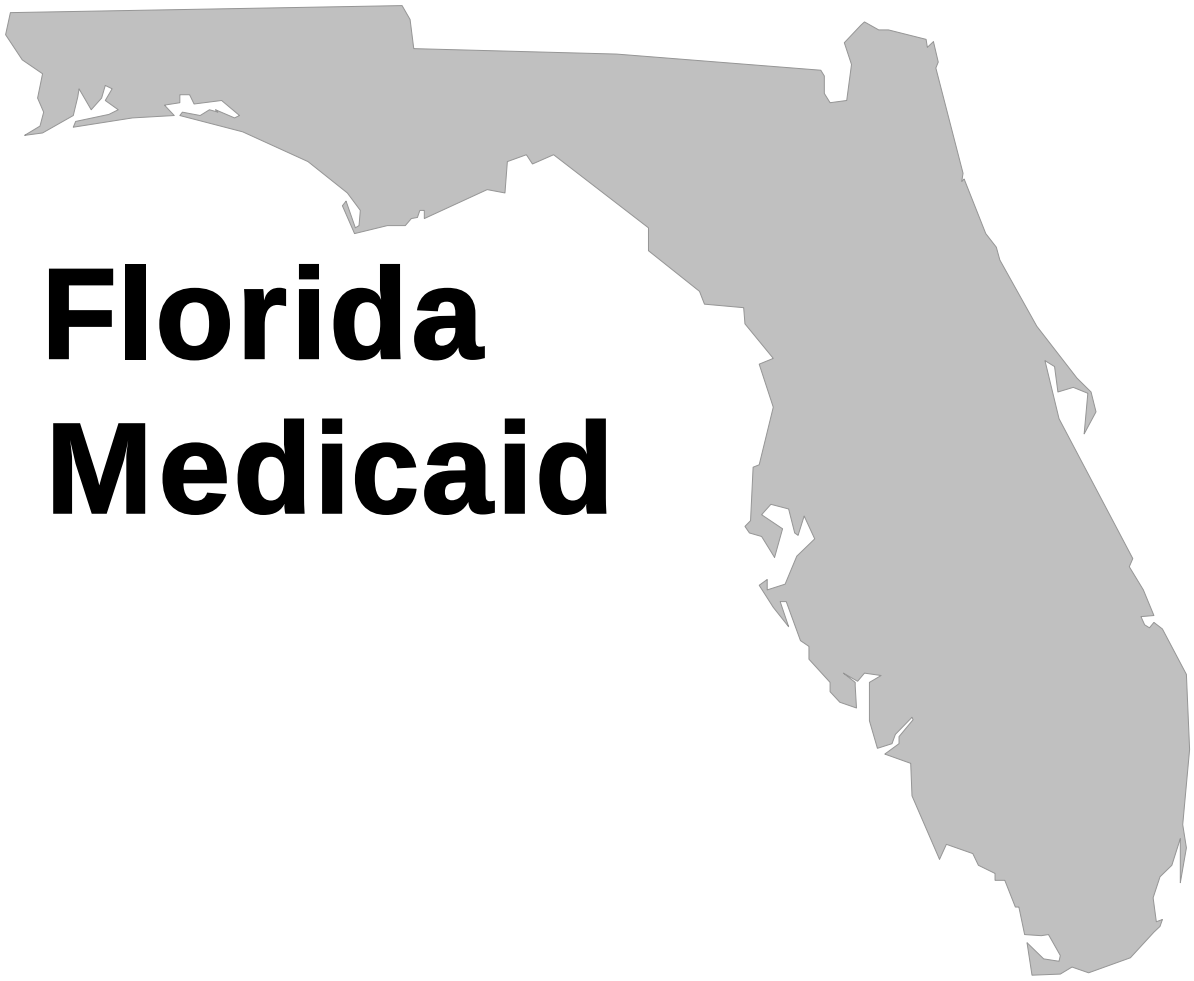
Medicaid Services in Schools

Medicaid Table of Contents



Florida Medicaid

Medicaid Certified School Match Program Coverage and Limitations Handbook

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Agency for Health Care Administration

FLORIDA MEDICAID

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FLORIDA MEDICAID

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

October 25, 2005

Dear Medicaid Certified School Match Provider:

Enclosed you will find the Medicaid Certified School Match Services Coverage and Limitations Handbook, which has been reformatted. This handbook is to be used in place of the previous version, which is now obsolete.

The updated handbook material contains new policy for speech therapy services, fee schedule changes, and service reimbursement policy changes.

New Speech Therapy Policy:

Past policy prohibited reimbursement for speech therapy treatment when evaluations were completed by bachelor's level staff and countersigned by master's level speech-language pathologists. The new policy will permit these countersignatures on evaluations completed on and after January 1, 2005. Countersigned evaluations cannot be reimbursed. However, school districts can now submit claims for therapy treatment sessions based on these evaluations.

Fee Schedule Changes:

The present Fee Schedule has been updated to indicate that reimbursement amounts listed may vary from district to district as fees can be based on cost for individual school districts. School districts may elect to complete cost reports to determine their fees instead of using the fees in the handbook fee schedule. Once these fees are calculated, submitted to the Agency for Health Care Administration and approved, the rates calculated for each district will be submitted to the Medicaid fiscal agent so the needed changes can be made to pay the new fees. The new district specific fees will be effective for service dates on July 1, 2005, or later.

Service Reimbursement Policy:

Appendix B of this handbook has been completely revised to reflect current service reimbursement requirements.

Miscellaneous:

You will note as you review your handbook in its entirety that there are a few minor changes to previous language; the purpose of these changes is to further clarify existing policy.

If you have any questions please contact your area Medicaid school services representative. Your services to children in this state are greatly appreciated.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid

Enclosure

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308

Visit AHCA online at
http://ahca.myflorida.com

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UPDATE LOG
MEDICAID CERTIFIED SCHOOL MATCH
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.

2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
Aug1999—Replacement Pages	August 1999
May2000—Replacement Pages	May 2000
Aug2000—Replacement Pages	August 2000
Jul2002—Replacement Pages	July 2002
Oct2003—Replacement Pages	October 2003
Jan2005—Revised Handbook	January 2005

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MEDICAID CERTIFIED SCHOOL MATCH PROGRAM COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
Note	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update No.” and the “Effective Date”.

Handbook Updates, continued

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following: 1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced. 2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update. 3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.
Numbering Update Pages	Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)
Effective Date of New Material	The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date. If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.
Identifying New Information	New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label	A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.
New Label and New Information Block	A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.
New Material in an Existing Information Block	New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.
New or Changed Paragraph	A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph. Paragraph with new material.

CHAPTER 1
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PURPOSE, BACKGROUND AND PROGRAM SPECIFIC INFORMATION

Overview

Introduction

This handbook describes the Medicaid certified school match program, services reimbursed under the program, provider qualifications, Medicaid-eligible student qualifications, and the general service requirements.

Legal Authority

School district provider eligibility and services are governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 440.110 and 440.130, respectively. The program was implemented through Sections 409.9071 and 1011.70, Florida Statutes, and Chapter 59G, Florida Administrative Code.

In This Chapter

This Chapter contains:

Purpose and Background

Medicaid Provider Handbooks

This handbook is intended for use by school district providers who are enrolled in Medicaid under the certified school match program. Specific policies for each certified school match service reimbursed by Medicaid are contained in service-specific chapters in this handbook. The chapters may be separated and forwarded to staff assigned to the appropriate service area. Chapter 1 must be provided to all staff.

The handbook must be used in conjunction with the Florida Medicaid Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general.

Purpose

The purpose of the Medicaid certified school match program is to provide reimbursement for medically necessary services provided by or arranged by a school district for Medicaid-eligible students.

Background

There are 67 public school districts in Florida. Each school district is responsible for ensuring that students with disabilities receive health care.

Options for Financing Health Care

School districts have several options available for financing health care for Medicaid-eligible students, including:

- The school district may use Medicaid providers in the community to serve Medicaid-eligible students. The community provider bills Medicaid directly for the Medicaid-eligible students' care, and the school district finances the non-Medicaid students' care.
- The school district may use county health departments or other public health agencies to serve Medicaid-eligible students. The county health department bills Medicaid directly for the Medicaid-eligible students' care and the county health department or school district finances the non-Medicaid students' care.
- The school district may enroll as a Medicaid provider to serve Medicaid-eligible students. The school district bills Medicaid to finance care rendered by a school district, health-care employee or by contracted health staff for Medicaid-eligible students' care.

School districts may use one or a combination of these options to finance health care services for Medicaid-eligible students. If a school district chooses to enroll as a Medicaid provider for any of the services included in this handbook, it must be reimbursed under the policies for the certified school match program. School districts interested in becoming providers for services other than those in this handbook such as physician, hearing or vision, should contact the Medicaid fiscal agent for an enrollment application.

School District Provider Qualifications

Qualified School District Providers	School districts that are part of the public education system are eligible to participate in the certified school match program. This includes the Florida School for the Deaf and Blind, which is considered a school district for Medicaid purposes. Also, charter schools and lab schools (also known as developmental research schools) may participate in the program if their contracts with their school districts indicate such. The school district submits Medicaid claims for services provided by or through the charter or lab schools, as done for public schools. Private schools are not eligible to participate in this program.
Enrollment Process	In order to bill Medicaid under the certified match program, each school district must be enrolled as a provider by applying for enrollment to the Medicaid fiscal agent. A separate Medicaid provider agreement must be submitted for each type of service for which the school district will bill Medicaid. Note: See Chapter 2 in the Medicaid Provider General Handbook for general enrollment requirements.
School District Staff Qualifications	The school district must employ or contract with staff who meet the Medicaid provider qualifications to provide the specific services for which the school district will bill Medicaid. The school district must sign an agreement with Medicaid attesting that staff providing health related services for which the school district will bill meet the Medicaid provider qualifications. There are no specific Medicaid provider qualifications for transportation services beyond the requirements for transportation in Chapter 1006, Florida Statutes (F.S.), and Chapter 63-A, Florida Administrative Code (F.A.C.). Note: See Appendix A in Chapter 1 of this handbook for the agreements that the school district must sign attesting that its staff (including contracted staff) providing health care services meet Medicaid provider qualifications. Note: See the service-specific chapters in this handbook for the individual provider qualifications for specific services.
FDLE Background Check	School districts are not required to submit Florida Department of Law Enforcement (FDLE) background checks or fingerprints to enroll as Medicaid providers.
Ownership Disclosure	School districts are not required to disclose ownership to enroll as Medicaid providers since the school districts are publicly financed.

Certified Match Reimbursement

Introduction

Medicaid is financed by state and federal public funds. The state and federal shares of these funds are set each federal fiscal year by the federal government. Although the federal share varies, it averages about 55 percent in Florida.

School districts participating in Medicaid as providers (see "Qualified School District Providers" above) "certify" quarterly that they have used non-federal education funds for health care services as the state share. Medicaid then reimburses the school district provider the federal share of its payment for the health care service. This unique reimbursement method is termed "certified match reimbursement."

Certified Match Reimbursement Procedures

See Appendix B in Chapter 1 of this handbook for the certified match service reimbursement procedures and form.

Rates for transportation services are developed as described in Chapter 5 of this handbook.

Student Qualifications

Students Qualified for Certified School Match

To be qualified under the Medicaid certified school match program described in this handbook, a Medicaid-eligible student must meet all the following criteria:

- Be Medicaid eligible on the date of service;
- Be under age 21;
- Be considered disabled under the State Board of Education Rule definitions;
- Be entitled to school district services under the Individuals with Disabilities Education Act (IDEA), Part B or Part C;
- Have Medicaid reimbursable services referenced in his Individual Educational Plan (IEP) or Family Support Plan (FSP); and
- Have Medicaid reimbursable services recommended by school district employees or contract staff meeting the requirements in this handbook.

Medicaid Criteria

Section 409.907(l), F.S., defines children qualified for certified school match reimbursement as "children with specified disabilities who are eligible for both Medicaid and Part B or Part C of IDEA or the exceptional student education program or who have an individualized educational plan." However, due to federal regulations, Medicaid cannot reimburse for services rendered to these students unless they also meet the criteria listed above in "Students Qualified for Certified School Match."

General Service Requirements

Medical Need for Services	Medicaid reimbursement is available only for services recommended by health care practitioners as defined in each service-specific chapter in this handbook.
Free Health Care	School districts may not bill Medicaid for health care services that they provide free of charge to non-Medicaid students, unless the exception below is met. If a school district establishes a fee schedule for billing families for health care services, the services are not considered to be free and Medicaid may be billed.
Exception to the Free Health Care Policy	Health care services provided under Part B or Part C of IDEA that are referenced in an IEP or FSP may be billed to Medicaid regardless of whether there is a charge for the service for non-Medicaid students. This includes transportation services that are included in the student's IEP or FSP.
Medicaid Reimbursable Services	It is recognized that many health care services may occur before or after the time an IEP or FSP is developed for a student. Behavioral evaluations are an example. Behavioral evaluations are considered as Medicaid reimbursable services if the need for behavioral services or a behavioral evaluation are referenced in an IEP or FSP or made an attachment or filed with an IEP or FSP. If an evaluation is done for a student and it is determined that he is not entitled to services under Part B or C of IDEA (an IEP or FSP is not completed), Medicaid will not reimburse the school district for the evaluation time.
Place of Service	For Medicaid purposes, services may be provided by school district staff at the school, on a school vehicle, at school activities and programs away from campus (example: community based instruction) or in the Medicaid-eligible student's home. If services are provided in a home, the place of service entered on the claim to Medicaid should be "home." (Place of service codes are contained in the Medicaid Provider Reimbursement Handbook, CMS-1500) The place of service entered on the claim form, other than services provided in the home, should be "school."

General Service Requirements, continued

Service Limitations

Medicaid reimburses only one provider, be it the school district or a community provider, for the same procedure (as determined by the Medicaid automated payment system comparing procedure codes on claims) provided to a student on the same day. There are reimbursement limitations contained in each of the service chapters in this handbook. Exceptions to any of the service limits may be requested by sending the following information to the area Medicaid school services representative:

- Physical or Occupational Therapy or Speech-Language Pathology–
  1. Copy of the plan of care or attachment recommending that the student needs more than four units of service per day or more evaluations than specified;
  2. Completed, paper CMS-1500 claim form(s); and
  3. Cover letter requesting the exception, including the length of time (from month/year to month/year) the additional services are needed. The cover letter should be from the therapist or pathologist.

- Transportation–
  1. Written statement from the Exceptional Student Education director explaining the reason for more than four one-way trips per day including the length of time (from month/year to month/year) the additional trips are needed; and
  2. Completed, paper CMS-1500 claim form(s).

- Behavioral/Nursing Services–
  1. Written statement from the school psychologist/psychologist or registered nurse explaining the reason for more than 32 units of service per day, including the length of time (from month/year to month/year) the additional services are needed; and
  2. Completed, paper CMS-1500 claim form(s).

Exceptions may be requested on a retroactive basis; however, Medicaid will not reimburse claims received more than 12 months from the date of service. Exceptions may also be requested in advance of service delivery. For an advance request, the CMS-1500 claim form is not attached to the above documents. If approved, advance exception requests are valid for one year from the approval date. For advance approvals, paper CMS-1500 claim forms would be sent to the area Medicaid office each month during the approved time period with a copy of the approval document from Medicaid.

The area Medicaid school services representative will forward complete exception packages to the Agency for Health Care Administration central Medicaid office for processing. The area Medicaid office will advise the school district of whether the request was approved and the time period of the approval; or, if denied, the reason for denial.

An exception cannot be made to the general “one provider per day limitation.”

General Service Requirements, continued

Medical Necessity	According to the definition of medical necessity in the Florida Medicaid Provider General Handbook, Appendix D, Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

Parental or Guardian Informing

Informing the Parent about FAPE	Although not a Medicaid requirement, the school district should inform the parent or guardian of the "Free and Appropriate Public Education" (FAPE) provisions of IDEA and the fact that Medicaid will be billed. The need for informing parents or guardians of these facts is important since third party insurance must be considered as a primary payer before Medicaid.
Informing the Parent about Services	Although not a Medicaid requirement, parents or guardians should be informed that Medicaid will only reimburse one provider for the same procedure on the same day.

Audit Requirements

Provider Records

The school district must have on file copies of their employed and contracted staffs' medical licenses, certifications, criminal background check results or other documentation that verifies that the staff meet the Medicaid provider qualifications for the specific services for which the school district bills Medicaid.

Provider records must be retained and presented upon request by an Agency for Health Care Administration (AHCA) or a Centers for Medicare and Medicaid Services (CMS) representative.

Documentation

Effective July 1995

Documentation of medical services rendered must be in the Medicaid-eligible student's record or electronically stored. If electronic documentation and signatures are used, the school district must have security procedures in place to prevent unauthorized use. Each district's security procedures should also be in written form for audit purposes. Also, the school district must assign a unique name or number or both for identifying and tracking user identity.

Service documentation must be retained and presented with the student's record upon request by an Agency for Health Care Administration (AHCA) or a Centers for Medicare and Medicaid Services (CMS) representative.

Note: See the service-specific chapters in this handbook for additional documentation requirements.

Recoupment

Failure to maintain records in accordance with this handbook and the Florida Medicaid Provider General Handbook may result in recoupment of Medicaid reimbursement.

APPENDIX A-1

AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT THERAPY SERVICES PROVIDERS ARE CREDENTIALED

(Physical Therapists, Physical Therapist Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech-Language Pathologists, Speech-Language Pathology Assistants)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Physical Therapists:

Current licensure from the Florida Board of Physical Therapy. All services billed to Medicaid must be within the validity period on the individual's license.

Physical Therapist Assistants:

Current licensure from the Florida Board of Physical Therapy. All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the general supervision of a licensed physical therapist, as required in the Medicaid Certified School Match Program Coverage and Limitations Handbook.

Occupational Therapists:

Current licensure from the Florida Occupational Therapy Council.
All services billed to Medicaid must be within the validity period on the individual's license.

Occupational Therapy Assistants:

Current licensure from the Florida Occupational Therapy Council, Division of Occupational Therapy Assistants. All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the general supervision of a licensed occupational therapist, as required in the Medicaid Certified School Match Program Coverage and Limitations Handbook.

Speech-Language Pathologists:

The requirements contained in federal regulation 42 CFR 440.110 (copy attached) must be met. The federal requirements can be met by the pathologist having any one of the following documents:

- Licensure from the Florida Board of Speech-Language Pathology and Audiology. All services billed to Medicaid must be within the validity period on the individual's license.
- Certification from the Department of Education in the area of Speech-Language Impaired, containing the words "Speech-Language Impaired-Professional." All services billed to Medicaid must be within the validity period on the individual's certification.

Speech-Language Pathologists: (continued)

- A Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA). The date on the CCC must be prior to the date services were rendered if those services will be billed to Medicaid.
- An ASHA membership card stating "Certified Member." All services billed to Medicaid must be prior to the "Valid Thru" date on the card.
- An ASHA "Certificate Holder" card. All services billed to Medicaid must be prior to the "Valid Thru" date on the card.
- A master's level degree in speech-language pathology (college transcripts may be necessary if the master's degree does not show a major and the degree title may show terminology such as "Communication Disorders").

Speech-Language Pathology Assistants:

Certification from the Florida Board of Speech-Language Pathology and Audiology. All services billed to Medicaid must be within the certification period.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____

ESE Director Date

_____ County School District

_____ _____

Thomas W. Arnold, Deputy Secretary for Medicaid Date

42 CFR §440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) "Physical therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational therapy.* (1) "Occupational therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupational therapist" is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1*)* "Services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

(2) A "speech pathologist or audiologist" is an individual who—

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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APPENDIX A-2
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT NURSING SERVICES PROVIDERS ARE CREDENTIALED
(Registered Nurses, Licensed Practical Nurses)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Registered Nurses:

Current licensure as a registered nurse under Chapter 464, Florida Statutes (F.S.). All services billed to Medicaid must be within the validity period on the individual's license.

Licensed Practical Nurses:

Current licensure as a practical nurse under Chapter 464, Florida Statutes (F.S.). All services billed to Medicaid must be within the validity period on the individual's license and must be rendered under the direction of a licensed registered nurse, as governed by the state nurse practice act.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____
ESE Director Date

_____ County School District

_____ _____
Thomas W. Arnold, Deputy Secretary for Medicaid Date

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ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT NURSING SERVICES PROVIDERS ARE CREDENTIALED

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for school health aides are met as follows:

School Health Aides

Individuals for whom Medicaid is billed must have completed the following courses/training:

- Cardiopulmonary resuscitation,
- First aid,
- Medication administration, and
- Patient specific training.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Nursing Services Providers are Credentialed" are met as applicable to school health aides.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____

ESE Director Date

_____County School District

_____ _____

Thomas W. Arnold, Deputy Secretary for Medicaid Date

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APPENDIX A-3
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Psychologists, Certified Behavior Analysts and Social Workers)

The below named school district agrees that Medicaid reimbursable services will be billed for only those employed or contract staff rendering health-related services who meet Medicaid credentialing requirements. Medicaid credentialing requirements must be met at the time services are rendered to a Medicaid-eligible student who meets the qualifications contained in the Medicaid Certified School Match Program Coverage and Limitations Handbook. Medicaid credentialing requirements are:

Psychologists/School Psychologists:

- Current licensure as a psychologist or school psychologist under Chapter 490, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a certified school psychologist; or
- Holder of a master's, specialist's, or higher degree accumulating the experience for licensure under Chapter 490, Florida Statutes (F.S.), or for DOE certification if services are rendered under the general supervision of a licensed psychologist, school psychologist, or DOE certified school psychologist.
- All services billed to Medicaid must be within the validity period on the individual's license and/or certification.

