user, the administrator from the provider's office must register users by going to the eMedicaid webpage: *https://emdhealthchoice.org/emedicaid/*.

If you have questions regarding this feature, how to register, or to determine if your provider type can submit eClaim, please email your questions to: *mdh.emedicaidmd@maryland.gov.*

Proper Completion of CMS - 1500

For Medical Assistance processing, **THE TOP RIGHT SIDE OF THE CMS-1500 MUST BE BLANK**. Notes, comments, addresses, or any other notations in this area of the form will result in the claim being returned unprocessed. Providers must be enrolled in Medicaid.

Block 1 – Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).

Block 1a – No entry required.

Block 2 – Patient's Name – (Last Name, First Name, and Middle Initial) – enter the patient's name as it appears on the Medical Assistance card.

Block 3 – Patient's Birth Date/Sex – enter the patient's date of birth and sex (Optional).

Block 4 – Insured's Name – Enter name (Last Name, First Name, and Middle Initial) of the person in whose name the third-party coverage is listed, when applicable (Optional).

Block 5 –Patient's Address – enter the patient's complete mailing address with zip code and telephone number (Optional).

Block 6 – Patient's Relationship to Insured – Enter the appropriate relationship only when there is third party health insurance besides Medicare and Medicaid (Optional).

Block 7 – Insured's Address – When there is third party health insurance coverage besides Medicare and Medicaid, enter the insured's address and telephone number (Optional).

Block 8 – No entry required.

Block 9 – No entry required.

Block 9a – Other Insured's Policy or Group Number - Enter the patient's ***eleven digit Maryland Medical Assistance number*** exactly as it appears on the Medical Assistance card. Check for transposition of numbers. The MA number must appear here regardless of whether or not a patient has other insurance. A patient's Medicaid eligibility should be verified on *each* date of service, *prior* to rendering service, by calling the EVS. EVS is operational 24 hours a day, 365 days a year at the following number: **1-866-710-1447.**

Block 9b – No entry required.

Block 9c –No entry required**.**

Block 9d – Insurance Plan or Program Name – Enter the insured's group name and group number if the patient has health insurance besides Medicare/Medicaid (Optional).

Block 10a thru 10c – Is Patient's Condition Related to – Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank (Optional).

Block 10d – No entry required.

Block 11 – Insured's Policy Group or FECA Number – If the patient has **other third-party insurance and the claim has been rejected by that insurance, enter the appropriate rejection code listed below:** For information regarding participant's coverage, contact the Third Party Liability Unit at **410-767-1765** (Optional).

Code Rejection Reasons

K Services Not Covered
L Coverage Lapsed
M Coverage Not in Effect on Service Date
N Individual Not Covered
Q Claim Not Filed Timely (Required documentation, e.g., a copy of rejection from the insurance company)
R No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., statement indicating a claim submission)
S Other Rejection Reasons Not Defined Above (Requires documentation e.g., a statement on the claim indicating that payment was applied to the deductible)

Blocks 11a – 16 – No entry required.

BLOCKS 17 and 17b must be completed on all claims for dates of service on or after September 3, 2019. This information should not be included on claims prior to the 9/3/19 dates of service.

Block 17- Name of Referring Provider.
Enter the name of the referring provider.

Block 17a-No entry required.

Block 17b –NPI of the Referring Provider
Enter the referring provider's 10-digit NPI. Errors or omissions of this number will result in non-payment of claims.

Blocks 18-19- No entry required.

Block 20 – Outside Lab - Check "no"

Block 21 - Diagnosis or Nature of the Illness or Injury

Enter the 3, 4, or 5 character code from the ICD-10 related to the procedures, or services, listed in Block #24e List the primary diagnosis on Line A and secondary diagnosis on Lines B-H. Additional diagnoses are optional and may be listed on Lines 3 and 4.

Block 22 – No entry required.

Block 23 – No entry required.

Block 24a – Date of Service - Enter each separate dates of service as a **six (6) digit numeric date (e.g. 03/31/14) under the "FROM" heading.** Leave the space under the "TO" heading blank. Each date of service on which a service was rendered must be listed on a separate line. **Ranges of dates are not accepted on this form.** If more than one type of billable service was rendered on a given day, each service should be billed on a separate line. Thus, one date of service may be used on more than one line.

Block 24b. – Place of Service – Enter 03 for School Health-Related or **Health-Related Early Intervention Services**.

Block 24c. – No entry required.

Block 24d. – Procedures, Services, or Supplies – List the appropriate five (5) character procedure code (refer to *IEP/IFSP Health-Related Service Procedure Codes & Fee Schedule* on pages 20-25.

Block 24e. – Diagnosis Pointer – Enter a single or combination of diagnosis from Block #21 above for each line on the invoice. Note: the Program only recognizes up to eight (8) pointers, A-H.

Block 24f. – Charges – Enter the Medicaid fee allowed for the procedure code indicated in block 24d.

Block 24g. – Days or Units of Service – Enter the total number of units or service for each procedure. Multiple, identical services rendered on different days should be billed on separate lines.

Block 24h. – 25 – No entry required.

Block 26 – No entry required.

Block 27 – No entry required.

Block 28 – Total Charge – Enter the sum of the charges shown on all lines of Block 24f.

Block 29 –No entry required.

Block 30 – No entry required.

Block 31 – No entry required.

Block 32 – 32b – No entry required.

Block 33 – Billing Provider Info & Phone # – Enter the name, complete street address, city, state, and zip code of the provider. This should be address to which claims may be returned. The nine (9) digit Maryland Medical Assistance provider number to which payment is to be made must be entered in the lower right hand section of this block. Errors in this area are likely to result in denied or misdirected payment.