Certified Behavior Analysts:

Certification by the Department of Children and Families with a master's level degree. All services billed to Medicaid must be within the validity period of the individual's certification.

Social Workers:

- Current licensure as a clinical social worker under Chapter 491, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a social worker with a master's level degree or higher in social work; or
- Graduate of a college or university with a master's degree or higher and working under the supervision of a licensed clinical social worker (or the equivalent as defined in Chapter 491, F.S., in order to obtain the work experience necessary for licensure).
- All services billed to Medicaid must be within the validity period of the individual's license or certification.

The school district agrees that each employed or contract staff member providing health-related services who meets Medicaid credentialing requirements has also been fingerprinted and has received a criminal background check in accordance with Department of Education rules and guidelines.

Further, the school district agrees that pertinent Medicaid provider handbooks and all other Medicaid policy informational material such as remittance voucher banner page messages, provider letters and bulletins will be supplied to employed or contract staff providing health-related services so that they are informed of Medicaid service and record keeping policies.

The school district agrees that Medicaid claims paid for services rendered by staff not meeting Medicaid credentialing requirements will be subject to recoupment.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____
ESE Director Date

_____ County School District

_____ _____
Thomas W. Arnold, Deputy Secretary for Medicaid Date

ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Bachelor's Degree Level Social Workers, Certified Associate Behavior Analysts, Marriage and Family Therapists, Mental Health Counselors, Guidance Counselors)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Bachelor's Degree Level Social Workers

The individual(s) must be certified by the Department of Education (DOE) as a social worker with a bachelor's level degree in social work and must render services under the supervision (as defined by DOE) of a licensed or DOE certified master's level degree social worker.

Certified Associate Behavior Analysts

The individual(s) must be certified by the Department of Children and Families and must render services under the general supervision of a certified behavior analyst with a master's level degree.

Marriage and Family Therapists

The individual(s) must be currently licensed as a marriage and family therapist under Chapter 491, Florida Statutes (F.S.).

Mental Health Counselors

The individual(s) must be currently licensed as a mental health counselor under Chapter 491, Florida Statutes (F.S.).

Guidance Counselors

The individual(s) must be DOE certified as a guidance counselor and must have a master's level degree or higher.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____

ESE Director Date

_____County School District

_____ _____

Thomas W. Arnold, Deputy Secretary for Medicaid Date

ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Bachelor's Degree Certified Behavior Analysts)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Bachelor's Degree Level Certified Behavior Analysts

The individual(s) must be certified by the Department of Children and Families (DCF) and must render services under the general supervision of a certified behavior analyst with a master's level degree.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____

ESE Director Date

_____County School District

_____ _____

Thomas W. Arnold, Deputy Secretary for Medicaid Date

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ADDENDUM
AGREEMENT FOR ASSURING THAT SCHOOL DISTRICT BEHAVIORAL HEALTH PROVIDERS ARE CREDENTIALED
(Provisionally Licensed and Board Registered Interns – Mental Health Counselors and Marriage and Family Therapists)

The school district agrees and maintains the necessary documentation that Medicaid credentialing requirements for behavioral services staff are met prior to billing, as follows:

Mental Health Counselors and Marriage and Family Therapists who are Provisionally Licensed or Board Registered Interns

The individual(s) must hold a provisional license or board registration as an intern under Chapter 491, Florida Statutes (F.S.) and must render services under the supervision of a licensed mental health counselor or marriage and family therapist.

The school district further agrees that all other requirements contained in the "Agreement for Assuring that School District Behavioral Health Providers are Credentialed (Psychologists, Certified Behavior Analysts and Social Workers)" are met as applicable to the employed or contract staff above.

The effective date of this agreement will be the date of the signature of the last party signing the agreement.

_____ _____

ESE Director Date

_____County School District

_____ _____

Thomas W. Arnold, Deputy Secretary for Medicaid Date

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APPENDIX B
CERTIFIED MATCH SERVICE REIMBURSEMENT

Overview

Reimbursements for services performed by school district providers are based either on their own reasonable and actual cost of providing that service or, if applicable, the established Medicaid rate in Appendix C. Reimbursement for all services listed in this handbook are pursuant to the State Plan Amendment (SPA) 98-08 or SPA 97-10, 409.9071 Florida Statutes and other applicable CMS or Medicaid laws, rules, regulations or policies. OMB Circular A-87 contains accounting principles for the reimbursable cost determinations and reporting requirements that school districts must follow when reimbursement is based on school district cost.

Fee Schedule, Appendix C

Appendix C contains all current procedure codes with their applicable fee. It should be noted that actual reimbursement that a billing school district receives is only for the federal share of that fee for each allowable unit of service.

There are two bases for the fee schedule:

- Therapies
  Currently, Occupational Therapists, Physical Therapists and Speech-Language Pathologists are reimbursed at the same current single statewide rate as Florida's regular Medicaid community based therapy providers. However, the statewide rate has been reviewed by CMS as being equal to or less than the submitted individual average costs for providing therapies from the initial school districts.

- Behavioral, Augmentative and Communication, and Nursing service providers are paid at a single statewide average cost. These listed fees were calculated in accordance with cost determination principles contained in the OMB Circular A-87. These fees were established at the beginning of the program with actual costs obtained from records from the Florida Department of Education. Allowable average costs from each school district in Florida for employees that possessed the required certifications for each provider type allowed in this handbook, were averaged with all other school districts with similar costs. The resultant fees for these services contained in Appendix C are an equitable averaged single statewide rate for each provider type and procedure code.

Cost Reports

As provided for in SPA 98-08 and SPA 97-10, providers may elect to submit cost reports that reflect their actual current reimbursable costs for providing the services described in the handbook. These costs must be reasonable and be determined by the principles contained in the OMB Circular A-87.

- Cost report basis:

  Cost determinations should be made with pertinent allowable annual costs contained in the school districts' annual financial reports. Audited costs from the school districts' annual financial reports do not have to be used. However, if the subsequent audit uncovers errors, omissions or unallowable accounting practices that directly affect the costs that were used to calculate rates, a school district must resubmit it's cost data with the corrected amounts for rate revisions.

  Costs used for rate calculation and reimbursement must eventually come from the school district's General Fund expenditures. This fund is also the basis for the school district's certification of nonfederal expenditures required for the matching requirement.

- Cost reporting format:

  There is no specific format for the cost report. Technical assistance is available for the submission of cost reports. Contact information is noted below.

- Units of service:

  The units of service used to calculate the unit costs must be identified. The unit will normally be the same as the units (minutes or hours) for all the procedure codes listed for each service in Appendix C. The most common units will be expressed in time (minutes or hours), applications, fittings, miles or trips.

- Cost reporting for indirect costs:

  School districts that submit cost reports may include indirect costs for reimbursement purposes. Indirect costs may only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. For this handbook, the cognizant agency is the U.S. Department of Education. Specifically, the current approved IDEA indirect cost percent will be used.

- Consultant/Billing agent costs:

  Consultants who assist the school districts in any aspect of Medicaid billing activities are considered billing agents. Costs for billing agent services based on amounts billed to or reimbursed by Medicaid (an example would be percentage payments to agents based on Medicaid reimbursement billed or received) are not allowable per Florida Statutes. School districts that submit cost determinations that include valid billing agent fees, such as a flat fee per Medicaid claim, must send a copy of the contract with the cost report.

- Depreciation and use allowance:

  Depreciation or a use allowance for buildings and equipment are allowable costs per OMB Circular A-87. To ensure these costs comply with the guidelines, a separate schedule must be included that identifies method and asset life if depreciation is claimed as a program cost. Acquisition costs of assets must relate back to financial statements and be net of federally purchased items. There will be a need to certify that the asset basis used for the calculation of depreciation or use allowance for program costs is net of any source of federal funds used for acquisition. The allocation basis for each service provided must be shown.

- Cost report approval:

  Each cost report submitted to the Agency for the purpose of changing a particular existing rate must be approved by the Agency. The Agency, at its discretion, will seek CMS approval for submitted cost determination methods that it considers non-compliant with the principles allowed in OMB Circular A-87.

- Effective date:

  The school district cost report containing the relevant costs and other statistical determinations must come from the district's annual costs and records for the fiscal year ending June 30. Normally, the approved rate changes based upon the submitted cost report by the district would be effective for dates of service on July 1, which would be the first day of the reporting period immediately succeeding the submitted cost report. Or, the district could request the effective date to be for dates of service on the first day of the first quarter after the quarter in which the cost report is received and approved. For example, if a district submits a cost report received and approved in October based on district costs and other pertinent data from their fiscal year ending June 30 of that year, the effective

date would be for dates of service on July 1. However, at district discretion, that same cost report received and approved in October, could be effective for dates of service on January 1, the following year. Claims that are paid after either effective dates of service but before a newer rate is placed on the charge file will not automatically be adjusted. However, a school district may choose to manually adjust those claims.

Local Match Certifications

School districts that provide Medicaid services that utilize local match for the nonfederal share of expenditures are required to submit an annual certification. This certification is necessary to ensure that the school district has expended nonfederal money for the matching requirement. Certifications will be for services rendered for one-year with dates of service between July 1st and June 30th. Certifications will be due by September 30th of each year. These certifications will be sent to the same address as the cost reports as shown below. The form in Attachment I of this Appendix may be used for this purpose. A school district form containing the same information shown on the form in Attachment I may be used, if desired.

Technical Support and Report Submission

Cost reports and quarterly certifications should be sent to the following address:

Agency for Health Care Administration
Office of Medicaid Program Analysis
Attention: School Based Program
2727 Mahan Drive, Mail Stop 21
Tallahassee, Florida 32308-5403

Technical assistance is offered either by writing to the above address or by the following:

Telephone: (850) 414-7563 or SunCom 994-7563

Fax: (850) 922-5172 or SunCom 292-5172

Email: robinsoj@ahca.myflorida.com

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Attachment I
Annual Certification of State Expenditures By School Districts

Agency for Health Care Administration
Medicaid Program Analysis
2727 Mahan Drive, Mail Stop 21
Tallahassee, Florida 32308-5403
Attn.: School Based Programs

Dear Sirs:

I, as financial officer or other responsible school district employee of

_____
(Name of School District or Special School)

am charged with the duties of supervising the administration of the provision and billing for services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school or school district has expended the state share of public, nonfederal funds needed to match the federal share of medical claims billed to the state Medicaid agency for

_____ services provided to eligible Medicaid students during the
(Type of Service Provided)

fiscal year ending _____.
(Month/Year Certified)

I also certify that the school or school district's certified expenditures were incurred in accordance with provisions of Florida's policies for the services. These certified expenditures are separately identified and supported in our accounting system.

_____
Name (please print)

_____
Signature

_____
Title

_____
Date

Instructions for Completing Form

The form, or the school district's equivalent form, is due to the Agency for Health Care Administration, Medicaid Program Analysis within 15 days after each quarter ends. The form may be photocopied from this handbook for the school districts' use.

A separate form must be completed for each service type billed to Medicaid. Each service type is defined as: Therapies, Behavioral, Nursing, Transportation and Augmentative Services.

Item Instructions

(1) Enter the name of the school district or special school.
(2) Type of service provided. For example: Therapies
(3) Fiscal year certified. For example: FYE 6/30/2006

APPENDIX C
PROCEDURE CODES AND FEE SCHEDULE

Procedure Code	Modifier	Description of Service	Fee*
		PHYSICAL THERAPY	
97001		Physical Therapy Evaluation by a Physical Therapist	$48.50
97110		Physical Therapy Individual Session by a Physical Therapist	$16.97 (per 15-minute unit)
97110	HM	Physical Therapy Individual Session by a Physical Therapist Assistant	$13.58 (per 15-minute unit)
97150		Physical Therapy Group Session by a Physical Therapist	$3.30 (per Medicaid-eligible student per 15-minute unit)
97150	HM	Physical Therapy Group Session by a Physical Therapist Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)
		OCCUPATIONAL THERAPY	
97003		Occupational Therapy Evaluation by an Occupational Therapist	$48.50
97530		Occupational Therapy Individual Session by an Occupational Therapist	$16.97 (per 15-minute unit)
97530	HM	Occupational Therapy Individual Session by an Occupational Therapy Assistant	$13.58 (per 15-minute unit)
97150	GO	Occupational Therapy Group Session by an Occupational Therapist	$3.30 (per Medicaid-eligible student per 15-minute unit)
97150	UC	Occupational Therapy Group Session by an Occupational Therapy Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)

*****School Districts are not reimbursed the full amount – Reimbursement is the Federal Share of these fees. Fees shown in this appendix were derived from an initial statewide average; however, reimbursement fees can be based on an individual school district's cost and may vary from school district to school district.

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
		SPEECH-LANGUAGE PATHOLOGY	
92506		Speech-Language Pathology Evaluation by a Speech-Language Pathologist	$48.50
92507		Speech-Language Pathology Individual Session by a Speech-Language Pathologist	$16.97 (per 15-minute unit)
92507	HM	Speech-Language Pathology Individual Session by a Speech-Language Pathology Assistant	$13.58 (per 15-minute unit)
92508		Speech-Language Pathology Group Session by a Speech-Language Pathologist	$3.30 (per Medicaid-eligible student per 15-minute unit)
92508	HM	Speech-Language Pathology Group Session by a Speech-Language Pathology Assistant	$2.60 (per Medicaid-eligible student per 15-minute unit)
		APPLIANCES AND EQUIPMENT	
29799	HA	Application of Cast or Splint	$18.58
97001	TG	Wheelchair Evaluation and Fitting-PT	$48.50
97003	TG	Wheelchair Evaluation and Fitting-OT	$48.50
		TRANSPORTATION	
Transportation fees vary for each school district. They are not included in this appendix, instead each district is notified of its fee.			
		BEHAVIORAL SERVICES	
96150	AH	Psychologist-Individual Service-Evaluation	$9.66 (per 15-minute unit)
96152	AH	Psychologist-Individual Service-All Else	$9.66 (per 15-minute unit)
96153	AH	Psychologist-Group Service	$4.95 (per Medicaid-eligible student per 15-minute unit)
96150		Certified Behavior Analyst-Individual Service-Evaluation	$8.00 (per 15-minute unit)
96152		Certified Behavior Analyst-Individual Service-All Else	$8.00 (per 15-minute unit)
96153		Certified Behavior Analyst-Group Service	$4.00 (per Medicaid-eligible student per 15-minute unit)

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
		BEHAVIORAL SERVICES, continued	
96150	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Individual Service-Evaluation	$6.70 (per 15-minute unit)
96152	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Individual Service-All Else	$6.70 (per 15-minute unit)
96153	HN	Certified Behavior Analyst (Bachelor's Level) and Certified Associate Behavior Analyst-Group Service	$3.35 (per Medicaid-eligible student per 15-minute unit)
96150	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Individual Service-Evaluation	$8.97 (per 15-minute unit)
96152	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Individual Service-All Else	$8.97 (per 15-minute unit)
96153	HO	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors-Group Service	$4.25 (per Medicaid-eligible student per 15-minute unit)
96150	UD	Social Worker (Bachelor's Level)-Individual Service-Evaluation	$7.17 (per 15-minute unit)
96152	UD	Social Worker (Bachelor's Level)-Individual Service-All Else	$7.17 (per 15-minute unit)
96153	UD	Social Worker (Bachelor's Level)-Group Service	$3.40 (per Medicaid-eligible student per 15-minute unit)

Procedure Codes and Fee Schedule, continued

Procedure Code	Modifier	Description of Service	Fee*
		AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) SERVICES	
92597		AAC Initial Evaluation by a Speech-Language Pathologist	$97.50
92597	GP	AAC Initial Evaluation by a Physical Therapist	$97.50
92597	GO	AAC Initial Evaluation by an Occupational Therapist	$97.50
92597	GN	AAC Re-Evaluation by a Speech-Language Pathologist	$50.00
92609		AAC Fitting, Adjustment and Training Visit	$40.00
		NURSING SERVICES	
T1002		Nursing Service-Registered Nurse	$6.20 (per 15-minute unit)
T1003		Nursing Service-Licensed Practical Nurse	$4.80 (per 15-minute unit)
T1004		Nursing Service-School Health Aide	$3.80 (per 15-minute unit)
T1002	KO	Medication Administration-Registered Nurse	$2.07 (per dose)
T1003	KO	Medication Administration-Licensed Practical Nurse	$1.06 (per dose)
T1004	KO	Medication Administration-School Health Aide	$.80 (per dose)

CHAPTER 2
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
PHYSICAL THERAPY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for physical therapy services, the requirements for service provision, the service limitations, and service exclusions.

In This Chapter

This chapter contains:

Definition

Introduction

Medicaid reimburses school district providers for the physical therapy services described in this handbook.

Physical Therapy

Physical therapy is a specific program to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Activities can include rehabilitation through exercise, massage, and the use of equipment through therapeutic activities.

Provider Qualifications

Physical Therapist Provider Qualifications	To render services in the Medicaid certified school match program a physical therapist must be currently licensed as a physical therapist under Chapter 486, Florida Statutes, (F.S.).
Physical Therapist Assistant Provider Qualifications	To render services in the Medicaid certified school match program, a physical therapist assistant must be currently licensed as a physical therapist assistant under Chapter 486, F.S. Temporary licenses are not acceptable for Medicaid purposes. Medicaid will reimburse a school district for a physical therapy assistant's services if the services are rendered under the supervision of a licensed physical therapist.

Physical Therapy Evaluations

Physical Therapy Evaluation (97001)	Evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits and limitations.
Service Requirements	To be reimbursed by Medicaid, the evaluation must be conducted by a licensed physical therapist. It must be based on the physical therapist's professional judgment and the specific needs of the student. A physical therapist assistant may not perform an evaluation.
Required Components	To be reimbursed by Medicaid, an evaluation must include the following components: • Student's name; • Diagnostic testing and assessment; and • A written report with needs identified. Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have to be a "stand alone" document. It may be a part of the plan of care or IEP or FSP.

Physical Therapy Evaluations, continued

Reimbursement Limitations	Although it is up to the physical therapist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one physical therapy evaluation per student, per school district provider, every six months.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the evaluation procedure code and fee.

Plan of Care

Plan of Care Requirement and Recommendation for Services	If an evaluation indicates that physical therapy is warranted, the physical therapist must develop and maintain a plan of care. The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care provided the IEP or FSP contains the required components as described below, or the information can be included in both documents. The plan of care or signed attachment (see section below on "Plan of Care Approval") may serve as the recommendation for services described in Chapter 1.
Provider Requirement	Only a licensed physical therapist may initiate, develop, submit, or change a plan of care. A physical therapist assistant may not initiate, develop, submit or change a plan of care.
Plan of Care Components	The plan of care must include the following information: • Student's name; • Description of the student's medical condition; • Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of physical therapy activities the student will need; and • Frequency and estimated length of treatments (may be total minutes per week) and the duration of treatment. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care, continued

Plan of Care Approval

The plan of care must be signed, titled and dated by a physical therapist. Also, a physician, advanced registered nurse practitioner (ARNP), or physician assistant (PA) must sign, title and date the plan of care if:

- Treatments for a student will be required beyond 21 days, and
- The student's condition has not been previously assessed by a physician, ARNP or PA.

An attachment may be used for the signature of a physician, ARNP or PA. A student is considered to have had a previous assessment if a prescription or a referral from a physician, ARNP or PA is present in school district records. A prescription or referral is only needed once unless the medical condition requiring the student's therapy significantly changes.

All required signatures on the plan of care must be legible and must be affixed to the plan before the school district may bill Medicaid for services. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document.

The plan of care must be retained in the student's record. Prescriptions as required by the Department of Education should also be retained in the student's record.

Plan of Care Review

A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. It is not necessary to obtain a physician's, ARNP's or PA's signature on annual plans of care subsequent to initial plans of care. A copy of annual plans of care should be sent to each Medicaid eligible student's physician for information to facilitate continuity of care.

The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care.

In the event that services are discontinued, the physical therapist must indicate the reason for discontinuing treatment in the student's record.

Reimbursement Limitations

Medicaid does not reimburse separately for developing the plan of care.

Physical Therapy Sessions

Introduction	In order to receive Medicaid reimbursement, physical therapy sessions can include rehabilitation through exercise, massage, and the use of equipment through therapeutic activities.
Provider Requirements	Medicaid reimburses for physical therapy sessions provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.
Individual Sessions by a Physical Therapist (97110)	Medicaid reimburses for individual physical therapy sessions performed by a licensed physical therapist.
Individual Sessions by a Physical Therapist Assistant (97110 HM)	Medicaid reimburses for individual physical therapy sessions performed by a physical therapist assistant under the supervision of a licensed physical therapist.
Group Sessions by a Physical Therapist (97150)	Medicaid reimburses for group physical therapy sessions performed by a licensed physical therapist.
Group Sessions by a Physical Therapist Assistant (97150 HM)	Medicaid reimburses for group physical therapy sessions performed by a physical therapist assistant working under the supervision of a licensed physical therapist.

Physical Therapy Sessions, continued

Service Requirement	Individual physical therapy sessions must consist of a minimum of 15 minutes of direct contact between the physical therapist or physical therapist assistant and the student. Group physical therapy sessions must consist of a minimum 15 minutes of direct contact between the physical therapist or physical therapist assistant and the students. Group sessions are limited to a maximum of four students. There is no requirement that all the members of the group be eligible for Medicaid. An evaluation (even if it was not reimbursed by Medicaid) and a plan of care must have been completed for a student by a licensed physical therapist prior to billing Medicaid for sessions with the student. Individual and group sessions do not include wheelchair evaluations and fittings or casts and splints. Note: See "Wheelchair Evaluations and Fittings" and "Casts and Splints" in this chapter for information on those services.
Supervision of Physical Therapist Assistants	Medicaid reimburses for sessions performed by a physical therapist assistant if the services are rendered under the supervision of a licensed physical therapist, pursuant to Chapter 486, F.S. A licensed physical therapist must have examined and evaluated the student and completed a plan of care before a physical therapist assistant can render services. Supervision does not have to be on-site; however, the physical therapist must be accessible at all times by two-way communication, which enables the physical therapist to respond to an inquiry and to be readily available for consultation during the delivery of care.
Reimbursement Limitations	Medicaid reimburses for a maximum total of four 15-minute physical therapy sessions per day, per student. The total of four sessions may be a combination of both individual and group sessions.
Service Exclusions	Medicaid reimbursement for physical therapy sessions does not include telephone responses to questions, conferences with the student's parent or guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the physical therapy session procedure codes and fee schedule.

Splints and Casts

Splints and Casts (29799 HA)	Medicaid reimburses for applying splints and casts by a licensed physical therapist that are needed for a Medicaid-eligible student's therapy.
Provider Requirements	To be reimbursed by Medicaid, the splint or cast service must be rendered by a licensed physical therapist.
Service Requirements	To be reimbursed by Medicaid, the splint or cast service must be: • Prescribed by a licensed physician, ARNP, or PA; and • Included in the student's plan of care.
Reimbursement Limitations	Medicaid reimburses for a maximum of two cast and splint applications per day, per student. This is a combined total and is per student, not per therapist. For example, one cast and one splint may be reimbursed or two casts or two splints, per day, per student, regardless of the number of therapists applying the casts and splints.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the splint and cast procedure codes and fee schedule.

Wheelchair Evaluations and Fittings

Wheelchair Evaluations and Fittings (97001 TG)	Medicaid reimburses for an initial evaluation of a Medicaid-eligible student's need for a wheelchair by a licensed physical therapist. Medicaid reimburses for a follow-up evaluation by a licensed physical therapist after the wheelchair is delivered to make adjustments and to properly fit the wheelchair to the student. Medicaid reimburses for wheelchair evaluations and fittings regardless of whether Medicaid purchased the student's wheelchair or if the evaluation indicates that a wheelchair is not needed. Note: Wheelchairs are purchased through the Medicaid Durable Medical Equipment (DME) program.

Wheelchair Evaluations and Fittings, continued

Provider Requirements

To be reimbursed by Medicaid, wheelchair evaluations must be performed by licensed physical therapists.

The physical therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider who is supplying the wheelchair; and
- Perform the follow-up evaluation(s) to make adjustments and properly fit the chair to the student.

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Student's name;
- Identification of the student's physical conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the student's capacity and medical condition;
- Justification of all accessories and add-on components based on the student's medical needs; and
- An explanation of the medical or health-related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the physical disability of the student justifies the inclusion of the item.

Finalization of the Wheelchair Evaluation Report

The wheelchair evaluation report must meet the following criteria:

- The physical therapist must complete, sign, title and date the report documenting the student's need for a wheelchair and the specific type of wheelchair needed; and
- The report must be filed in the student's record.

Wheelchair Evaluations and Fittings, continued

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per student, per wheelchair except that an occupational therapist may also be reimbursed for the evaluation of the student;
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the student (an occupational therapist may also be reimbursed); and
- One additional follow-up evaluation six months after the wheelchair is delivered (an occupational therapist may also be reimbursed).

Wheelchair Follow-up Evaluation Report

The wheelchair follow-up evaluation report must contain the following information:

- Student's name; and
- Description of adjustments and fittings made.

The physical therapist must complete, sign, title and date the report.

The report must be filed in the student's record.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, a wheelchair evaluation that is sent to a wheelchair manufacturer or a plan of care sent to a physician should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation or plan of care. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's records should include the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Therapy Audit Requirements, continued

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist, or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, OTA, 10/20/98; Mary Smith, PT, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation, unless they meet all of the service documentation requirements above.

CHAPTER 3
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
OCCUPATIONAL THERAPY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for occupational therapy services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

Definition

Introduction

Medicaid reimburses school district providers for the occupational therapy services described in this handbook.

Occupational Therapy

Occupational therapy is a specific service to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior and sensory, motor, postural development, and emotional deficits that have been limited by a physical injury, illness or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Provider Qualifications

Occupational Therapist Provider Qualifications

To render services in the Medicaid certified school match program an occupational therapist must be currently licensed as an occupational therapist under Chapter 468, Florida Statutes, (F.S.). Individuals with temporary licenses can render reimbursable services if done under the supervision of an actively licensed occupational therapist.

Occupational Therapy Assistant Provider Qualifications

To render services in the Medicaid certified school match program, an occupational therapy assistant must be currently licensed as an occupational therapy assistant under Chapter 468, F.S. Temporary licenses are not acceptable for Medicaid purposes.

Medicaid will reimburse a school district for an occupational therapy assistant's services if the services are rendered under the supervision of a licensed occupational therapist.

Occupational Therapy Evaluations

Occupational Therapy Evaluation (97003)

Evaluations determine the Medicaid-eligible student's level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student's functional abilities, capabilities, activities performance, deficits, and limitations.

Service Requirements

To be reimbursed by Medicaid, the evaluation must be conducted by a licensed occupational therapist. It must be based on the occupational therapist's professional judgment and the specific needs of the student. An occupational therapy assistant may not perform an evaluation.

Required Components

To be reimbursed by Medicaid, an evaluation must include the following components:

- Student's name;
- Diagnostic testing and assessment; and
- A written report with needs identified.

Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have be a "stand alone" document. It may be a part of the plan of care or IEP or FSP.

Occupational Therapy Evaluations, continued

Reimbursement Limitations

Although it is up to the occupational therapist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one occupational therapy evaluation per student, per school district provider, every six months.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the evaluation procedure code and fee.

Plan of Care

Plan of Care Requirements and Recommendation for Services

If an evaluation indicates that occupational therapy is warranted, the occupational therapist must develop and maintain a plan of care.

The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care provided the IEP or FSP contains the required components as described below, or the information can be included in both documents.

The plan of care will serve as the recommendation for services described in Chapter 1.

Provider Requirement

Only a licensed occupational therapist may initiate, develop, submit or change a plan of care. An occupational therapy assistant may not initiate, develop, submit or change a plan of care.

Plan of Care Components

The plan of care must include the following information:

- Student's name;
- Description of the student's medical condition;
- Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of occupational therapy activities the student will need; and
- Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care, continued

Plan of Care Approval	The plan of care must be signed, titled and dated by an occupational therapist prior to billing Medicaid for services. The signature on the plan of care must be legible. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document. The plan of care must be retained in the student's record.
Plan of Care Review	A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this chapter. The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care. In the event that services are discontinued, the occupational therapist must indicate the reason for discontinuing treatment in the student's record.
Reimbursement Limitations	Medicaid does not reimburse separately for developing the plan of care.

Occupational Therapy Sessions

Introduction	In order to receive Medicaid reimbursement, occupational therapy sessions can include perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment, and other techniques related to improving motor development.
Provider Requirements	Medicaid reimburses for occupational therapy sessions provided by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

Occupational Therapy Sessions, continued

Individual Session by an Occupational Therapist (97530)	Medicaid reimburses for individual occupational therapy sessions performed by a licensed occupational therapist.
Individual Session by an Occupational Therapy Assistant (97530 HM)	Medicaid reimburses for individual occupational therapy sessions performed by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.
Group Session by an Occupational Therapist (97150 GO)	Medicaid reimburses for group occupational therapy sessions performed by a licensed occupational therapist.
Group Session by an Occupational Therapy Assistant (97150 UC)	Medicaid reimburses for group occupational therapy sessions performed by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.
Service Requirements	Individual occupational therapy sessions must consist of a minimum 15 minutes of direct contact between the licensed occupational therapist or occupational therapy assistant and the student. Group occupational therapy sessions must consist of a minimum 15 minutes of direct contact between the licensed occupational therapist or occupational therapy assistant and the students. Group size is limited to a maximum of four students. There is no requirement that all the members of the group be eligible for Medicaid. An evaluation (even if it was not reimbursed by Medicaid) and plan of care must have been completed for a student by an occupational therapist prior to billing Medicaid for sessions with the student. Individual and group sessions do not include wheelchair evaluations and fittings or casts and splints. Note: See “Wheelchair Evaluations and Fittings” and “Casts and Splints” in this chapter for information on those services.

Occupational Therapy Sessions, continued

Supervision of Occupational Therapy Assistants	Medicaid reimburses for sessions performed by a licensed occupational therapy assistant if the services are rendered under the supervision of a licensed occupational therapist, pursuant to Chapter 468, F.S. A licensed occupational therapist must have examined and evaluated the student and completed a plan of care before an occupational therapy assistant can render services. Supervision does not have to be on-site; however, the supervising occupational therapist must be available to the assistant for consultation.
Reimbursement Limitations	Medicaid reimburses for a maximum total of four 15-minute occupational therapy sessions per day, per student. The total of four sessions may be a combination of both individual and group sessions.
Service Exclusions	Medicaid reimbursement for occupational therapy sessions does not include telephone responses to questions, conferences with the student's parent, guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the occupational therapy session procedure codes and fee schedule.

Splints and Casts

Splints and Casts (29799 HA)	Medicaid reimburses for applying splints and casts by a licensed occupational therapist that are needed for a Medicaid-eligible student's therapy.
Provider Requirements	To be reimbursed by Medicaid, the splint or cast service must be rendered by a licensed occupational therapist.
Service Requirements	To be reimbursed by Medicaid, the splint or cast service must be: • Prescribed by a licensed physician, ARNP, or PA; and • Included in the student's plan of care.

Splints and Casts, continued

Reimbursement Limitations	Medicaid reimburses for a maximum of two cast and splint applications per day, per student. This is a combined total and is per student, not per therapist. For example, one cast and one splint may be reimbursed or two casts or two splints, per day, per student, regardless of the number of therapists applying the casts and splints.
Codes and Fees	See Appendix C in Chapter 1 in this handbook for the splint and cast procedure codes and fee schedule.

Wheelchair Evaluations and Fittings

Wheelchair Evaluations and Fittings (97003 TG)	Medicaid reimburses for an initial evaluation of a Medicaid-eligible student's need for a wheelchair by a licensed occupational therapist. Medicaid reimburses for a follow-up evaluation by a licensed occupational therapist after the wheelchair is delivered to make adjustments and to properly fit the wheelchair to the student. Medicaid reimburses for wheelchair evaluations and fittings regardless of whether the student's wheelchair was purchased by Medicaid or if the evaluation indicates that a wheelchair is not needed. Note: Wheelchairs are purchased through the Medicaid Durable Medical Equipment (DME) program. See the DME handbook for further information on equipment purchasing policies.
Provider Requirements	To be reimbursed by Medicaid, wheelchair evaluations must be performed by licensed occupational therapists. The occupational therapist who performed the initial wheelchair evaluation must: • Be available to the durable medical equipment provider who is supplying the wheelchair; and • Perform the follow-up evaluation to make adjustments and properly fit the chair to the student.

Wheelchair Evaluations and Fittings, continued

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Student's name;
- Identification of the student's occupational conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the student's capacity and medical condition;
- Justification of all accessories and add-on components based on the student's medical needs; and
- An explanation of the medical or health-related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the occupational disability of the student justifies the inclusion of the item.

Finalization of the Wheelchair Evaluation Report

The wheelchair evaluation report must meet the following criteria:

- The occupational therapist must complete, sign and date the report documenting the student's need for a wheelchair and the specific type of wheelchair needed; and
- The report must be filed in the student's record.

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per student, per wheelchair except that a physical therapist may also be reimbursed for an evaluation of the student;
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the student (a physical therapist may also be reimbursed); and
- One additional follow-up evaluation six months after the wheelchair is delivered (a physical therapist may also be reimbursed).

Wheelchair Follow-up Evaluation Report

The wheelchair follow-up evaluation report must contain the following information:

- Student's name; and
- Description of adjustments and fittings made.

The occupational therapist must complete, sign, title and date the report. The report must be filed in the student's record.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, a wheelchair evaluation that is sent to a wheelchair manufacturer should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.
Each Medicaid-eligible student's records should include, at a minimum, the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, OTA, 10/20/98; Mary Smith, OT, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation unless they meet all of the service documentation requirements above.

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CHAPTER 4
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
SPEECH-LANGUAGE PATHOLOGY SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for speech-language pathology services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

Definition

Introduction

Medicaid reimburses school district providers for the speech-language pathology services described in this handbook.

Speech-Language Pathology

Speech-language pathology services involve the evaluation and treatment of speech and language disorders. Services include evaluating and treating disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory or visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the student's communication needs, when appropriate. Speech-language pathology services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Provider Qualifications

Speech-Language Pathologist Provider Qualifications

To bill Medicaid for services in the Medicaid certified school match program, a school district must have one of the following forms of credentials for speech-language pathologists:

- Current license as a speech-language pathologist under Chapter 468, Florida Statutes. Individuals with provisional licenses may render reimbursable services if done under the supervision of an actively licensed speech-language pathologist;
- Department of Education Certification in the area of Speech-Language Impaired, containing the words “Speech-Language Impaired-Professional”;
- Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
- ASHA membership card stating “Certified Member”;
- ASHA Certificate Holder card; or
- Master’s level degree in speech-language pathology (the degree title may show terminology such as “Communication Disorders”).

Speech-Language Pathology Assistant Provider Qualifications

To render services in the Medicaid certified school match program, a speech-language pathology assistant must be currently certified as a speech-language pathology assistant under Chapter 468, F.S.

Medicaid will reimburse a school district for a speech-language pathology assistant’s services if the services are rendered under the supervision of a licensed speech-language pathologist.

Speech-Language Pathology Evaluations

Speech-Language Pathology Evaluation (92506)

Evaluations determine the Medicaid-eligible student’s level of functioning and competencies through professionally accepted techniques. They are used to develop baseline data to identify the need for early intervention and to address the student’s functional abilities, capabilities, activities performance, deficits and limitations.

Speech-Language Pathology Evaluations, continued

Service Requirements	To be reimbursed by Medicaid, the evaluation must be conducted by a speech-language pathologist. It must be based on the speech-language pathologist's professional judgment and the specific needs of the student. A speech-language pathology assistant may not perform an evaluation.
Required Components	To be reimbursed by Medicaid, an evaluation must include the following components: • Student's name; • Diagnostic testing and assessment; and • A written report with needs identified. Diagnostic testing may be standardized or may be composed of professionally accepted techniques. Any available medical history records should be filed in the student's records. An evaluation does not have to be a "stand alone" document. It may be a part of the plan of care, IEP or FSP.
Reimbursement Limitations	Although it is up to the speech-language pathologist to determine when an evaluation or follow-up evaluation(s) should be done for a student, Medicaid will only reimburse for a maximum of one speech-language pathology evaluation per student, per school district provider, every six months.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the speech-language pathology evaluation procedure code and fee.

Plan of Care

Plan of Care Requirements and Recommendation for Services

If an evaluation indicates that speech-language pathology treatment is warranted, the speech-language pathologist must develop and maintain a plan of care.

The student's Individual Educational Plan (IEP) or Family Support Plan (FSP) may suffice as the plan of care as long as the IEP or FSP contains the required components as described below.

The plan of care may serve as the recommendation for services described in Chapter 1.

Provider Requirement

Only a speech-language pathologist may initiate, develop, submit or change a plan of care. A speech-language pathology assistant may not initiate, develop, submit or change a plan of care.

Plan of Care Components

The plan of care must include the following information:

- Student's name;
- Description of the student's medical condition;
- Achievable, measurable, time-related goals and objectives that are related to the functioning of the student and include the type of speech-language pathology activities the student will need; and
- Frequency and the estimated length of treatments (may be total minutes per week) and the duration of treatment necessary. Examples: The plan of care might state "treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)" or "treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)".

Plan of Care Approval

The plan of care must be signed, titled and dated by a speech-language pathologist prior to billing Medicaid for services.

The signature on the plan of care must be legible. All stamped signatures must be initialed and dated by the person whose signature is stamped. Initials alone are not acceptable. If an IEP or FSP is used as a plan of care, the date of the IEP or FSP meeting, as entered on the IEP or FSP, will suffice as the therapist's date for the document.

The plan of care must be retained in the student's record.

Plan of Care, continued

Plan of Care Review	A plan of care is required annually, or more frequently if the student's condition changes or alternative treatments are recommended. Each plan of care must contain all the plan of care components listed in this chapter. The plan of care must be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services must be added to the plan of care. In the event that services are discontinued, the speech-language pathologist must indicate the reason for discontinuing treatment in the student's record.
Reimbursement Limitations	Medicaid does not reimburse separately for developing the plan of care.

Speech-Language Pathology Sessions

Introduction	In order to receive Medicaid reimbursement, speech-language pathology sessions should include procedures to maximize the student's oral functions.
Provider Requirements	Medicaid reimburses for speech-language pathology sessions provided by a credentialed speech-language pathologist or a certified speech-language pathology assistant under the supervision of a licensed speech-language pathologist.
Individual Session by a Speech-Language Pathologist (92507)	Medicaid reimburses for individual speech-language pathology sessions performed by a speech-language pathologist.
Individual Session by a Speech-Language Pathology Assistant (92507 HM)	Medicaid reimburses for individual speech-language pathology sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist.

Speech-Language Pathology Sessions, continued

Group Session by a Speech-Language Pathologist (92508)	Medicaid reimburses for group speech-language pathology sessions performed by a speech-language pathologist.
Group Session by a Speech-Language Pathology Assistant (92508 HM)	Medicaid reimburses for group speech-language pathology sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist.
Service Requirement	Individual speech-language pathology sessions must consist of a minimum of 15 minutes of direct contact between the speech-language pathologist or speech-language pathology assistant and the student. Group speech-language pathology sessions must consist of a minimum 15 minutes of direct contact between the speech-language pathologist or speech-language pathology assistant and the students. Group size is limited to a maximum of eight students. There is no requirement that all the members of the group be eligible for Medicaid. An evaluation (even if it was not reimbursed by Medicaid) and plan of care must be: • Completed by a licensed or DOE-certified or ASHA-certified or master's degree level speech-language pathologist; or • The document must be countersigned by a master's level speech-language pathologist prior to billing Medicaid for sessions with the student.
Supervision of Speech-Language Pathology Assistants	Medicaid reimburses for sessions performed by a certified speech-language pathology assistant if the services are rendered under the supervision of a speech-language pathologist, pursuant to Chapter 468, F.S. A speech-language pathologist must have examined and evaluated the student and completed a plan of care before a speech-language pathology assistant can render services. The speech-language pathologist must be physically present in the same facility in order to be available for consultation and direction.
Reimbursement Limitations	Medicaid reimburses for a maximum total of four 15-minute speech-language pathology sessions per student, per day. The total of four sessions may be a combination of both individual and group sessions.

Speech-Language Pathology Sessions, continued

Service Exclusions

Medicaid will not reimburse for assisting foreign speaking students in comprehending or speaking English or for interpreter's services.

Medicaid reimbursement for speech-language pathology sessions does not include telephone responses to questions, conferences with the student's parent, guardian or teacher, informing the physician of concerns, mileage or travel time off school campus.

Medicaid will not provide reimbursement for treatment based on evaluations completed by a bachelor's speech-language pathologist unless one of the following conditions exists:

- A master's level speech-language pathologist has interpreted and countersigned if the testing documents from the evaluation are available and current; or
- A statement is written by the master's level speech-language pathologist after reviewing the student's IEP and the evaluation report, indicating that the master's level speech-language pathologist concurs with the findings.

In either case the signature of the master's level speech-language pathologist must be accompanied by his title, and dated.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the speech-language pathology session procedure codes and fee schedule.

Therapy Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of all Medicaid reimbursable or required services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's records should include the following:

- Current and valid plan of care;
- Test results and evaluation reports; and
- Documentation describing each session as listed in the following section.

Therapy Audit Requirements, continued

Documentation Components

Documentation of each individual or group session must include the following information:

- Student name;
- Date of service;
- Type of service (physical or occupational therapy or speech-language pathology);
- If a group session, the number of students in the group;
- Length of time the therapy was performed (time may be recorded based on start and stop times or length of time spent with the student);
- Description of therapy activity or method used;
- Student's progress toward established goals; and
- Signature of service provider (or initials of service provider if weekly documentation method as described below is used), title and date.

The above documentation requirements may be kept on a weekly basis and may be in any combination of narrative, checklist or log-type format.

If documentation is done on a weekly basis, the documentation must include the therapy method used for each session. Further, it is not necessary to repeat student name and type of service on weekly documentation (one entry for the week will suffice).

All documentation must be signed, titled and dated by the provider of the services, i.e., Sally Jones, SLPA, 10/20/98; Mary Smith, SLP, 10/5/98. If the same health care provider rendered all of the services during the week, his signature, title and date are only required once; however, he must initial each per service encounter entry. Initials under any other circumstance are not acceptable.

Attendance forms, sometimes referred to as "bubble sheets," do not alone constitute documentation unless they meet all of the service documentation requirements above.

CHAPTER 5
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM TRANSPORTATION SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for transportation, the eligibility requirements for service provision, how rates are established and claims submitted, and the documentation and record keeping requirements.

In This Chapter

This chapter contains:

Provider Qualifications

Enrollment Process

To be reimbursed for transportation services under the certified school match program, the school district must enroll as a Medicaid provider and submit a Medicaid provider agreement for transportation services. (The school district must submit a separate provider agreement for each type of service for which it will bill Medicaid.)