Block 33a – NPI – Enter the 10-digit NPI number of the billing provider in Block # 33. Errors or omissions of this number will result in non-payment of claims.

Block 33b (gray shaded area) – Enter the ID Qualifier 1D (Medicaid Provider Number) followed by the shaded area) 9-digit MA provider number of the provider in Block #33. Errors or omissions of this number will result in non-payment of claims.

NOTE: It is the provider's responsibility to promptly report all changes of name, pay to address, correspondence address, practice locations, tax identification number, or certification to ePREP. Contact information and instructions on how to access ePREP can be found at this link: https://mmcp.health.maryland.gov/Pages/ePREP.aspx

Completed CMS-1500's are to be mailed to the following address**:**

Maryland Department of Health
Medical Care Operations Administration
P.O. Box 1935
Baltimore, MD 21203-1935

IEP/IFSP HEALTH-RELATED SERVICE PROCEDURE CODES & FEE SCHEDULE EFFECTIVE 01/01/2020

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.

Procedure Code	Procedure Description		Qualified Provider	Unit of Service	Rate per Unit	Maximum Units of Service
90791	Psychiatric Diagnostic Interview	Modifier				
		AF	Licensed Psychiatrist	1	$169.04	
		AH	Licensed Psychologist	1	137.64	
		AJ	LCSW-C	1	$116.44	
		AJ	LCPC	1	$120.52	
		AJ	Licensed Nurse Psychotherapist	1	120.52	
90832	Individual psychotherapy		Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LCPC, Licensed Nurse Psychotherapist	20-30 min	$45.57	one per day; cannot bill 90834 on the same day
90834	Individual psychotherapy		Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LCPC, Licensed Nurse Psychotherapist	45-50 min	$82.58	one per day; cannot bill 90832 on the same day

90847	**Family psychotherapy**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LCPC, Licensed Nurse Psychotherapist**	**1**	**86.87**	
90853	**Group psychotherapy**	**Licensed Psychiatrist, Licensed Psychologist, LCSW-C, LCPC, Licensed Nurse Psychotherapist**	**1**	**$28.15**	
92521	Evaluation of speech fluency	Licensed Speech Pathologist	1	$91.35	maximum units: 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	maximum units: one time per 12 months; cannot bill 920507, 92508 or 92523 on the same day
92523	Evaluation of speech sound production with evaluation of language comprehension & expression	Licensed Speech Pathologist	1	$153.97	maximum units: 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	maximum units: 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 or Licensed Speech Pathology Assistant	1	$77.40	maximum units: 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**	**$26.13**	**one time per day; cannot bill 92507 on the same day**
92550	**Tympanometry & Reflex Threshold**	**Licensed Audiologist**	**1**	**$24.18**	**one time per day**
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
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; cannot bill 92550 or 92570 on the same day**
92568	Acoustic Reflex Testing	Licensed Audiologist	1	$16.22	one time per day; cannot bill 92550 or 92570 on the same day
92570	**Acoustic Immittance Testing**	**Licensed Audiologist**	**1**	**$36.00**	**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
96130	**Psychological Testing, Evaluation, Treatment Planning and Report, and Interactive feedback to**	**Licensed Psychologist**	**First hour**	**$128.66**	**One per 12 months**
96131	**Psychological Testing, Evaluation, Treatment Planning and Report, and Interactive feedback to the student, family**	**Licensed Psychologist**	**Each addition al hour**	**$97.78**	**Two per 12 months**
96136	**Psychological Test Administration and Scoring**	**Licensed Psychologist**	**First 30 minutes**	**$53.06**	**One per 12 months**

96137	**Psychological Test Administration and Scoring**	**Licensed Psychologist**	**Each additional 30 minutes**	**$49.46**	**Three units per day, Nine units per 12 months**
96158	**Therapeutic Behavior Services**	**Therapeutic Behavior Aide**	**First 30 minutes**	**$26.00**	**One time per day**
96159	**Therapeutic Behavior Services**	**Therapeutic Behavior Aide**	**Each additional 15 minutes**	**$13.00**	
97161	Physical therapy evaluation, Low complexity, 20 min	Licensed Physical Therapist	1	$69.20	one time per 12 months, cannot bill with 97110
97162	Physical therapy evaluation, Moderate complexity, 30 min	Licensed Physical Therapist	1	$69.20	one time per 12 months, cannot bill with 97110
97163	Physical therapy evaluation, High complexity, 45 min	Licensed Physical Therapist	1	$69.20	one time per 12 months, cannot bill with 97110
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 min	$29.03	4 units per day; cannot bill 97161, 97162, 97163, or 97164 on the same day
97165	Occupational therapy evaluation, low intensity, 30 min	Licensed Occupational Therapist	1	$67.01	one time per 12 months, cannot bill 97530, or 97150 on the same day
97166	Occupational therapy evaluation, Moderate intensity 45 min	Licensed Occupational Therapist	1	$67.01	one time per 12 months, cannot bill 97530, or 97150 on the same day
97167	Occupational therapy evaluation, High intensity 60 min	Licensed Occupational Therapist	1	$67.01	one time per 12 months, cannot bill 97530, or 97150 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

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
T1000	Nursing services	Registered Nurse	15 min	$13.98	8 units per day
T1000 with 52 Modifier	Nursing Services	Licensed Practical Nurse	15 min	$ 9.06	8 units per day
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
T1023-TG	Initial IEP/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
T2003	Non-Emergency Transportation Services		1	$12.50	2 units per day
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

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 EARLY INTERVENTION AND SCHOOL HEALTH-RELATED SERVICES MANUAL WILL BE RECOVERED.