Note: See Chapter 1 in this handbook for the general provider qualifications.

Transportation Services Provider Qualifications

There are no specific Medicaid provider qualifications for transportation services beyond the requirements for school bus transportation in Chapter 1006, F.S., and Chapter 6A-3, F.A.C.

Service Requirements

Introduction	To receive Medicaid reimbursement for transportation services, the following requirements must be met.
Non-Emergency	The transportation must be non-emergency.
Two Types of Categories of Specialized Transportation Service	To qualify for Medicaid reimbursement one of the two types of categories of services described below must be met.
Type One: Handicapped Equipped or Adapted Vehicle	The bus or vehicle must be adapted or specially equipped to serve the disabled student.
Type Two: Attendant Required to Accompany Student	When an attendant rides with the student(s) during the transport to assist the student(s) with behavioral or physical disability related needs the trip is defined as type two specialized transportation. The vehicle may be any vehicle used to transport students to school or to a medical appointment to and from school, and may not necessarily be adapted or specially equipped to serve the disabled student.
Recipient Eligibility	The student must meet the criteria for the Exceptional Student Education (ESE) program under the provisions of the Individuals with Disabilities Education Act (IDEA), Part B or Part C.

Service Requirements, continued

Individual Education Plan or Family Support Plan	Transportation can only be reimbursed when a Medicaid-covered service other than transportation is rendered, and when the other medical or behavioral service provided is referenced in the student's IEP or FSP. The services of the attendant under type two specialized transportation cannot satisfy the requirement as the other Medicaid-covered service. For example, if the need for a bus attendant is identified, as a related service on a student's IEP, the service of the attendant cannot be considered the Medicaid-covered service for which the transportation is provided. The cost of the attendant under type two specialized transportation may be added to the provider's cost base when calculating a new trip rate. The transportation must be referenced as a service in the student's IEP or FSP as specialized transportation meeting one of the following three criteria for specialized transportation: • Medical or vehicle adaptive equipment required; • Medical condition that requires a special transportation environment; or • Attendant required due to (physical or behavioral) disability and specific needs of student. (Note of Clarification: The three criteria above are based on the criteria also used by the Department of Education for specialized funding for transportation.)

Reimbursable Transportation Services

Medicaid-Covered Service at the School	Medicaid may reimburse for a trip to and from the school only when a Medicaid-covered service is provided at the school. Specialized transportation to or from the school must be provided on the same day that the Medicaid-covered service is provided at the school. The services of the attendant under type two specialized transportation cannot satisfy this requirement as the other Medicaid-covered service.

Reimbursable Transportation Services, continued

Medicaid-Covered Service Provided Off Campus

When a Medicaid-covered service is provided off the school campus, Medicaid may reimburse for the trip from the school to the medical service and back.

Medicaid cannot reimburse for a trip from home to the school and back when the only Medicaid-covered medical service is provided at a location off the school campus.

Service Limitations

Medicaid reimbursement for certified school match transportation services is limited to four one-way trips per day, per Medicaid-eligible student. Four trips in one day may only be claimed when a Medicaid-covered service is provided at the school, and a different Medicaid-covered service is provided off campus on the same day.

Reimbursement Information

Reimbursement Rate

Medicaid reimburses the school districts on a per trip basis at a district-specific rate determined by information provided to the Department of Education (DOE) from each school district's annual financial reports and other available sources. Medicaid reimburses only the federal share of the trip rate for specialized transportation. Only type one and type two specialized transportation, as defined above, meet the criteria for specialized transportation; and, only specialized transportation is reimbursable under this program. The district-specific rate is applicable to type one and type two specialized transportation for reimbursement.

Claim Instructions (For Claims Filed Electronically or by Paper)

To receive reimbursement, the school district must submit school-related transportation claims on CMS-1500 claims using the following instructions:

- Enter procedure code T2003 (non-emergency transportation).
- Enter diagnosis code 999.9 for all Medicaid-eligible students.
- Enter keyed claim type 88 in field 19.
- Use a separate claim line for each date of service.
- For units of service, enter the total number of one-way trips that the student was transported to and from Medicaid-covered services for each date of service.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500, for complete information on completing the CMS-1500 claim.

Trip Logs

Introduction

In addition to the audit requirements listed in Chapter 1 of this handbook, and the Medicaid Provider General Handbook, the school district must keep a trip log as described in this section. A school district may submit a proposal to the area Medicaid school services representative for an alternate plan of documentation other than daily trip logs. The area liaison will forward complete descriptive alternate plans of documentation to the Agency for Health Care Administration central Medicaid office for processing. The area Medicaid office will advise the school district of whether the request was approved and the time period of the approval; or, if denied, the reason for denial.

Documentation

To document the provision of transportation to Medicaid services, provided at school or off campus, the school districts must keep dated trip logs that contain the following information:

- Student's name,
- Date the student was transported, and
- Bus or loading dock attendant's or bus driver's daily initials on the date of each trip verifying that the student(s) listed on each trip log actually rode in the vehicle.

The school district may list multiple student names on one trip log. Preprinted trip log forms listing all the students that normally ride a specific route may be used with only one set of initials required per route log indicating which students rode the vehicle for that trip.

Electronic documentation and electronic signatures are allowed but these records must be available upon request, as required in Chapter 1 of this handbook.

Matching Logs to Services

The school district must have the capacity to match the trip logs to health care records to document that a Medicaid-covered service referenced in the student's IEP or FSP was provided to the student on each day for which a claim was submitted for transportation reimbursement.

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CHAPTER 6
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
BEHAVIORAL SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for behavioral services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

Definitions

Introduction

Medicaid reimburses school districts for the behavioral services described in this handbook.

Behavioral Services

Behavioral services are services which can include:

- Testing, assessment and evaluation that appraise cognitive, developmental, emotional, social and adaptive functioning;
- Interviews, behavioral evaluations and functional assessments, including interpretations of information about the student's behavior and conditions relating to functioning;
- Development of evaluative reports;
- Consultation and coordination, follow-up referrals with other health care staff, other entities or agencies, parents, teachers, and family during the Individual Educational Plan or Family Support Plan (IEP or FSP) development and review process or at other times deemed appropriate by the school district staff performing behavioral services;

Definitions, continued

Behavioral Services, continued

- Therapy and counseling;
- Behavioral analysis or assessment and treatment or intervention; and
- Unscheduled activities for the purpose of resolving an immediate crisis situation.

Terminology

The term "behavioral" services is used in this chapter as a generic term to cover the many behavioral services (the above list consists of examples) school districts offer to students. Procedure codes have been assigned by type of qualified provider (see Appendix C in Chapter 1 for a list and definition of each code). School district staff members should be aware of the specific services their licenses or certifications allow them to provide and must work within practice parameters allowed.

Provider Qualifications

Provider Types for Behavioral Services

For Medicaid purposes, the following types of employed or contracted school district staff may render reimbursable services:

- School psychologists and psychologists;
- Social workers (master's and bachelor's level degrees);
- Certified behavior analysts (master's and bachelor's level degrees);
- Associate certified behavior analysts;
- Mental health counselors;
- Marriage and family therapists; and
- Guidance counselors.

Unless noted otherwise in this chapter, the various staff above will be referenced as "school district staff." The list of examples of covered services is not intended as a comprehensive or all-inclusive list for every school district staff member.

Provider Qualifications, continued

School Psychologist or Psychologist Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a school psychologist or psychologist must have one of the following:

- Current license as a school psychologist or psychologist under Chapter 490, Florida Statutes (F.S.); or
- Certification by the Department of Education (DOE) as a temporary certified school psychologist or as a certified school psychologist; or
- Master's, specialist's, or higher degree and the individual is accumulating the experience for licensure under Chapter 490, F.S., or for DOE certification if services are rendered under the general supervision of a licensed psychologist, school psychologist, or DOE certified school psychologist.

School Social Worker or Social Worker Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a school social worker or a social worker must have one of the following:

- Current license as a clinical social worker under Chapter 491, Florida Statutes, (F.S.);
- Certification by the Department of Education (DOE) as a school social worker with a master's level degree or higher in social work;
- A master's degree or higher from a college or university and working under the supervision of a licensed clinical social worker (or the equivalent as defined in Chapter 491, F.S.) or DOE-certified school social worker with a master's degree or higher in social work in order to obtain the work experience necessary for licensure or certification; or
- Certification by DOE as a school social worker with a bachelor's level degree in social work and working under the supervision of a licensed or DOE-certified master's level degree school social worker.

Temporary licenses are not acceptable for Medicaid purposes.

Certified Behavior Analyst and Associate Certified Behavior Analyst Provider Qualifications

To render reimbursable services in the Medicaid certified school match program, a certified behavior analyst must have a bachelor's or master's level degree and be currently certified by the Department of Children and Families. Certified behavior analysts with bachelor's level degrees must be working under the supervision of a master's level degree certified behavior analyst for Medicaid to reimburse the services.

To render reimbursable services in the Medicaid certified school match program, an associate certified behavior analyst must hold current certification issued by the Department of Children and Families and must be working under the supervision of a certified behavior analyst with a master's level degree.

Provider Qualifications, continued

Mental Health Counselor Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a mental health counselor must have one of the following: • Current license as a mental health counselor under Chapter 491, Florida Statutes, (F.S.); or • Master's degree and provisional license or board registration as an intern and working under the supervision of a licensed mental health counselor. Temporary licenses are not acceptable for Medicaid purposes.
Marriage and Family Therapist Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a marriage and family therapist must have one of the following: • Currently licensed as a marriage and family therapist under Chapter 491, Florida Statutes, (F.S.); or • Master's degree and provisional license or board registration as an intern and working under the supervision of a licensed marriage and family therapist. Temporary licenses are not acceptable for Medicaid purposes.
Guidance Counselor Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a guidance counselor must be DOE-certified as a guidance counselor and have a master's level degree or higher.

Service Requirements

Introduction	To receive Medicaid reimbursement for behavioral services, the following requirements must be met.
General Service Requirements	To be reimbursed by Medicaid, the service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services. If a Medicaid eligible student receives counseling, therapy or behavioral treatments from a school district and a community mental health provider during the same time period, these activities should be coordinated by both providers.

Service Requirements, continued

Individual Educational Plan or Family Support Plan	The need for behavioral services must be referenced in the student's Individual Educational Plan (IEP) or Family Support Plan (FSP).
Recommendation for Services	Except as noted, qualified providers of behavioral services who have master's level or higher degrees and are licensed or certified, must sign, title and date the IEP, FSP or separate document indicating that behavioral services are needed for the Medicaid-eligible student prior to the time any claims for behavioral services are submitted to Medicaid. However, recommendations for behavioral services rendered by guidance counselors must be signed by school psychologists or psychologists or master's level social workers.
Diagnosis Code	Medicaid requires that an ICD-9 diagnosis code be entered on the CMS-1500 claim. The student's diagnosis statement or ICD-9 diagnosis code must be contained in his record.
Abbreviated Title for Psychologists	School psychologists or psychologists may sign IEPs, FSPs or service documentation as follows: • A licensed psychologist may sign his name and enter degree earned (ex. Ph.D., Ed.D., Psy.D.) or "LP" or "licensed psychologist"; • A licensed school psychologist may sign his name and enter degree earned (ex. M.S., Ph.D.) or "LSP" or "licensed school psychologist"; • A DOE-certified school psychologist may sign his name and enter degree earned (ex. M.S., Ph.D.) or "CSP" or "certified school psychologist" ("NCSP" could be used if the individual holds national certification); or • An individual with a master's, specialist's or higher degree accumulating the experience necessary to obtain a license should sign his name and enter degree earned (example: M.S., Ed.S., Ph.D.).
Place of Service	Travel time off school campus for the provision of behavioral services is not reimbursable unless reimbursable services are rendered during travel.

Individual Behavioral Services

Individual Behavioral Service-Evaluation (96150 or 96150 followed by AH, HN, HO or UD)

Individual Behavioral Service-All Else (96152 or 96152 followed by AH, HN, HO or UD)

Individual behavioral services as defined in this chapter may be billed to Medicaid when the school district staff are rendering services to or on behalf of a specific Medicaid-eligible student.

Two procedure codes are used for billing individual behavioral services.

- One code, 96150 or 96150 with a modifier, is used to bill for services related to evaluating a student; and
- Another code, 96152 or 96152 with a modifier, is used to bill for all other services rendered to or on behalf of a specific Medicaid-eligible student.

Service Requirements

If services are rendered to or on behalf of an individual Medicaid-eligible student, regardless of which service or combinations of services are being rendered, the school district must bill for individual behavioral services.

When a consultation is performed for one Medicaid-eligible student, the service is considered to be an individual service, regardless of the number of family members, school staff or health care staff present.

Service Reimbursement

Medicaid reimbursement is based on the amount of time spent by the school district staff with or on behalf of each Medicaid-eligible student. One unit of individual behavioral service equals a maximum of 15 minutes.

The total time spent per day providing behavioral services to or on behalf of a Medicaid-eligible student must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, three individual behavioral services of 27 minutes, 8 minutes and 30 minutes equals a daily total of 65 minutes and would be billed to Medicaid as 5 units.

It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Individual Behavioral Services, continued

Reimbursement Limitations	Medicaid reimburses a maximum of 32 units **per school district staff member**, per day. The school may bill for behavioral services provided by the same staff member to multiple Medicaid-eligible students on the same day of service; however, the total individual and group units cannot exceed 32 units. It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the individual behavioral services procedure codes and fees.

Group Behavioral Services

Group Behavioral Service (96153 or 96153 followed by AH, HN, HO or UD)	Group behavioral services as defined in this chapter may be billed to Medicaid when the school district staff are rendering services to or on behalf of a group of students.
Service Requirements	If services are rendered to or on behalf of a group of students, regardless of which service or combinations of services are being rendered, the school district must bill for group behavioral services. For Medicaid to reimburse the service, the group size must be a minimum of two students and must not exceed ten students. It is not required that all the students in a group be eligible for Medicaid.

Group Behavioral Services, continued

Service Reimbursement

Medicaid reimbursement is based on the amount of time spent by school district staff with or on behalf of a group of students. One unit of group behavioral service equals a maximum of 15 minutes.

The total time spent per day providing group behavioral services to or on behalf of a group of students must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, if the school district staff member conducted a 35-minute group counseling session and spent 18 minutes that same day documenting the results of the group session for a daily total of 53 minutes, 4 units of service would be billed to Medicaid. If two of the students in the group were Medicaid-eligible, two claims would be submitted, each showing 4 units of service.

Only one Medicaid claim (or claim line) per day, per Medicaid-eligible student can be reimbursed. This one claim must show the cumulative total units for the Medicaid-eligible student for the day.

It is permissible to include time spent preparing documentation of behavioral health services rendered. However, time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Reimbursement Limitations

Medicaid reimburses a maximum of 32 units **per school district staff member**, per day. The school may bill for behavioral services provided by the same staff member to multiple Medicaid-eligible students on the same day of service; however, the total individual and group units for the staff member cannot exceed 32 units.

Travel time off school campus for provision of behavioral services is not reimbursable unless reimbursable services are rendered during travel.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the group behavioral services procedure code and fee.

Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of Medicaid reimbursable behavioral services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook. Services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's record must include, at a minimum, the following:

- Current IEP or FSP indicating the need for behavioral services;
- Test and assessment results; and
- Documentation describing each behavioral service, as listed in the following sections.

Diagnosis Code

A diagnosis statement or ICD-9 diagnosis code must be contained in each Medicaid-eligible student's record.

Documentation Components for Testing, Assessment, Evaluation and Consultative and Referral Activities

Documentation of each behavioral service billed to Medicaid, other than therapy or counseling, must include the following information:

- Student name;
- Date of service;
- Description of tests, assessments or other evaluative methods such as interviews, observations and record reviews, or description of consultative or referral activities;
- Length of time the service was performed;
- The school district staff member's signature, title and date (for example, Susan Jones, CBA, October 2, 1998).

Audit Requirements, continued

Narrative Descriptions or Logs

It is acceptable to use either narrative descriptions or logs as documentation of services if the content meets the above requirements. For example, a school psychologist might enter:

Name	Date	Time	Description of Service
James Doe	10/2/98	90 minutes	AAMD Adaptive Developmental Inventory, observation and interview
James Doe	10/3/98	60 minutes	Compiling evaluative report

If a log-type format is used, the school district staff may either:

- Sign, date, and title the log by each entry on the log; or
- Initial each entry and sign, date and title the log on a weekly basis.

Documentation Components for Treatment Services

Documentation of therapy or counseling sessions billed to Medicaid must include the following information:

- Student name;
- Date of service;
- Description of therapy or counseling session;
- Description of the student's progress toward any established goals, if appropriate (can be weekly);
- Length of time the service was performed;
- Identify if group or individual therapy; and
- School district staff member's signature, title and date (for example, Mike Smith, LCSW, October 18, 1998).

These records may be kept in narrative form or on logs if the above components are present. Daily initials may be used if weekly signatures are present in the manner described on the preceding page.

CHAPTER 7
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for augmentative and alternative communication (AAC) therapy services, the requirements for service provision, the service limitations, and service exclusions.

AAC devices and auxiliary equipment are **not** covered through the certified school match program. AAC devices and auxiliary equipment are covered through the Durable Medical Equipment (DME) and Medical Supply Services program. Some steps in obtaining an AAC system do not require school district involvement, but are included in this chapter so that school districts will have an understanding of the complete process for obtaining AAC systems.

In This Chapter

This chapter contains:

Definitions and Descriptions

Introduction	Medicaid reimburses school district providers for the augmentative and alternative communication (AAC) therapy services described in this handbook.
Augmentative and Alternative Communication (AAC)	AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association, (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments. Medicaid reimburses only for systems and services that are deemed medically necessary. Note: For description of medical necessity, refer to Chapter 1 of this handbook.
AAC Therapy Services Covered	AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid certified school match program.
AAC Systems Reimbursement	AAC systems are not reimbursed through the Medicaid certified school match program. AACs are reimbursed through the Medicaid Durable Medical Equipment (DME) and Medical Supply Services program. AAC systems must be prior authorized by the Medicaid consultant (see definition on the next page). It is important for the family to be involved throughout the process of obtaining an AAC system for a student. The AAC system will be purchased for the Medicaid eligible student (not the school district) and is designed to be used both in home and school settings.

Definitions and Descriptions, continued

Coverage and Limitations	Medicaid reimburses only AAC systems that are dedicated systems as described below. Medicaid will reimburse for one AAC system every five years per Medicaid-eligible student and a software upgrade every two years, if needed. Modifications, which may be in the form of replacing the AAC system or upgrading the AAC's software, may be reimbursed only if the new technology will improve communication significantly. Medicaid will reimburse for replacement of devices, components or accessories when there is irreparable failure or damage not caused by willful abuse or neglect.
Dedicated System	A dedicated system is designed specifically for a disabled population. A non-dedicated system is a commercially available device such as a laptop computer with special software.
Medicaid Consultant	A Medicaid consultant is a licensed speech-language pathologist employed with or contracted by the Agency for Health Care Administration with responsibility for reviewing requests for AAC systems.

Service Requirements

Introduction	To receive Medicaid reimbursement for AAC therapy services the following requirements must be met.
General Service Requirements	To be reimbursed by Medicaid, the therapy service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services.
IEP or FSP Requirement	The need for AAC services does not have to be specifically referenced in the student's IEP or FSP if the need for speech-language pathology services is referenced.

Service Requirements, continued

Eligibility for Receiving an AAC

For Medicaid to reimburse a DME provider for an AAC system, the Medicaid-eligible student must have the physical, cognitive and language abilities necessary to use the AAC system.

Interdisciplinary Team

An interdisciplinary team (ID team) must be formed to evaluate the student, recommend an AAC and write an individualized action plan.

The ID team must consist of at least two members and must include a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist and physical therapist. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. If appropriate, the student who will use the AAC should be encouraged to participate on the ID team as well as the student's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

Conflict of Interest

The medical professionals who evaluate the student, serve on the ID team, or prescribe the AAC must not have a financial relationship with or receive any gain from the AAC manufacturer.

Steps for Completion of a Prior Authorization Package

The **DME provider** must submit a prior authorization package to the Medicaid fiscal agent for Medicaid review and approval. For the therapist's information, the following components must be included in the prior authorization package (the DME provider may obtain items 1 through 4 from the school district):

1. The AAC evaluation signed by the ID team members;
2. The individualized action plan;
3. A prescription for the AAC signed and dated by the recipient's physician, advanced registered nurse practitioner, or physician's assistant that includes the provider's name, address, telephone number, and medical license number;
4. The MediPass authorization number if the student is a MediPass participant;
5. A completed Florida Medicaid Prior Authorization form;
6. An itemized invoice listing retail costs for the equipment; and
7. Manufacturer's catalogue information regarding cost and warranty information.

The DME provider is responsible for completing items 5, 6 and 7.

Service Requirements, continued

Medicaid Approval of the AAC	Medicaid's decision for coverage will be based on a medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to a medical need. Medicaid will not deny an AAC based solely on the fact that the student can communicate in writing.
DME Provider Responsibilities	Prior to billing for an AAC system, the DME provider is responsible to ensure the properly selected system and all components have been delivered to the student and are operational in the student's home.
School District Speech-Language Pathologist Responsibilities	The Medicaid fiscal agent is not responsible for notifying the school district of approval or denial of the AAC systems. The school district should maintain contact with the DME provider to ensure notification of approval or denial of the AAC request. Each step for which the school district or speech-language pathologist is responsible is described in detail in the following topics.

Initial AAC Evaluations

Initial Evaluation (92597 92597 GP 92597 GO)	The ID team, led by the speech-language pathologist, must perform an initial evaluation on the student for an AAC system, which meets, at a minimum, evaluation requirements that are listed under "Evaluation Documentation Requirements" in this chapter.

Initial AAC Evaluations, continued

Provider Qualifications for Initial Evaluations

Medicaid reimburses school districts for AAC initial evaluations performed by the following types of health care providers through the certified school match program:

- Licensed and provisionally-licensed speech-language pathologists;
- Speech-language pathologists who have a:
  - Department of Education Certification in the area of Speech-Language Impaired, containing the words "Speech-Language Impaired-Professional";
  - Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
  - ASHA membership card stating "Certified Member";
  - ASHA Certificate Holder card; or
  - Master's level degree in speech-language pathology (the degree title may show terminology such as "Communication Disorders").
- Licensed physical therapists; and
- Licensed occupational therapists.

Provider Exclusions

Medicaid does not reimburse for AAC evaluations performed by bachelor's degree level speech-language pathologists, speech-language pathology assistants, occupational therapy assistants, or physical therapist assistants.

Initial AAC Evaluations, continued

Initial Evaluation Documentation Requirements

Once the ID team has evaluated the student and recommended an AAC, the speech-language pathologist must document the following information in writing (the first three items are obtained from the student's medical record):

- Significant medical diagnosis(es);
- Significant treatment information and medications;
- Medical prognosis (per student records, physician, ARNP, PA, or designee);
- Motor skills, i.e., posture and positioning, selection abilities, range and accuracy of movement, etc.;
- Cognitive skills, i.e., alertness, attention span, vigilance, etc.;
- Sensory or perceptual abilities, i.e., hearing, vision, etc.;
- Language comprehension;
- Expressive language capabilities;
- Oral motor speech status;
- Use of communication and present communication abilities;
- Communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs;
- Writing impairments, if any;
- Environment, i.e., home, work, etc., with a description of communication barriers; and
- AAC recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns.

AAC Selection

The ID team must select an AAC that is based on the recipient's current medical needs and projected changes in the recipient's communication development over at least a 5-year period.

Team Approval of the Evaluation

The evaluation, which includes the individualized action plan (IAP), must be signed, titled (credentials) and dated by all contributing interdisciplinary team members.

Initial AAC Evaluations, continued

Initial Evaluation Reimbursement Limitations	Medicaid reimburses school districts for the initial evaluation services provided by one speech-language pathologist (who meets the provider qualifications for initial evaluations); one licensed occupational therapist; and one licensed physical therapist who are designated members of the interdisciplinary team for an initial evaluation. Medicaid reimburses for one initial evaluation per student, per therapy type.
Additional Evaluation Requested by Medicaid	Florida Medicaid reserves the right to request an AAC evaluation of a student from either another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist, or ophthalmologist.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the procedure codes and fees.

AAC Trial Periods and Rental Systems

Trial Period for AACs	The ID team may recommend that the student have a trial period with the AAC system. The trial period must be prior authorized by the Medicaid consultant. All the steps for completion of a prior authorization package and the components of the prior authorization package must be completed for a trial period to be authorized.
Rental-Only AAC Systems	Medicaid reimburses DME providers for rental-only AAC systems for trial periods. Rental-only reimbursements can continue past the trial period when the ID team recommends and Medicaid approves a continued rental-only situation.

Individualized Action Plan

Individualized Action Plan Requirement	The ID team members, led by the speech-language pathologist, must develop an individualized action plan.
Individualized Action Plan Components	The ID team members, led by the speech-language pathologist, must write the student's individualized action plan. The plan must include the following information: • An explanation of any AAC system currently being used or owned by the student at home, work or school; • The current use of the system(s) and its limitations; • Appropriate long and short-term therapy objectives; • The recommended AAC(s); • The recommended length of a trial period, if applicable; • A description of any AAC systems the student has previously tried; • The specific benefits of the recommended AAC over other possibilities; • An established plan for mounting, if necessary; repairing; and maintaining the AAC; • Name of person responsible for delivering and programming the AAC to operate at the level recommended by the ID team; and • Name of person(s) who will train the support staff, student and primary caregiver in the proper use and programming of the AAC.
Reimbursement Limitations	Reimbursement for development of the individualized action plan is included in the reimbursement for the AAC evaluation.

AAC System Approval

Physician Approval of AAC System

The school district must send the evaluation, which includes the recommended AAC and the individualized action plan to a physician, ARNP or PA or designated physician specialist. The physician, ARNP or PA or designated physician specialist must review the evaluation and individualized action plan and if he or she concurs, prescribe the AAC.

The prescription must include the physician's, ARNP or PA or designated physician specialist's name; address; telephone number; medical license number; and MediPass authorization number, if applicable. If the student is in MediPass, the student's MediPass primary care provider must authorize the AAC.

The physician, ARNP or PA or designated physician specialist returns the evaluation, individualized action plan and prescription to the school district.

If the MediPass primary care provider does not respond timely, the school district should contact the Medicaid area school services representative. The school services representative will work with the area MediPass liaison to resolve any problems.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500, for information on MediPass.

Referral to the DME Provider

The school district is responsible for submitting the following information to the DME provider:

- The student's evaluation, which is completed, signed, titled (credentials) and dated by the interdisciplinary team members;
- Individualized action plan; and
- The physician, ARNP or PA or designated physician specialist's prescription for the AAC system.

Re-Evaluations

Re-Evaluations (92597 GN)

Medicaid reimburses school districts for re-evaluations performed by speech-language pathologists for students with AACs. Re-evaluations may be scheduled at the discretion of the speech-language pathologist, based on the ongoing needs of each student.

Re-Evaluations, continued

Re-Evaluation Documentation	Documentation for a re-evaluation must describe the session with the student and AAC, and any alterations made to the initial evaluation or the individualized action plan.
Provider Qualifications for Re-Evaluations	Medicaid reimburses school districts for re-evaluations that are performed by: • Licensed and provisionally-licensed speech-language pathologists; • Speech-language pathologists who have a: ➢ Department of Education Certification in the area of Speech-Language Impaired, containing the words "Speech-Language Impaired-Professional"; ➢ Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); ➢ ASHA membership card stating "Certified Member"; ➢ ASHA Certificate Holder card; or ➢ Master's level degree in speech-language pathology (the degree title may show terminology such as "Communication Disorders").
Provider Exclusions	Medicaid does not reimburse school districts for AAC re-evaluations performed by occupational therapists, physical therapists, bachelor's degree level speech-language pathologists or therapy assistants.
Re-Evaluations Reimbursement Limitations	Medicaid reimburses for a maximum of two re-evaluations, per student, per AAC system, per school district, per calendar year.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for procedure codes and fees.

AAC Fitting, Adjustment and Training Sessions

AAC Fitting, Adjustment and Training Sessions (92609)

Medicaid reimburses school districts for AAC fitting, adjustment and training sessions. Treatment sessions for AAC fitting, adjustment and training are face-to-face encounters with a student for the purpose of providing instruction on the use of the AAC device and making minor adjustments on the device as needed.

The sessions must be face-to-face contacts with individual students. Medicaid does not reimburse for group AAC fitting, adjustment and training.

Provider Qualifications for AAC Fitting, Adjustment and Training Sessions

Medicaid reimburses school districts for AAC fitting, adjustment and training sessions performed by speech-language pathologists who meet one of the qualifications listed below:

- Current license as a speech-language pathologist under Chapter 468, Florida Statutes. Individuals with provisional licenses may render reimbursable services if done under the supervision of an actively licensed speech-language pathologist;
- Department of Education Certification in the area of Speech-Language Impaired, containing the words “Speech-Language Impaired-Professional”;
- Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA);
- ASHA membership card stating “Certified Member”;
- ASHA Certificate Holder card; or
- Master’s level degree in speech-language pathology (the degree title may show terminology such as “Communication Disorders”).

Provider Exclusions

Medicaid does not reimburse school districts for AAC fitting, adjustment and training sessions performed by bachelor’s degree level speech-language pathologists or speech-language pathology assistants.

AAC Sessions Reimbursement Limitations

Medicaid reimburses the school district for up to a maximum of eight 30-minute AAC fitting, adjustment and training sessions, per device.

Medicaid reimbursement for AAC fitting, adjustment and training sessions is based on 30-minute units. There is no daily limit on the number of 30-minute units billed; however, there is a maximum of eight units per device as stated above.

Medicaid reimburses school districts for AAC sessions in addition to regular speech-language pathology sessions (i.e., a school district may be reimbursed by Medicaid for a speech-language pathology treatment session and an AAC session occurring on the same day).

AAC Fitting, Adjustment and Training Sessions, continued

Service Exclusions	Medicaid reimbursement for the AAC fitting, adjustment and training sessions does not include telephone responses to questions, conferences with the student's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.
Documentation for AAC Fitting, Adjustment and Training	The therapist must record on a per treatment basis the services rendered and the progress of the student in the use of the AAC device***.***
Documentation Components	Documentation of each fitting, adjustment and training session must include the following information: • Student's name; • Date of service; • Length of time the therapy or service was performed (time may be recorded based on start and stop times or length of time spent with the student); • Description of the services provided during the session; and • Dated signature and title (credentials) of the speech-language pathologist providing the service. All documentation must be signed, titled (credentials) and dated by the provider of the services, i.e., Sally Jones, SLP, 3/26/78.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the procedure code and fee.

AAC Services Audit Requirements

Student Records

The school district is required to maintain a record for each Medicaid-eligible student, which includes documentation of all Medicaid reimbursable services. Electronic documentation and electronic signatures are allowed for Medicaid purposes. However, initial evaluations or individualized action plans sent to a physician, ARNP, PA, physician specialist or DME provider should be transmitted on paper unless the school district maintains appropriate security systems to prevent unauthorized access to the evaluation or action plan. If electronic documentation and signatures are used, these records must be available upon request, as required in Chapter 1 of this handbook.

Each Medicaid-eligible student's records must include, at a minimum, the following:

- An individualized action plan, plan of care, IEP or FSP if used as the plan of care, indicating the student's need for services;
- Test results and evaluation reports; and
- Documentation describing each fitting, adjustment and training session as listed in the above applicable section.

Note: See Medicaid Provider Reimbursement Handbook, CMS-1500, for further information.

CHAPTER 8
MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
NURSING SERVICES

Overview

Introduction

This chapter describes the services covered under the Medicaid certified school match program for nursing and medication administration services, the requirements for service provision, the service limitations and service exclusions.

In This Chapter

This chapter contains:

Definitions

Introduction

Medicaid reimburses school district providers for the nursing and medication administration services described in this handbook.

Nursing Services

Nursing services are services which can include:

- Health assessments;
- Individual student health training and counseling;
- Catheterizations;
- Tube feedings;
- Maintenance of tracheostomies;

Definitions, continued

Nursing Services, continued

- Oxygen administration;
- Specimen collection;
- Ventilator care;
- Health monitoring and management;
- Health care treatments and procedures;
- Management of chronic health care;
- Health care coordination and referrals;
- Crisis intervention (e.g., life-threatening accidents or situations);
- Compilation of health histories;
- Screenings such as scoliosis, dental, vision, hearing, growth and development;
- Emergency health care (e.g., treatment of minor wounds); and
- Consultation and coordination with other health care staff, parents, teachers and family during the Individual Educational Plan (IEP) or Family Support Plan (FSP) development and review process or at other times deemed appropriate by the nurse.

Note: Medication administration is explained below.

Excluded Services

Medicaid cannot reimburse school districts for nursing services provided to a group, such as group education or classroom education. In accordance with Florida Statutes, Medicaid may not reimburse school districts for family planning services, prenatal care or immunizations.

Medication Administration Services

Although medication administration is a nursing service in the context of general nursing activities, Medicaid reimburses separately for medication administration on a fee-per-dose basis. The fee for medication administration includes time spent preparing medication for administration, administering medication and documenting the service.

Nursing time spent observing or treating a student's reaction to medication is considered to be a nursing service, as defined in the above section.

Service Reimbursement

Medicaid will reimburse for nursing services and medication administration provided on the same date of service for the same student.

Provider Qualifications

Registered Nurse Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a registered nurse must be currently licensed under Chapter 464, Florida Statutes.
Licensed Practical Nurse Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a licensed practical nurse must be currently licensed under Chapter 464, Florida Statutes.
School Health Aide Provider Qualifications	To render reimbursable services in the Medicaid certified school match program, a school health aide must have completed the following courses or training through or by the school district: • Cardiopulmonary resuscitation (CPR); • First aid; • Medication administration; and • Patient (i.e., student) specific training. Student specific training must be face-to-face between the registered nurse and the school health aide. Records of CPR and first aid training must be retained by the school district indicating that the school health aide did attend and the date of the training. Records attesting to the fact that all school health aides in a school district are given medication administration and student specific training must also be retained. Documentation to this effect should be signed by a registered nurse and must be on file at the school district.
Supervision of Licensed Practical Nurses and School Health Aides	To receive Medicaid reimbursement for services rendered by a licensed practical nurse or school health aide, the services must be performed under the direction of a licensed registered nurse, as governed by the state nurse practice act.
Temporary Licenses	Medicaid cannot reimburse for services provided by nurses with temporary licenses.

Service Requirements

Introduction

To receive Medicaid reimbursement for nursing services, the following requirements must be met.

General Service Requirements

To be reimbursed by Medicaid, the service must comply with the requirements listed in Chapter 1 of this handbook that pertain to all Medicaid certified school match services.

Individual Educational Plan or Family Support Plan

The need for nursing services must be referenced in the student's Individual Educational Plan (IEP) or Family Support Plan (FSP). The need for medications does not have to be referenced separately in the IEP or FSP if the student needs nursing services. If a student needs only medication but no other nursing services, an entry indicating either nursing services or medication administration must be referenced in the IEP or FSP. A preprinted statement attesting to the fact that the student needs nursing services is acceptable.

Recommendation for Services

The IEP, FSP or separate document indicating that nursing services are needed must be signed, titled and dated by a registered nurse, an advanced registered nurse practitioner, physician or physician's assistant prior to billing Medicaid for nursing services. Prescription medications have already been recommended by a health care practitioner by virtue of a labeled container; thus, a separate, written recommendation is not required. Non-prescription medications, for Medicaid purposes, are recommended by a registered nurse via his or her completion of a medication log for the drug or approval of a log if dispensed by a licensed practical nurse or aide.

Diagnosis Code

Medicaid requires that an ICD-9 diagnosis code be entered on the CMS-1500 claim.

The code should represent the Medicaid-eligible student's primary diagnosis. The specific code may be obtained from the attending physician, advanced registered nurse practitioner, physician's assistant, or through use of the *International Classification of Diseases, 9th Edition, Clinical Modifications* (ICD-9–CM). The student's diagnosis statement or ICD-9 diagnosis code must be contained in his record.

For services not directly related to the student's primary diagnosis (for example, an accident in the classroom or administration of medications for illnesses not related to the student's diagnosis), for students with no specific medical diagnosis, and over-the-counter medication, the provider should enter diagnosis code 999.9 on the claim.

Nursing Services

Nursing Service—Registered Nurse (T1002)	Medicaid reimburses for nursing services as defined in this chapter that are rendered by a licensed registered nurse to or on behalf of a Medicaid-eligible student.
Nursing Service-Licensed Practical Nurse (T1003)	Medicaid reimburses for nursing services as defined in this chapter that are rendered by a licensed practical nurse to or on behalf of a Medicaid-eligible student.
Nursing Service-School Health Aide (T1004)	Medicaid reimburses for nursing services as defined in this chapter that are rendered by a qualified school health aide to or on behalf of a Medicaid-eligible student.
Service Reimbursement	Medicaid reimbursement is based on the amount of time spent by the nurse or aide with or on behalf of each Medicaid-eligible student. One unit of service for nursing services is a maximum of 15 minutes. The total time spent per nurse or aide per day, providing nursing services to or on behalf of a Medicaid-eligible student must be added as a cumulative total and rounded up to the nearest 15-minute increment. For example, if the nurse or aide provided two nursing services of 20 minutes and 18 minutes on the same day, the nursing services equal a daily total of 38 minutes and would be billed to Medicaid as 3 units. Only one Medicaid claim (or claim line) per day per Medicaid-eligible student can be reimbursed. This one claim must show the cumulative total units that the nurse or aide provided services to or on behalf of the Medicaid-eligible student for the day. Medicaid will reimburse the school district for time spent preparing documentation of nursing services rendered, and the time spent may be added to the day's cumulative total for nursing services. However time spent preparing documentation for medication administration or time spent preparing a claim(s) for Medicaid reimbursement is not covered.

Nursing Services, continued

Reimbursement Limitations

Medicaid reimburses a maximum of 32 units **per nurse or aide**, per day. The school may bill for nursing services provided by the same nurse or aide to multiple Medicaid-eligible students on the same day of service; however, the total units for the nurse or aide cannot exceed 32 units.

Travel time off school campus is not reimbursable unless nursing services are rendered during travel. For example, nursing services would be reimbursable if a licensed registered nurse, licensed practical nurse or school health aide accompanies a student on a specialized school bus or other vehicle and renders nursing services during transport.

If Medicaid is reimbursing a home health agency for the services of a private duty nurse while a Medicaid-eligible student attends school, the only nursing services billable to Medicaid by the school district for the same day are screenings for scoliosis, dental, vision, hearing and growth and development. Medicaid reimbursement for all billable nursing services provided on the same day by a home health agency and by a school district under the Medicaid certified school match program may be billed by both providers if services are not provided at the same time to a Medicaid-eligible student.

Codes and Fees

See Appendix C in Chapter 1 of this handbook for the licensed registered nurse, licensed practical nurse and school health aide services procedure codes and fees.

Medication Administration

Medication Administration-Registered Nurse (T1002KO)	The administration of medication as defined in this chapter by a licensed registered nurse may be billed to Medicaid when the nurse provides the medication directly to a Medicaid-eligible student.
Medication Administration-Licensed Practical Nurse (T1003KO)	The administration of medication as defined in this chapter by a licensed practical nurse may be billed to Medicaid when the nurse provides the medication directly to a Medicaid-eligible student.
Medication Administration-School Health Aide (T1004KO)	The administration of medication as defined in this chapter by a qualified school health aide may be billed to Medicaid when the school health aide provides the medication directly to a Medicaid-eligible student.
Service Reimbursement	Medicaid reimbursement is on a per dose basis, regardless of the route for the medication or whether the drug is prescribed or over-the-counter. If two drugs are administered at the same time, two doses may be billed to Medicaid.
Reimbursement Limitations	Travel time off school campus is not reimbursable. However, medication administered during transport on a specialized school bus or other form of transportation is reimbursable. Time spent observing or treating a student's reaction to medication is not reimbursed as medication administration. It can be reimbursed as a nursing service. Medicaid reimbursement for medication administration provided on the same day by a home health agency and by a school district under the Medicaid certified school match program may be billed by both providers if services are not provided at the same time to a Medicaid-eligible student.
Codes and Fees	See Appendix C in Chapter 1 of this handbook for the medication administration procedure codes and fee schedule.

Audit Requirements

Student Records

School districts are required to maintain a record for each Medicaid-eligible student that includes documentation of each Medicaid reimbursable nursing and medication administration service. Nursing services billed to Medicaid must be referenced in each Medicaid-eligible student's IEP or FSP.

Each Medicaid-eligible student's record must include, at a minimum, the following:

- Current IEP or FSP indicating the need for nursing services;
- Documentation describing each nursing and medication administration service; and
- Student's diagnosis statement or diagnosis code.

Diagnosis Code

A diagnosis statement or ICD-9 diagnosis code must be contained in each Medicaid-eligible student's record.

Documentation Components for Nursing Services

Documentation of each nursing service must include the following information:

- Student name;
- Date of service;
- Length of time the service was performed;
- Description of the service;
- Student's reaction to the service, unless the service was a consultation, a referral or compilation of health history; and
- Nurse's or school health aide's signature, title and date.

It is acceptable to use either narrative descriptions or logs as documentation of nursing services if the content meets the above requirements.

Audit Requirements, continued

Documentation Components for Medication Administration

Documentation of each occurrence of medication administration must include the following information:

- Student name;
- Date of service;
- Name of medication;
- Time medication was given;
- Dosage and route; and
- Nurse's or school health aide's signature, title and date.

It is acceptable to use either narrative descriptions or logs as documentation of medication administration if the content meets the above requirements.

Signature Requirements for Logs

If a log-type format is used for nursing services or medication administration, the nurse may either:

- Sign, title and date the log by each entry on the log, or
- Initial each entry and sign, title and date the log on a weekly basis.

For Medicaid purposes, all signatures (not initials) should be followed by an abbreviated title. For example, Jane Doe, RN or Jack Smith, SHA.

Electronic documentation and electronic signatures are allowed but these records must be available upon request, as required in Chapter 1 of this handbook.

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Jeb Bush
Governor

Alan Levine
Secretary

2727 Mahan Drive
Tallahassee, FL 32308

www.fdhc.state.fl.us

Medicaid Certified School Match Program Fee Schedule

2024

*Reimbursement amount is the Federal Share of these fees; however, reimbursement can also be based on the individual school district's cost and vary from school district to school district.

Occupational Therapy Services				
Code	**Modifier**	**Description of Service**	**Maximum Fee**	**Maximum Allowable Units**
97165		Occupational Therapy Evaluation, Low Complexity	$51.05	1 per year
97166		Occupational Therapy Evaluation, Moderate Complexity	$51.05	1 per year
97167		Occupational Therapy Evaluation, High Complexity	$51.05	1 per year
97168		Occupational Therapy Re-Evaluation	$51.05	1 per 6 months
97530		Occupational Therapy Individual Session Provided by an Occupational Therapist	$17.86	4 per day, 14 per week
97530	HM	Occupational Therapy Individual Session Provided by an Occupational Therapy Assistant	$14.30	4 per day, 14 per week
97150	GO	Occupational Therapy Group Session Provided by an Occupational Therapist	$3.47	4 per day, 14 per week
97150	UC	Occupational Therapy Group Session Provided by an Occupational Therapy Assistant	$2.74	4 per day, 14 per week
97542	GO	Wheelchair Evaluation and Fitting Provided by an Occupational Therapist	$51.05	1 per 5 years
92597	GO	AAC Initial Evaluation Provided by an Occupational Therapist	$102.63	1 per 5 years
29799	HA	Application of Casting or Strapping	$19.56	2 per day

Physical Therapy Services				
Code	**Modifier**	**Description of Service**	**Maximum Fee**	**Maximum Allowable Units**
97161		Physical Therapy Evaluation, Low Complexity	$51.05	1 per year
97162		Physical Therapy Evaluation, Moderate Complexity	$51.05	1 per year
97163		Physical Therapy Evaluation, High Complexity	$51.05	1 per year
97164		Physical Therapy Re-Evaluation	$51.05	1 per 6 months
97110		Physical Therapy Individual Session Provided by a Physical Therapist	$17.86	4 per day, 14 per week
97110	HM	Physical Therapy Individual Session Provided by a Physical Therapist Assistant	$14.29	4 per day, 14 per week
97150	GP	Physical Therapy Group Session Provided by a Physical Therapist	$3.47	4 per day, 14 per week
97150	HM	Physical Therapy Group Session Provided by a Physical Therapist Assistant	$2.74	4 per day, 14 per week
97542	GP	Wheelchair Evaluation and Fitting Provided by a Physical Therapist	$51.05	1 per 5 years
92597	GP	AAC Initial Evaluation Provided by a Physical Therapist	$102.63	1 per 5 years
29799	HA	Application of Casting or Strapping	$19.56	2 per day

Speech-Language Pathology Services				
Code	**Modifier**	**Description of Service**	**Maximum Fee**	**Maximum Allowable Units**
92521		Evaluation/Re-evaluation of speech fluency (e.g., stuttering, cluttering)	$51.05	1 per 6 months
92522		Evaluation/Re-evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	$51.05	1 per 6 months
92523		Evaluation/Re-evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	$51.05	1 per 6 months
92524		Evaluation/Re-evaluation of behavioral and qualitative analysis of voice and resonance	$51.05	1 per 6 months
92610		Evaluation/Re-evaluation of oral and pharyngeal swallowing function	$51.05	1 per 6 months
92526		Treatment of swallowing dysfunction and/or function for feeding	$51.05	1 per day
92507		Speech-Language Pathology Individual Session Provided by a Speech-Language Pathologist	$17.86	4 per day, 14 per week
92507	HM	Speech-Language Pathology Individual Session Provided by a Speech Therapy Assistant	$14.30	4 per day, 14 per week
92508		Speech-Language Pathology Group Session Provided by a Speech-Language Pathologist	$3.47	4 per day, 14 per week
92508	HM	Speech-Language Pathology Group Session Provided by a Speech-Language Pathology Assistant	$2.74	4 per day, 14 per week
92597		AAC Initial Evaluation Provided by a Speech-Language Pathologist	$102.63	1 per 5 years
92597	GN	AAC Re-Evaluation Provided by a Speech-Language Pathologist	$52.63	1 per 6 months
92609		AAC Fitting, Adjustment, and Training Visit	$42.11	8 per year

Behavioral Services					
Code	**Modifier 1**	**Modifier 2**	**Description of services**	**Maximum Fee**	**Maximum Allowable Units**
H0031	AH		Psychologist - Individual Service-Evaluation	$9.66	32 units per school district staff member, per day
H0046	AH		Psychologist - Individual Service-All Else	$9.66	32 units per school district staff member, per day
H0046	AH	HQ	Psychologist - Group Service	$4.95	32 units per school district staff member, per day
H0031	SE		Certified Behavior Analyst - Individual Service-Evaluation	$8.00	32 units per school district staff member, per day
H2019	HA		Certified Behavior Analyst - Individual Service-All Else	$10.41	32 units per school district staff member, per day
H2019	HA	HQ	Certified Behavior Analyst - Group Service	$3.24	32 units per school district staff member, per day
H0002	HA		Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst - Individual Service-Evaluation	$6.70	32 units per school district staff member, per day
H2014	HA		Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst - Individual Service-All Else	$6.70	32 units per school district staff member, per day
H2014	HA	HQ	Certified Behavior Analyst (Bachelor's Level) and Certified Assistant Behavior Analyst - Group Service	$3.35	32 units per school district staff member, per day
H0031	HU		Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors - Individual Service-Evaluation	$8.97	32 units per school district staff member, per day
H0046	SE		Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors - Individual Service-All Else	$8.97	32 units per school district staff member, per day

Behavioral Services (continued)					
Code	**Modifier 1**	**Modifier 2**	**Description of services**	**Maximum Fee**	**Maximum Allowable Units**
H0046	SE	HQ	Social Worker (Master's Level); Marriage and Family Therapist; Mental Health and Guidance Counselors - Group Service	$4.25	32 units per school district staff member, per day
H0002	HN		Social Worker (Bachelor's Level) - Individual Service-Evaluation	$7.17	32 units per school district staff member, per day
H0046	HN		Social Worker (Bachelor's Level) - Individual Service-All Else	$7.17	32 units per school district staff member, per day
H0046	HN	HQ	Social Worker (Bachelor's Level) - Group Service	$3.40	32 units per school district staff member, per day

Nursing Services				
Code	**Modifier**	**Description of Service**	**Maximum Fee**	**Maximum Allowable Units**
T1002		Nursing Service - Registered Nurse	$6.20	32 units per school district staff member, per day
T1003		Nursing Service - Licensed Practical Nurse	$4.80	32 units per school district staff member, per day
T1004		Nursing Service - School Health Aide	$3.80	32 units per school district staff member, per day
T1002	KO	Medication Administration - Registered Nurse	$2.07	32 units per school district staff member, per day
T1003	KO	Medication Administration - Licensed Practical Nurse	$1.06	32 units per school district staff member, per day
T1004	KO	Medication Administration - School Health Aide	$0.80	32 units per school district staff member, per day

Transportation

Transportation fees vary for each school district. They are not included in this appendix, instead each district is notified of its fee.

MEDICAID CERTIFIED SCHOOL MATCH PROGRAM
MONITORING INSTRUMENT

Therapy Services (Physical, Occupational, Speech)

Student Name		**Medicaid ID**	
School District & School Name		**Review Period (Service Date)**	
Diagnosis Code		**Reviewer**	Leila Jett
Procedure Code(s)		**Type of Therapy (check one box)**	PT ☒ OT ☒ ST ☒

DOCUMENTATION

Reference	Standard	Score (Met, Not Met, Not Applicable)	Comments	
	Documentation: Student Record			
MCSM handbook, pages 2-2, 3-2, 4-2	1. Is the most recent evaluation present in the student's record?		Date of evaluation:	
MCSM handbook, pages 2-3, 3-3, 4-4 1-4	2. Does the IEP, IFSP, or an attachment reference therapy services?			
	Documentation: Therapy Session			
MCSM handbook, pages 2-10, 3-9, 4-8	3. Provider name:			
	4. Title:			
	5. Does documentation of therapy session include:			
	a. Student's name?			
	b. Date of service?			
	c. Type of service?			

	d. Length of time therapy/treatment was performed?		
	e. Daily initials and weekly signatures by service provider (if weekly therapy and progress notes used)?		
	f. Description of therapy, activity, or method used?		
	g. Student's progress toward established goals?		
	6. Does the therapy session billed address at least one objective found in the IEP/IFSP/POC?		
	7. Is the therapy session note legibly signed, is the signature titled, is the signature dated, and is the documentation dated?		
	Documentation: Splints and Cast Services		
MCSM handbook, pages 2-7 and 3-6 to 3-7	8. Provider Name:		
	9. Title:		
	10. Is the splint or cast service included in the Plan of Care?	N/A	
	11. Has it been rendered by a licensed PT or OT?	N/A	
	12. Has the service been prescribed by a licensed physician, ARNP, or PA?	N/A	

	13. Is the documentation legibly signed, is the signature titled, is the documentation dated, and is the signature dated?	N/A	
	Documentation: Wheelchair Evaluations and Fittings		
MCSM handbook, pages 2-8	14. Has the evaluation been developed by a therapist meeting the Medicaid requirements and qualifications?	N/A	
	15. Provider Name:		
	16. Title:		
MCSM handbook, pages 2-7 to 2-8 and 3-7 to 3-8 2-8, 9; 3-8	17. Does the evaluation report contain:		
	a. Student's name?	N/A	
	b. Student's physical condition that makes it necessary for a wheelchair?	N/A	
	c. Justification of all accessories and add-on components?	N/A	
	18. Is the documentation for the wheelchair evaluation or fitting legibly signed, is the signature titled, is the documentation dated, and is the signature dated?	N/A	
	19. Are copies of both reports retained in the student's record for the follow-up?	N/A	
REIMBURSEMENT			
	Reimbursement: Evaluation (Physical, Occupational, Speech)		
MCSM handbook, pages 2-2, 3, 10; 3-2, 3,	20. If an evaluation was billed, did the documentation include:		
	a. Student's name?		

9; 4-2, 3, 7, 8	b. Diagnostic testing and assessments?		
	c. Written report with needs identified?		
	21. Is the therapy evaluation legibly signed, is the signature titled, is the signature dated, and is the documentation dated?		
	Reimbursement: Plan of Care (IEP or IFSP if used as the POC)		
MCSM handbook, pages 2-3, 3-3, 4-4	22. Has a plan of care been developed by a therapist meeting the Medicaid requirements and qualifications?		
	23. Provider name:		
	24. Title:		
MCSM-pages 2-3, 4; 3-3, 4; 4-4, 5	25. Does the plan of care include:		
	a. Student's name?		
	b. Description of the student's medical condition?		
	c. Therapy that was provided (individual or group)		
	d. Achievable, measurable, time-related goals and objectives?		
	e. Frequency and duration of treatment?		
MCSM handbook, pages 2-10, 3-9, 4-8	26. Is the plan of care legibly signed, is the signature titled, is the signature dated, and is the documentation dated?		

MCSM handbook, pages 2-4, 3-4, 4-5	27. Has the plan of care been updated at least annually or more often due to progress?		
	Reimbursement: Therapy Sessions		
MCSM handbook, pages page 2-6; 3-5; 4-6	28. With the therapy sessions, including group, is the minimum of 15 minutes of direct contact met?		
	29. If the service billed was a group therapy session, was there documentation of group size (maximum of four students for physical & occupational therapy; eight students for speech therapy)?		
	30. Is there documentation/evidence (i.e., signature on an IEP/POC by a licensed therapist) that supervision is taking place by a licensed therapist?		
Provider General Handbook, July 2012	35. Are documented units of service for the date of service in agreement with the paid claim?		
	Reimbursement: Wheelchair Evaluations and Fittings		
MCSM handbook, page 2-8	31. Did the same therapist who performed the initial wheelchair evaluation also perform the follow-up evaluation?	N/A	
MCSM handbook, pages 2-7 to 2-8 and 3-	32. Does the wheelchair follow-up evaluation contain:		
	a. Student's name	N/A	

7 to 3-8	b. Description of adjustments and fittings made?	N/A	

SUMMARY/RECOMMENDATIONS

MEDICAID SCHOOL DISTRICT ADMINISTRATIVE CLAIMING GUIDE

Overview

The Agency for Health Care Administration (AHCA), the Florida Department of Education (DOE) and individual school districts share in the responsibility for promoting access to health care for students in the public school system by preventing costly or long term health care problems for at risk students, and coordinating students' health care needs with other providers. Many of the activities performed by school district staff meet the criteria for Medicaid administrative claiming. The primary purpose of the Medicaid School District Administrative Claiming (SDAC) program is to reimburse school districts for these activities, where allowed in this guide.

Definition

The SDAC program is a federally funded program administered by AHCA in coordination with DOE. The program allows school districts to be reimbursed for some of their costs associated with school based health and outreach activities which are not claimable under the Medicaid Certified School Match "fee for service" program or under other Medicaid "fee for service" programs. In general, the types of school based health and outreach activities funded under SDAC are the referral of students/families for Medicaid eligibility determinations, the provision of health care information and referral, coordination and monitoring of health services and interagency coordination.

Unlike the "fee for service" program, individual claims for each service rendered to or on behalf of a student are not specifically required under the SDAC program. However, it is necessary to determine the amount of time school district staff spends performing Medicaid administrative activities. Time spent by school district staff on Medicaid administrative activities is captured through the use of time studies. The results of time studies are then used in a series of calculations to determine the percentage of school district costs that can be claimed under SDAC. Reimbursement to school districts for SDAC is made from Medicaid federal funds.

School District Administrative Claiming Program Guide

This guide contains the policies and procedures which school districts must follow in order to submit an administrative claim to Medicaid for reimbursement, as well as audit requirements. In the event that it is revised, the date of the revision will be indicated at the bottom of each updated page.

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CHAPTER 1

IMPLEMENTING SCHOOL DISTRICT ADMINISTRATIVE CLAIMING

Overview

School districts wishing to participate in the School District Administrative Claiming (SDAC) program must meet a specific set of requirements. These requirements are as follows:

- The school district must sign an SDAC agreement with the Agency for Health Care Administration (AHCA) and a Medicaid non-institutional provider agreement;
- Staff training must be conducted;
- Time studies using samples or time logs must be kept at prescribed time intervals;
- Statistically valid time sample results must be determined;
- Cost determinations and allocations must be performed; and
- A quarterly Medicaid administrative claim must be prepared and submitted to AHCA.

Further, monitoring of administrative claiming records is required by AHCA and the federal Centers for Medicare and Medicaid Services (CMS). SDAC payments are from federal funds and school districts must make such SDAC records available for periodic AHCA and CMS audits.

Participation Agreement

Each school district that decides to participate in SDAC must sign the administrative claiming agreement included in this chapter as Appendix 1. The agreement must be signed before AHCA can request federal reimbursement for administrative claiming activities. Appendix 1 must be copied and used for signature. The address for submission of a signed agreement is:

Medicaid Program Analysis
Attn: Jim Robinson
2727 Mahan Drive, Mail Stop 23
Building Three, Room 3211
Tallahassee, Florida 32308-5407

After the AHCA signature is affixed, a signed copy will be returned to the school district through the Medicaid area office.

Provider Agreement

The school district must also sign a Medicaid provider agreement. A notation stating "Administrative Claiming" must be made by the school district on the first or last page of the agreement. It must be signed by a school district wishing to participate in the SDAC program before AHCA can reimburse a school district for administrative claiming activities. The address for submission of the signed agreement is the same address shown in the above paragraph. This agreement is needed as a separate document even if the school district already participates in Medicaid through the Medicaid Certified School Match program.

SDAC Reimbursement

AHCA reimbursement under the SDAC program may be made retroactive to school districts implementing a program that meets the requirements in this guide.

Contracting for Administrative Claiming

There are companies in the state offering support to school districts for obtaining administrative claiming funds. Funds paid to these companies by school districts for administrative claiming services are not considered as allowable costs in Medicaid cost determinations for administrative claiming reimbursement (see Chapter 6).

Appendix 1

AGREEMENT BETWEEN THE AGENCY FOR HEALTH CARE ADMINISTRATION AND THE _____ County School District FOR THE PROVISION AND REIMBURSEMENT OF ADMINISTRATIVE CLAIMING ACTIVITIES

The Agency for Health Care Administration (AHCA) and the _____ County School District hereby agree to the principles, terms and effective dates carried in this agreement. This agreement is set forth to define each party's responsibilities in order to effectively administer the provision of and reimbursement for Medicaid administrative claiming activities and is necessary to implement parts of the Medicaid state plan under Title XIX of the Social Security Act. Legal authority for this program is found in sections 1011.70, 409.9071, and 409.908, Florida Statutes, and Title XIX of the Social Security Act. AHCA is the single state agency in Florida under Title XIX of the Social Security Act. Additional, specific federal governing policies and procedures are found in the Office of Management and Budget's (OMB) Circular A-87 and the Code of Federal Regulations (CFR), Title 45, Parts 74 and 95.

I. General Principles

This agreement is to be based on the following general principles:

1. The aforementioned parties have a common and concurrent interest in providing and reimbursing Medicaid administrative claiming activities, within parameters set by the federal Centers for Medicare and Medicaid Services (CMS) and only as approved by CMS. Any changes in the program required by CMS are to be implemented by both of the aforementioned parties.

2. This agreement is in no way intended to modify the responsibilities or authority delegated to the parties.

3. This agreement is not intended to override or obsolete any other agreements or memorandums of understanding which may already exist between these parties.

4. Any County School District contractors involved with administrative claiming activities are bound by this agreement with regard to administrative policies and procedures.

5. A lead County School District representing one or more other county school districts within the state for the purposes of billing Medicaid for school district administrative claiming activities, shall also comply with the provisions of Attachment I of this agreement. Attachment I will be made part of and included in this Agreement.

6. This agreement provides a mechanism for payment of federal funds from CMS and the parties agree that it in no way creates a requirement for AHCA to reimburse any County School District from AHCA state funds.

II. Terms

AHCA agrees to the following terms:

1. AHCA will develop a list and description of Medicaid reimbursable school district administrative claiming activities performed by County School District contract or salaried staff, in coordination with the Department of Education. Administrative claiming activities are found in Attachment II of this agreement.

2. AHCA will review school district administrative claims for Medicaid reimbursement on a quarterly basis and reimburse the County School District for administrative claiming where allowed under CMS policies and procedures for the program.

3. AHCA will reimburse the County School District based on federally established rates of 50 percent of allowable administrative activities performed by personnel.

4. AHCA will reimburse the County School District 100 percent of the federal share of actual and reasonable costs for Medicaid administrative activities provided by county school districts, as determined by CMS approved cost allocation methodologies and time study formulas.

5. AHCA will forward claims for funding to CMS for Title XIX participation.

6. AHCA will periodically monitor the County School District for compliance with record keeping requirements for reporting reimbursable activities and capturing time, as well as the sampling process and results.

7. AHCA will produce any Medicaid specific reports deemed necessary for the County School District.

8. AHCA will develop procedures for recoupment from the County School District, if warranted by AHCA or CMS monitoring.

9. AHCA will notify the County School District in the event of any changes made by CMS to federal matching percentages or costs eligible for match.

10. AHCA will designate an employee to act as a liaison for the County School District for the administrative claiming program.

The County School District agrees to the following terms:

1. The time accounting system used by the County School District or its contractor must comply with the requirements contained in OMB Circular A-87 and 45 CFR.

2. The County School District must follow the policies and procedures contained in the AHCA "School District Administrative Claiming Guide."

3. Any recoupment of funds due to an audit exception, deferral or denial deemed appropriate by CMS or AHCA will be the responsibility of the County School District, even after withdrawal from the program.

4. The County School District will maintain (or coordinate a contractor's assistance in maintaining) an AHCA/CMS approved administrative claiming program to include training, the use of standardized sample forms, sampling, the development and maintenance of clearly identifiable cost accounting pools and the application of sample percentages to accounting pools in a manner which will document the process for audits.

5. The County School District will submit claims to AHCA for administrative activities on a quarterly basis. Each claim shall be accompanied by an AHCA certification of funds form indicating that sufficient funds were available to support the non-federal share of the cost of each claim.

6. The County School District shall maintain and be able to produce within specified time frames requested records and material for CMS or AHCA audits.

7. The County School District will designate an employee to act as liaison with AHCA for issues concerning this agreement.

III. Confidentiality

The County School District agrees to safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

IV. Effective Date, Changes, Life of this Agreement

1. The effective date of the initial agreement will be the first day of the first quarter during which valid time studies were conducted in the County School District. The effective date of a renewal agreement will be the first day after the expiration date of the previous executed agreement. If an agreement is terminated by either AHCA or the County School District, a new contract will be considered the initial contract with the effective date of the first day of the first quarter during which valid time studies were conducted in the County School District.

2. Changes may be made to the agreement in the form of amendments and must be signed by all parties.

3. Changes in the CMS matching percentage or costs eligible for match will not be made via this agreement but will be applied pursuant to changes in applicable Medicaid federal regulations and effective the date specified by CMS.

4. The initial agreement will continue in effect for the earlier of five years or until terminated by either AHCA or the County School District. Thereafter, each renewal agreement shall be in effect for a period of ten years or until terminated by either AHCA or the County School District. AHCA or the County School District may terminate this agreement by providing a thirty (30) day written notification to the other party.

SIGNATORIES:

_____ _____

Authorized School District Representative Date

_____

County School District

_____ _____

Deputy Secretary for Medicaid Date

SCHOOL DISTRICT ADMINISTRATIVE CLAIMING PROGRAM
LEAD COUNTY SCHOOL DISTRICT CONSORTIUM REQUIREMENTS

County school districts may join or establish a consortium with other county school districts for the school district administrative claiming program. If a consortium is formed with a Lead County School District to serve as the single recipient of Medicaid administrative claiming funds for the members of the consortium, the Lead County School District shall comply with the following requirements:

- The Lead County School District may contract with any county school district in the state of Florida; however, a copy of each contract must be provided to AHCA prior to any reimbursements under the administrative claiming program. The Lead County School District shall provide AHCA with a current listing of county school districts that participate in the Lead County School District consortium.
- The Lead County School District shall not pool the Medicaid eligibility percentage and school district expenditures for all the member county school districts and reimburse based on an average consortium rate.
- The Lead County School District for the consortium has the following responsibilities:
    1. Submission of the member contracts and a list of the participating county school districts.
    2. Notification to AHCA of any change in membership within the consortium.
    3. Repayment of any overpayment due to exceptions, deferrals or denials due to activities on the part of participating county school districts within the consortium.
    4. Training or arranging for training of every participating county school district.
    5. Ensuring that participating county school districts maintain and are able to produce within specified time frames requested records and material for CMS or AHCA audits.
- If a County School District withdraws from the Lead County School District consortium or if the consortium dissolves, the Lead County School District retains the responsibility for recoupment of overpaid funds for any periods during which the participant county school district claimed Medicaid administrative claiming reimbursement through the Lead County School District consortium.
-

Attachment II

SDAC ACTIVITIES LIST

The major categories of SDAC activities are:

1. Outreach to the Medicaid Program

   This activity occurs generally when staff are:

   - informing eligible or potentially eligible students about Medicaid and how to access it, and
   - describing to an individual(s) the range of services covered under Medicaid and how to obtain Medicaid preventive services.

2. Outreach to Non-Medicaid Programs

   This activity occurs generally when staff are:

   - informing eligible or potentially eligible students about non-Medicaid, social, vocational and educational programs and how to access them, and
   - describing the range of benefits covered under these non-Medicaid programs and how to obtain them.

3. Facilitating an Application for Medicaid

   This activity is applicable when staff are assisting a student or family to apply for Medicaid.

4. Facilitating an Application for Non-Medicaid Programs

   This activity is applicable when staff are assisting a student or family to apply for non-Medicaid programs.

5. Care Planning and Coordination for Medical/Mental Health Services

   This activity occurs generally when staff are:

   - coordinating and/or monitoring the delivery of medical/mental health services, and
   - linking the student and family with Medicaid service providers to plan, carry out and maintain a health service plan.

6. Client Assistance to Access Medicaid Services

   This activity is used to record staff time spent arranging for transportation or translation assistance, which is necessary for a student or family to access Medicaid services.

7. Child Health Check-Up (CHCUP) Training

   CHCUP is a Medicaid service available to children under age 21, which allows for physical examinations to detect health care problems and referrals for treatment. The program is federally termed Early and Periodic Screening, Diagnosis and Treatment. This activity occurs generally when staff are:

   - coordinating, conducting or participating in training events and seminars for school district staff performing outreach activities regarding the benefits of CHCUP services, on methods of assisting families to access CHCUP services, and ways to more effectively refer students for CHCUP services; and
   - informing outreach staff about how to find (early identification and intervention), screen and refer students with special/severe health needs for CHCUP services.

8. Coordination with the Agency for Health Care Administration (AHCA) and Contracted Medicaid Providers

   This activity is used when staff are performing collaborative activities with AHCA and its contracted Medicaid providers to:

   - improve the cost effectiveness of providing health care services;
   - improve the availability of services;
   - reduce service overlaps, duplications or gaps;
   - focus services on specific population groups or geographic areas in need of special attention to ensure effective child health programs; and
   - define the scope of each agency's or resource's programs.

9. Program Planning, Development and Monitoring

   These are activities associated with the development of strategies to improve the coordination and delivery of medical/mental health services to school age children. The activities include developing, monitoring and maintaining tracking systems to assess the effectiveness of these services and programs.

10. Direct Medical and School Health-Related Services

    This activity is applicable when staff are providing direct medical care, counseling and therapeutic services or treatment. The activity includes screening, evaluations and treatment.

11. Non-Medicaid, Other Educational and Social Activities

    This activity is used when job duties are performed which are not health or Medicaid related, such as education and teaching, employment, job training and social services related activities.

12. General Administration
    This activity occurs when staff are performing general administrative activities of the school or school district as well as lunch or other breaks and paid leave.

13. Not Scheduled to Work

    This activity should be selected to account for time during the workday for which an employee is not working and is not being compensated.

Note that the above activities are reiterated and more fully explained in the Medicaid School District Administrative Claiming Guide, which is provided to each school district participating in the administrative claiming program. Minor changes in terminology in the guide may not be reflected on this list.

CHAPTER 2

SCHOOL DISTRICT STAFF ACTIVITIES INCLUDED UNDER SCHOOL DISTRICT ADMINISTRATIVE CLAIMING

Overview

As stated in previous material in this guide, some of the activities routinely performed by school districts are activities that could be eligible for Medicaid reimbursement under the School District Administrative Claiming (SDAC) program. The purpose of this chapter is to define school district activities that are included in SDAC time studies and specify which are Medicaid reimbursable. Also, the chapter defines the type of staff eligible to have their activities claimed by school districts as SDAC funded activities. It is important to note that 100 percent of school district staff time is considered during SDAC time studies but only certain staff activities are actually eligible for Medicaid reimbursement, as defined in this chapter.

School District Job Activities

There are 13 major categories of SDAC activities. These activities are not intended to address detailed, educational classroom type activities. They are designed to capture reimbursable and non-reimbursable SDAC activities. Consequently, educational activities are grouped into one generic category. Each SDAC activity is assigned a numeric code in this guide for convenience. Codes used in time studies may be alpha, numeric or any form that clearly identifies work activities in this guide. These codes are used on time study forms for the purpose of determining the percentage of school district staff time spent on each activity. The 13 categories of SDAC activities are listed in the next section of this guide. Some activities, which are ineligible for SDAC reimbursement, such as direct health care services billed under the Medicaid Certified School Match Program, are included in the list because all job activities must be considered when time sampling is conducted. Activities reimbursable under the SDAC program are detailed in Appendix 1 of this chapter. .

SDAC Activities List

The major categories of SDAC activities are:

1. Outreach to the Medicaid Program

This activity occurs generally when staff are:

- informing eligible or potentially eligible students about Medicaid and how to access it; and
- describing to an individual(s) the range of services covered under Medicaid and how to obtain Medicaid preventive services.
-

A description of the eligibility categories and services available under Florida's Medicaid program is found in the "Florida Medicaid Summary of Services," which is the last attachment to this guide (after Chapter 8).

2. Outreach to Non-Medicaid Programs

   This activity occurs generally when staff are:

   - informing eligible or potentially eligible students about non-Medicaid, social, vocational and educational programs and how to access them; and
   - describing the range of benefits covered under these non-Medicaid programs and how to obtain them.

3. Facilitating an Application for Medicaid

   This activity is applicable when staff are assisting a student or family to apply for Medicaid.

4. Facilitating an Application for Non-Medicaid Programs

   This activity is applicable when staff are assisting a student or family to apply for non-Medicaid programs.

5. Care Planning and Coordination for Medical/Mental Health Services

   This activity occurs generally when staff are:

   - coordinating and/or monitoring the delivery of medical/mental health services; and
   - linking the student and family with Medicaid service providers to plan, carry out and maintain a health service plan.

6. Client Assistance to Access Medicaid Services

   This activity is used to record staff time spent arranging for transportation or translation assistance, which is necessary for a student or family to access Medicaid services.

7. Child Health Check-Up (CHCUP) Training

   CHCUP is a Medicaid service available to children under age 21, which allows for physical examinations to detect health care problems and referrals for treatment. A detailed description of this service is contained in the "Florida Medicaid Summary of Services," which is the last attachment to this guide (after Chapter 8). Medicaid federal law refers to this program as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Thus, time study forms may contain the federal title of EPSDT or the state program title of CHCUP. This activity occurs generally when staff are:

- coordinating, conducting or participating in training events and seminars for school district staff performing outreach activities regarding the benefits of CHCUP services, on methods of assisting families to access CHCUP services, and ways to more effectively refer students for CHCUP services; and
- informing outreach staff about how to screen and refer students with special/severe health needs for CHCUP services.

8. Coordination with the Agency for Health Care Administration (AHCA) and Contracted Medicaid Providers

   This activity is used when staff are performing collaborative activities with AHCA and its contracted Medicaid providers to:

   - improve the cost effectiveness of providing health care services;
   - improve the availability of services;
   - reduce service overlaps, duplications or gaps;
   - focus services on specific population groups or geographic areas in need of special attention to ensure effective child health programs; and
   - define the scope of each agency's or resource's programs.

9. Program Planning, Development and Monitoring

   These are activities associated with the development of strategies to improve the coordination and delivery of medical/mental health services to school age children. The activities include developing, monitoring and maintaining tracking systems to assess the effectiveness of these services and programs.

10. Direct Medical and School Health-Related Services

    This activity is applicable when staff are providing direct medical care, counseling and therapeutic services or treatment. The activity includes screening, evaluations and treatment.

11. Non-Medicaid, Other Educational and Social Activities

    This activity is used when job duties are performed which are not health or Medicaid related, such as education and teaching, employment, job training and social service related activities.

12. General Administration

    This activity occurs when staff are performing general administration activities of the school or school district as well as lunch or other breaks and paid leave.

13. Not Scheduled to Work

This activity should be selected to account for time during the workday for which an employee is not working and is not being compensated.

Definition of School District Job Activities

More detailed definitions of each of the categories of job activities used in the SDAC program are located in Appendix 2 of this chapter. This appendix should be made available to staff involved with the time study process. It is critical that job activities be correctly identified during the time study process. If job activities are not identified in an accurate manner, Medicaid administrative reimbursements may be inappropriately claimed. SDAC reimbursements are subject to federal and state audits. Each school district should have an ongoing pre- and in-service training program to ensure that staff understand the meaning of each of the SDAC activity codes. This is explained further in Chapters 4 and 5 of this guide.

Charter Schools

Administrative claiming is allowed for charter schools on the same basis as individual public schools, if the school district contract with the charter school(s) includes this function.

Activities During Summer Months

The completion of time studies during summer months is addressed in Chapter 4 of this guide.

School District Staff Performing Direct Service Activities

As stated in various chapters in this guide, the intent of the SDAC program is to reimburse school districts for Medicaid administrative functions. Direct, face-to-face health care services are included in the SDAC activities list in order to obtain a statistically valid accounting of staff time; however, SDAC reimbursement for these activities is prohibited by the federal Medicaid office. An example of a direct service activity would be counseling of a student by a social worker or school psychologist or conducting a home assessment. An SDAC administrative function would be case planning and coordination of care for a student, unless billed under the Medicaid Certified School Match program.

SDAC Interface with the Medicaid Certified School Match (MCSM) Program

School districts may enroll as Medicaid providers for the following MCSM services:

- Physical Therapy,
- Occupational Therapy,
- Speech-language Pathology,
- Transportation,
- Behavioral Services, and
- Nursing Services.

One basic rule for the MCSM program is that reimbursement under the program is only available for Medicaid eligible students with MCSM services referenced in their Individualized Educational Plans (IEPs). SDAC activities and reimbursement are not limited to IEP students or services since student Medicaid eligibility status is not captured during the time study process. However, there is similarity between the MCSM and

SDAC programs in the area of services to students, particularly when planning, coordinating and referring services for the student. School districts are **prohibited** from requesting Medicaid reimbursement for the same service under both programs. Note that SDAC reimbursement is for activities performed during an entire quarter. Thus, the MCSM program cannot be billed for SDAC reimbursed, identical services during the same quarter. It is recommended that staff not participate in both programs. If this cannot be done the potential for duplication must be controlled by procedure code. The school district is responsible for maintaining documentation to identify that functions performed by school district staff does not overlap among programs.

Behavioral and nursing services covered under the MCSM program can include services other than direct, face-to-face health care services, such as referrals, documentation time and consultations. If a school district is enrolled as an MCSM provider of these services and is billing Medicaid for the services, the same services will not be reimbursed under the SDAC program for the same quarter. Some of the activities described in this chapter would be reimbursed under the SDAC program regardless of whether the district is reimbursed under the MCSM program, such as outreach for Medicaid eligibility, if done by school behavioral services staff or nurses. In addition, travel time by behavioral and nursing employed or contract staff is not allowed for MCSM reimbursement but is allowed for SDAC reimbursement.

If a school district determines that Medicaid will not be billed under the MCSM program for behavioral or nursing services, SDAC activities other than direct student care services would be reimbursable as referenced on page 2-10. Direct student care services include behavioral evaluations, therapy, counseling, behavioral interventions and nursing treatments/medication administration.

If a school district wishes to seek Medicaid reimbursement for school bus or contract vehicle trips, the school district must enroll as a Medicaid provider under the MCSM program and bill under that program. If a school district is enrolled as a Medicaid transportation provider, the arrangement for school transportation services for students in need of health care services at school would be reimbursable under the SDAC program. Another example would be a school district social worker arranging Medicaid private van transportation for a student to receive services from a private health provider.

Direct Billing Requirement

School districts participating in the SDAC program must meet the federal guidelines to be eligible to receive funding for referrals and care coordination activities as described in activity code 5. The school district must refer students to a Medicaid participating provider. Each school district must be an enrolled provider to participate in the SDAC program. At a minimum quarterly, one claim must be submitted for the following services:

- Therapies (PT, OT, SLP),
- Behavioral Health, and
- Nursing Services.

It is permissible to refer students to providers in the community to meet this requirement if they are a Medicaid eligible provider.

If claims are not submitted for the services referenced above or if documentation of referrals to the community providers are not maintained, activity code 5 cannot be reimbursed for the quarter

determined to be out of compliance. Claims for this requirement must be submitted in accordance with the CMS 1500 Provider Reimbursement Handbook. Claims cannot be submitted after twelve months from the date of service to satisfy this requirement. There are no exceptions to this rule. Claims submitted for this rule must have a reasonable expectation to pay. The school district cannot submit these claims for this requirement if the student is ineligible or the service did not take place.

SDAC Interface with "Fee for Service," Medicaid Services Other than MCSM Services

School districts may enroll as Medicaid group providers for the following, non-MCSM services:

- Community Mental Health Services,
- Mental Health Targeted Case Management,
- Child Health Check-Up,
- Physician Services,
- Advanced Registered Nurse Practitioner Services,
- Early Intervention Services, and
- Dental, Vision, and Hearing Services.

School districts enrolled as group providers and billing Medicaid for any of the above services will not be reimbursed for any directly associated administrative functions under the SDAC program because the fees include administrative expenses. Most associated administrative functions fall under the SDAC activity code titled "Care planning and Coordination for Medical/Mental Health Services." The primary example of an associated administrative function would be a referral by a physician to a medical specialist such as a cardiologist or orthopedic specialist. Medicaid's payment to the physician would include the referral activity.

ADMINISTRATIVE CLAIMING REIMBURSEMENT LEGEND

Activity	Reimbursable	Medicaid Discount	FFP Rate
1. Outreach to Medicaid Program	Yes	No	50%*
2. Outreach to Non-Medicaid Programs	No		
3. Facilitating Application for Medicaid	Yes	No	50%*
4. Facilitating Application for Non-Medicaid Programs	No		
5. Care Planning and Coordination for Medical/Mental Health Services	Yes	Yes	50%*
6. Client Assistance to Access Medicaid Services	Yes	Yes	50%*
7. CHCUP (EPSDT) Training	Yes	Yes	50%*
8. Coordination with AHCA and Contracted Medicaid Providers	Yes	No	50%*
9. Program Planning, Development and Monitoring	Yes	Yes	50%*
10. Direct Medical and School Health-Related Services	No		
11. Non-Medicaid, Other Educational and Social Activities	No		
12. General Administration	Activity reallocated across other activities.		
13. Not Scheduled to Work	No		

KEY:

Reimbursable - means that Medicaid will reimburse school districts for time spent on this activity, subject to the calculations explained in Chapter 6.

Medicaid Discount - means that time spent on certain activities is reduced to reflect the percentage of Medicaid eligible students in the total student population for the school district(s), as explained in Chapter 6.

FFP Rate - is the percentage available from Medicaid federal funds to pay SDAC claims, as explained in this chapter and Chapter 6.

***** This is an approximation. The FFP Rate changes annually.

Appendix 2

SCHOOL DISTRICT ADMINISTRATIVE CLAIMING PROGRAM
TIME STUDY ACTIVITIES

1. OUTREACH TO MEDICAID PROGRAM

Informing eligible or potentially eligible individuals about Medicaid and how to access it, describing the range of services covered under Medicaid, and how to obtain Medicaid preventive services. Both written and oral methods may be used. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Compiling brochures designed to effectively inform eligible individuals about the Child Health Check-Up (CHCUP) program and services, and about how and where to obtain services;
- Informing families and distributing literature about the benefits and availability of the CHCUP program and other Medicaid programs;
- Informing Medicaid eligible and potential Medicaid eligible children and families of the benefits of the preventive medical/mental health services of the Medicaid program;
- Providing information about CHCUP screening in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid;
- Informing children and their families on how to effectively use and maintain participation in all health resources under the federal Medicaid program;
- Informing children and their families about the early diagnosis and treatment services for medical/mental health conditions that are available through the CHCUP program;
- Conducting Medicaid outreach activities such as:
  - Assisting in identification of children with special medical/mental health needs (this does not include district-wide Child Find screenings mandated under IDEA…activity code 2 would be used to record these screenings);
  - Encouraging families to access medical/mental health services provided by health plans; and
  - Notifying families of CHCUP program initiatives, such as screenings conducted at a school site, and Medicaid eligibility outstation activities;
- Providing information to individuals and families regarding the Florida Medicaid program and its managed care system;

- Designing and implementing strategies to identify individuals who may be at high risk of poor health outcomes; and
- Designing and implementing strategies to respond to emergency health problems affecting individuals who may be at high risk of poor health outcomes.

2. OUTREACH TO NON-MEDICAID PROGRAMS

Performing activities that inform eligible or potentially eligible individuals about non-Medicaid, social, vocational, and educational programs and how to access them; describing the range of benefits covered under these non-Medicaid, social, vocational, and educational programs and how to obtain them. Both written and oral methods may be used. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices;
- Conducting district-wide Child Find screenings mandated under IDEA;
- Conducting general health education programs or campaigns addressed to the general population; and
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.

3. FACILITATING AN APPLICATION FOR MEDICAID

Assisting an individual or family in becoming eligible for Medicaid. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Referring an individual or family to the local assistance office to make application for Medicaid benefits;
- Explaining the Medicaid eligibility process to prospective applicants;
- Providing assistance to the individual or family in collecting required information and documents for the Medicaid application;
- Assisting the individual or family in completing the application, including necessary translation activities; and
- Verifying a student's Medicaid eligibility status.

4. FACILITATING AN APPLICATION FOR NON-MEDICAID PROGRAMS

Assisting an individual or family in becoming eligible for non-Medicaid programs. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Informing an individual or family about programs such as food stamps, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application;
- Explaining the eligibility process for non-Medicaid programs; and
- Assisting an individual or family in completing an application, including necessary translation activities.

5. CARE PLANNING AND COORDINATION FOR MEDICAL/MENTAL HEALTH SERVICES

Coordinating and/or monitoring the delivery of medical/mental health services. Linking the individual and family with Medicaid service providers to plan, carry out and maintain a health service plan. Includes related paperwork, clerical activities or staff travel required to perform these activities.

NOTE: *This activity code does not include writing initial or follow-up IEPs, FSPs or Individual Transition Plans or meetings related to writing these plans. Activity code 11 should be used to record these activities. Also, linking the student and family with health care staff in the school district is not a reimbursable activity unless the school district is participating in Medicaid for the service provided by the health care staff, or the service is performed by a Medicaid participating provider such as county health department nurse or community mental health provider.*

Examples:

- Scheduling and/or coordinating CHCUP screens, health evaluations or other medical and mental health diagnostic services;
- Gathering any information that may be required in advance of these referrals or evaluations;
- Coordinating necessary medical, mental health or substance abuse services covered by Medicaid which were identified as a result of a screen or evaluation;
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition;
- Assisting in coordinating and/or scheduling health care appointments for the individual or family;
- Monitoring and evaluating the medical components of the individualized plan as appropriate;
- Participating in meetings/discussions to coordinate or review an individual's need for health related services covered by Medicaid;
- Providing information to other staff about the individual's related medical/mental health services and plans;

- Coordinating medical/mental health service provision with managed care plans as appropriate;
- Coordinating the delivery of medical/mental health services for a child with special/severe health needs in the least restrictive community setting; and
- Coordinating the completion of the prescribed services, termination of services, and the referral of the individual to other Medicaid service providers as may be required to provide continuity of care.

6. CLIENT ASSISTANCE TO ACCESS MEDICAID SERVICES

Arranging for transportation or translation assistance, which is necessary for an individual or family to access Medicaid services. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Arranging for or providing translation or signing services that assist an individual or family accessing and understanding necessary care or treatment; and
- Arranging for transportation for an individual or family to access Medicaid services.

7. CHCUP (EPSDT) TRAINING

Coordinating, conducting or participating in training events and seminars for outreach staff regarding the benefits of the CHCUP program, how to assist families in accessing CHCUP services, and how to more effectively refer students for CHCUP services. Informing outreach staff about how to screen and refer students with special/severe health needs for CHCUP services. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Participating in or presenting training that improves the medical knowledge and skills of skilled medical personnel necessary to effectively and efficiently perform outreach activities;
- Participating in or presenting training that is designed to address the specific health or mental health standards and criteria associated with the CHCUP program;
- Participating in or presenting training regarding the clinical importance of maintaining the scheduled CHCUP screenings;
- Participating in or presenting training that describes the medical protocols associated with referrals for treatment services that may be identified during an evaluation, assessment or CHCUP screen;
- Participating in or presenting training that improves the quality of identification, referral and coordination of care for children with special/severe health or mental health needs;

- Participating in, presenting or coordinating training designed to address the specific administrative and reporting requirements associated with the CHCUP program; and
- Participating in or presenting training regarding history, structure and function of the Medicaid CHCUP program in Florida.

8. COORDINATION WITH AHCA AND CONTRACTED MEDICAID PROVIDERS

Performing collaborative activities with AHCA and its contracted providers to: improve the cost effectiveness of providing health care services; improve the availability of services; reduce service overlaps, duplications or gaps; focus services on specific population groups or geographic areas in need of special attention to ensure effective child health programs; define the scope of each agency's or resource's programs. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Working with other agencies and resources providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical/mental health problems;
- Working with Medicaid resources, to make good faith efforts to locate and develop CHCUP health service referral relationships;
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to certain Medicaid populations;
- Developing CHCUP referral resources (e.g., determining which providers take Medicaid, including managed care providers, who will provide CHCUP services to certain population groups);
- Coordinating with interagency committees to identify, promote and develop CHCUP services in the school system;
- Coordinating with advisory committees for CHCUP programs or other Medicaid health initiatives; and
- Coordinating the medical/mental health service programs provided in schools with other community medical/mental health programs and agencies.

NOTE: For coordination with other agencies and resources not enrolled as Medicaid providers, time should be allocated to activity code 11, "Non-Medicaid, Other Educational and Social Activities."

9. PROGRAM PLANNING, DEVELOPMENT AND MONITORING

Activities associated with the development of strategies to improve the coordination and delivery of medical/mental health services to school age children. Developing, monitoring, and tracking systems to assess the effectiveness of these services and programs. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Identifying gaps or duplication of medical/mental health services to school age children and developing strategies to improve the delivery and coordination of these services;
- Developing strategies to assess or increase the capacity of school medical/mental health programs;
- Monitoring the delivery of medical/mental health services in schools; and
- Developing procedures for tracking the requests of families for assistance with Medicaid services and providers.

10. DIRECT MEDICAL AND SCHOOL HEALTH-RELATED SERVICES

Providing direct medical care, counseling and therapeutic services or treatment. These activities include screening, evaluations, and treatment. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Direct clinical treatment and therapeutic services;
- Developmental assessments;
- Diagnostic testing and assessments/evaluations;
- Counseling about a health, mental health, or substance abuse issue;
- Performing vision, hearing, scoliosis and speech-language screens and other CHCUP screens;
- Providing immunizations, family planning, or pre-natal care services, including all counseling, education and referral activities; and
- Administering first aid, emergency care, or prescribed medications or injections.

11. NON-MEDICAID, OTHER EDUCATIONAL AND SOCIAL ACTIVITIES

Performing activities that are not health or Medicaid related, such as education and teaching, employment, job training, and social activities. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Providing classroom instruction, including lesson planning, testing, and correcting papers;

- Developing, coordinating and monitoring the educational component of the IEP and the associated meetings/conferences;
- Writing an IEP, FSP or Individual Transition Plan, even if writing the medical part of these plans during the time sampled;
- Participating in meetings about how to write a student's IEP, FSP or Individual Transition Plan;
- Participating in a Section 504 plan meeting;
- Training or referrals related solely to state mandated screenings for vision, hearing, scoliosis and speech-language;
- Conducting a parent-teacher conference about a student's educational progress;
- Compiling attendance reports;
- Performing activities that are specific to instructional, curriculum, and student focused areas;
- Providing general supervision of students (e.g., lunchroom, playground, bus);
- Monitoring student academic achievement;
- Evaluating curriculum and instructional services, policies and procedures; and
- Providing individualized instruction (e.g., math concepts) to a special education student.

12. GENERAL ADMINISTRATION

Performing general administration activities of the school or local education agency, as well as time associated with breaks, lunch or paid leave. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Taking lunch, breaks, or paid leave;
- Attending staff meetings/training, including CPR training;
- Reviewing school or district procedures and rules;
- Reviewing technical literature and research articles;
- Attending or facilitating general school or unit staff meetings or board meetings;
- Providing general supervision of staff;
- Developing budgets and maintaining records;
- Processing payroll or other personnel related documents;
- Maintaining inventories and ordering supplies; and
- Performing other administrative or clerical activities related to general building or district functions or operations.

13. NOT SCHEDULED TO WORK

This activity should be used to account for time during the work day for which an employee or contracted individual is not working and is not being compensated.

Examples:

- Unpaid leave,
- Vacant position,
- Terminated position, and
- No longer employed by the district

CHAPTER 3

TIME STUDY PARTICIPANTS

Overview

Only certain school district staff may be included in the School District Administrative Claiming (SDAC) sample universe. The sample universe will be termed "sample pool" for the purpose of this guide. Once it is determined by a school district that certain school district staff or categories of staff are to be included in its sample pool, a random sample of school district staff in the pool is done to determine which staff must participate in time studies. For those school district staff sampled, all of their time must be considered during time studies in order to obtain a statistically valid accounting of their SDAC compensable time.

Who Should be Included in the SDAC Sample Pool

As a general rule, school district staff spending time on any of the Medicaid reimbursable SDAC activities described in Chapter 2 may be included in the SDAC sample pool (see information below for staff excluded from sample pools). This includes direct employees of the school district, contract employees, part time employees, temporary employees and any other category of individuals receiving pay from the school district. This does not include individuals such as parents or other volunteers who receive no compensation for their work or in-kind contributions. For purposes of this guide, individuals receiving compensation from school districts for their services are termed "school district staff." Direct replacement staff must be of the same title, FIRN code and job duties of those they replace. They must have the same position/budget number and may be included in the sample and reimbursement. Position numbers that have been re-classified to another chapter 3 category may also be included.

Examples of Job Categories that Might be Included in the SDAC Sample Pool

The sample pool may include those eligible to bill under the Medicaid School Certified Match Program. Employed or contract school district staff within the following job categories could reasonably be expected to perform SDAC reimbursable activities:

1. Speech-Language Pathologists and Speech-Language Pathology Assistants;
2. Audiologists and Audiology Assistants;
3. Occupational Therapists and Occupational Therapist Assistants;
4. Physical Therapists and Physical Therapist Assistants;
5. Behavior Analysts;
6. Social Workers;
7. Psychologists and Interns;
8. Counselors;
    - Guidance
    - Marriage and Family Therapist
    - Mental Health
9. Diagnosticians;
10. Physicians;

11. Nurses;
    - Advanced Registered Nurse Practitioner
    - Registered Nurse
    - Licensed Practical Nurse
    - School Health Aides
    - Health Specialists
12. Interpreters;
13. Orientation and Mobility Specialists;
14. Bilingual Specialists;
15. Program and Staffing Specialists;
16. Substance Abuse Specialist
17. Administrators for Exceptional Student Education (ESE);
18. Augmentative Specialists;
19. Dietitians;
20. Respiratory Therapists; and
21. Liaisons and Related ESE Teachers (See Appendix 2).

Staff in these job categories cannot automatically be included in sample pools. A district must also determine whether they, in fact, render SDAC reimbursable activities. Both factors should be met in order to avoid audit exceptions. Note that there is no job category for "early identification/intervention (EI) personnel" on the above list. Individuals classified as "EI" personnel must be cleared with the Medicaid area office, per the instructions below.

Who Should Not be Included in the SDAC Sample Pool

The following employed or contract staff should not normally be included in time studies, per federal requirements:

1. Contract staff that are not paid for referrals or outreach or any other function beyond direct services;
2. Staff 100 percent funded by other federal grants;
3. Non-ESE teachers or ESE teachers not included in Appendix 2;
4. Transportation staff;
5. Cafeteria staff;
6. Maintenance staff;
7. Coaches;
    - P.E. Teachers
    - Adaptive P.E. Teachers
8. Job/occupational specialists; and
9. Principals (except that elementary school principals and principals for some schools containing only disabled students may perform certain outreach functions).

Staff in these job categories may be included in time studies only if they routinely perform multiple functions or are dually certified by the Department of Education. For example, a non-ESE teacher also routinely serving as a sign language interpreter might be included in a time study. However, these situations must be documented by a school district and cleared through the Medicaid area office (please see the paragraph titled Avoidance of Audit Penalties). Note that the list above (begins on page 3-1) is not intended to serve as a method to classify staff for

purposes of obtaining SDAC reimbursement. For example, a non-ESE elementary school teacher should not automatically be classified as a "Program and Staffing Specialist". Individuals sampled and claimed must be identified by an actual official school district title.
In addition, staff with position numbers that are re-classified with a different FIRN code and job title which is no longer acceptable job titles as described in Chapter 3 Chapter 3 title are not permitted to complete the form. Please mark the replaced person as a 13 and remove that person's name from the sample list as soon as possible. This position may be qualified to be certified as described in Chapter 3.

Avoidance of Audit Penalties

If a school district has staff performing SDAC reimbursable activities whose job titles do not fit those above (begins on page 3-1), a position description for these must be sent through Medicaid Headquarters office for review and approval prior to inclusion in the sample pool. The same procedure should be followed if new positions are added which do not fit the above job titles. The use of this approval system should assist school districts in avoiding fiscal penalties stemming from audits. The job title certification form contained in Appendix 3 of this chapter or the equivalent of the form may be used to obtain Medicaid approval. Submission of the documents for approval should be sent to the Medicaid area office for routing to Medicaid Headquarters staff for approval. Medicaid may require a grouping or clustering sample of these other requested job titles to ensure that the people in these positions actually perform some of the reimbursable activities described in Chapter 2. Clustering is further explained in Chapter 4. School district titles to be certified will be the districts assigned FIRN (Florida Information Resource Network) title and FIRN code as verified in the employees personnel file.

Clerical and Supervisory School District Staff

Clerical staff (aides, other than school health aides, secretaries and clerks), supervisory staff and administrators who provide direct support or supervision exclusively to sample pool participants usually do not participate in time studies. If a school district determines that staff in these positions actually performs SDAC reimbursable activities, the district may request approval from the Medicaid area office school services representative to have them included in the sample pool. Clerical and supervisory staff included in the reimbursement claim must also be certified. Clerical aides such as secretaries, non-professional administrative aides and non-accounting type clerks do not need certification.

Audit Lists of School District Staff Included in an SDAC Sample Pool

Each school district participating in SDAC must compile a quarterly master list of all school district staff to be included in their SDAC sample pool. A copy of each list must be maintained for three years after each time study is completed for audit purposes. If assistance is needed in determining whether certain staff positions are to be included in the time study process, the school district should contact the Medicaid area office school services representative for review and approval.

Aide Level Staff

For purposes of the SDAC program, aides are considered to be support staff and are usually not included in time studies unless they are "school health aides." School health aides are aides, which are rendering medical and administrative services under the supervision of a licensed registered nurse.

Maintaining the Sample Pool

The sample pool must be maintained and updated quarterly

Appendix 1

INCLUSION OF EXCEPTIONAL STUDENT EDUCATION (ESE) TEACHERS IN TIME STUDIES

ESE teachers certified by the Department of Education to teach students with the following exceptionalities may be included in time studies without the permission of the Medicaid area offices:

1. Prekindergarten Handicapped
2. Educable Mentally Handicapped;
3. Trainable Mentally Handicapped;
4. Orthopedically Impaired;
5. Speech Impaired;
6. Language Impaired;
7. Deaf or Hard of Hearing;
8. Visually Impaired;
9. Emotionally/ Behaviorally Disabled Handicapped;
10. Profoundly Mentally Handicapped;
11. Autistic;
12. Severely Emotionally Disturbed;
13. Traumatic Brain Injured;
14. Developmentally Delayed;
15. Varying Exceptionalities;
16. Physically Impaired;
17. Other Health Impaired;
18. Specific Learning Disabled; and
19. Dual Sensory Impaired; and
20. Intellectually Disabled.

As a reminder, district staff included in time studies must actually perform reimbursable SDAC activities.

Appendix 2

SAMPLE POOL PERSONNEL/JOB TITLE CERTIFICATION

The Department of Health and Human Services, Office of the Inspector General, reviewed four participating school districts and found certain job titles of individuals included in the sample and cost pools that did not appear to relate to accessing Medicaid health care services. Use of this job title certification form will allow the school districts to review sample pool and support personnel for compliance with program guidelines to minimize future audit exceptions.

Chapter 3 of this guide lists examples of school district staff that may be included in the sample pool. Because this list is not considered all-inclusive and due to the fact that job titles can vary from district to district, there is a provision for including other school district personnel titles in the sample pool. The actual job function(s) of school district personnel is the primary basis for sample pool inclusion if the assigned FIRN code is compatible with Chapter 3 requirements. It should be noted that the FIRN code assigned by the district and included in that person's personnel file will not be approved if the FIRN code is from functions 5100, 5300, 5400, 5500, 5600, 5700, 5800, 5900, 7100, 7200, 7400, 7400, 7500, 7600, 7700, 7800, 7900, 8100, or 9200.. It should be noted that reimbursable activities are aimed at helping students become/stay Medicaid eligible and obtaining/monitoring access to medical care needed by the student. This job title certification document will serve as the school district's justification for the inclusion of job titles not specifically listed in Chapter 3.

This form must be completed by the school district for each specific job title/job code different from the categories specified in Chapter 3 for personnel included in the sample pool. One certification will be completed for each job title/job code; however, multiple staff may be located on the attached list (all personnel in a certified job title/job code may not perform SDAC reimbursable activities). This form must be sent to the Medicaid area office for submission to Headquarters staff for review and approval. Headquarters staff will return the completed form to the Medicaid area office who will then return the original, signed copy of the form to the school district. This signed form must be retained by the school district and produced if requested to by state or federal officials. The Medicaid area office will also retain a copy of the form. It is not necessary for a school district to send another form to the Medicaid area office if new staff are hired under a previously approved job title/job code. A record of staff changes should be maintained with the original approved job title/job code form in school district files.

If the costs for support staff are claimed, there must be a direct correlation between a clerical support staff or supervisor to the sampled worker. The burden of proof for this correlation rests with the school district. Correlation could be support staff that work in the same physical location as the sampled worker and perform administrative functions, i.e., filing or typing for that sampled worker. Examples of clerical support staff could be non-health related aides, secretaries, administrative aides and non-financial clerks. Titles similar to those generally do not need certification. Financial functions are considered reimbursed through the school districts' indirect rates. One level up supervisors must be officially responsible for the sample pool workers they supervise. It should be noted that if either support or supervisory staff support or supervise other than people in the claim, their costs must be pro-rated before claiming.

Generally, principals and non-ESE teachers are not to be included in the sample pool per CMS Region IV Program Issuance, Transmittal Notice MCD-06-09. Their main function is the total administration of the school and educating students. However, some of their duties and responsibilities might be described in the reimbursable activities in Chapter 2 and thus they may be includable in the sample pool after school district certification and Medicaid approval.

JOB TITLE CERTIFICATION

FIRN JOB TITLE _____

FIRN CODE _____ (From this individuals personnel file.)

Please select one
SAMPLED STAFF (YES) _____ SUPPORT STAFF (YES) _____

This is to certify for the job title and FIRN code identified above, that the personnel on the attached list perform the Medicaid administrative claiming reimbursable duties or provide clerical support to those that perform Medicaid administrative activities in accordance with Chapter 3 of the federally approved School District Administrative Claiming Guide. FIRN district job title refers to the title the district has given or assigned to the title in question and is used by the district to report expenditures to the Florida Department of Education. The FIRN equivalent is not acceptable for this certification. It must be the assigned FIRN code. The district is asked to identify the source of the FIRN title and code.

I am aware that further review of the title and listed participants in either the sample pool or support staff by appropriate federal or state officials may disallow the inclusion of these personnel with their associated costs and adjust reimbursement claims for the disallowance as claimed. Said judgment as to non-inclusion of this job title class or specific personnel within this class for reimbursement purposes from federal and state officials will be in compliance with specific existing federal policies or the guide. Tests for allow ability may be evaluation of this title's sampling results for reimbursable utilization, direct interview of the listed personnel by Medicaid area office staff, or other tests deemed necessary by appropriate federal or state officials to ensure compliance with the guide.

Attached are the official job duties and responsibilities as they relate to reimbursable activities identified in Chapter 2 of this guide for this job title and a list of personnel with this job title currently being claimed under the School District Administrative Claiming Program. Also attached is additional school district documentation substantiating the job titles inclusion in the sample pool or as support staff included in the claim's cost pool. These documents, after AHCA approval, are to be filed in the school district audit file.

_____
Name (Print)

_____
Signature

_____
Title

_____
Date

AHCA Headquarters School-Based Medicaid Staff

_____ _____
Signature/Approval Date

CHAPTER 4

THE TIME STUDY PROCESS

Overview

Florida permits the random moment sampling (RMS) methodology for collection of data or time studies for the School District Administrative Claiming (SDAC) program. Two RMS methodologies are accepted by the Agency for Health Care Administration to participate in the program. The first is a standard paper generated sample process and the other is an electronic version which uses approved programming logic in a web based process to disseminate and record outreach activities performed by approved staff.

Both sampling methodologies involve the use of a statistically appropriate random selection of school district staff (as defined in Chapter 3) and times to collect data that is statistically representative of the time all district staff of specific disciplines or classifications spend performing approved Medicaid SDAC activities during a specified quarter. One hundred percent (100%) of school district staff time during the time study is captured through the various activities detailed in Chapter 2. Medicaid only reimburses school districts for the percentage of time spent on reimbursable activities as defined in Chapter 2 of this guide.

For the purposes of illustration, this guide defines the following roles established to define the management of the selection/oversight process and the staff who perform activities to support the Medicaid program:
1) Data Manager,
2) District Contact,
3) Sample Participant, and
4) Monitor.

The role of the Data Manager is to perform managerial functions which directs and monitors the entire program for districts who decide to enroll with an approved provider to ensure the validity of the sampling requirements and the RMS process. Their functions may include importing quarterly sampled participants, generating the sample and authenticating sampled activities for coding. The District Contact is a position which shares an association with the Data Manager and the Sample Participant to make certain that the RMS time studies are accurately distributed, notifications are acted upon in a timely manner before and after the moment is selected and coded before the sample expires. The Sample Participant is the individual (defined in Chapter 3 of this guide) who performs administrative functions including facilitating Medicaid access, promoting public awareness of child find activities, outreach and coordination, interagency referral for students who are in need of health and behavioral services in the school district. These individuals will be the ones to complete the RMS form that will be sent to the District Contact for activity coding. Finally, the Monitor is the Medicaid Area Office School Specialist who will assure the legitimacy of the RMS process and authenticate the activity coding of each sample form.

Methodology for Establishing the Sample Pool

School districts participating in the SDAC program must prepare a master listing of sample (per Chapter 3) and cost pool (see Chapter 6) participants by the school district's function, job code and title. The Data Manager will collect all employees roster to create a statistically appropriate computer generated random sample of staff in the sample pool. The sample participant will be selected from the sample pool listing for participation in the random moment sampling process.

Training

An important element in the successful implementation of new sampling systems is the development of standardized time study or observation forms with clear definitions and clear instructions. These materials must be developed in a manner to ensure consistent and uniform use by the sample takers and staff. All staff selected to participate in the random moment sample must participate in training that ensures an adequate understanding of SDAC activities, in accordance with Chapter 5 of this guide. Chapter 5 contains more detail relative to SDAC training.

Time Study Method - Random Moment Sampling

The random moment sample (RMS) method measures the work effort of the entire group of approved staff involved in the school district medical and health-related services program, by sampling and analyzing the work efforts of only a cross-section of the group. RMS methods employ a technique of polling employees at random moments (one minute) over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services.
The following defines the process of participant notification prior to and after the moment of sampling.
The District Contact will either disseminate the RMS forms either manually or via a web based system. If an approved web is utilized the Sample Participant will be notified electronically via email that he or she has been selected to complete an RMS. This initial contact will originate from the District Contact's email server and function as a notification letting the Sample Participant know to check their email often over the next seven days because during that timeframe, another email will be sent containing the valid date and time of the RMS that needs their attention. During the time between the initial email and the definite RMS moment, the participant will not be able to view their form. On the actual day of the RMS, the District Contact will send an invitation email to the participant containing the date/time of the moment. The email will contain a hyperlink to a secured website where the participant can access the form using a temporary password. The participant will be asked to supply a personalized password so there will be no way for other users of the system to view or have access to the new password. With the private/personalized password the Sample Participant will logout of the hyperlinked system and log back into the RMS system to complete an online training demonstrating how to complete the form and to provide information about the purpose of Medicaid outreach and the purpose of being selected as a Sample Participant for the program. The Sample Participant will have seven working days to complete the form. After the moment is completed (or after 7 working days expire) the moment will be locked from further access or editing by anyone in the process.

The sampling period is defined as the same three-month period comprising each quarter of the federal calendar. The RMS software produces a random selection of observation moments concurrent with the entire reporting period, which are paired with randomly selected members of the designated staff population. The sampling frame is constructed to provide each staff person in the pool with an equal opportunity, or chance, to be included in each sample observation. Sampling occurs with replacement, so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each observation, which ensures true independence of sample moments.

Once the random moment samples of staff-have been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as observation forms for collecting the observation data. The school District Contact distributes the appropriate control lists and observation forms to designated RMS coordinators/sample takers at some time prior to the beginning of the reporting period. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the observation should take place.

The master list is used by the District Contact to monitor the status of each observation form so that appropriate follow-up contacts can be made for delinquent observation forms or missing data on submitted forms. The location control listing is distributed to the local District Contacts. The District Contact at each location is responsible for ensuring that a copy of the form and instructions are distributed to sampled staff just prior to the time at which observation data will be collected. The completed sample observation forms are returned to the District Contact, generally on a weekly basis, for filing in the audit file in preparation for monitoring. The form may be so designed that for the moment selected, the school district staff may indicate their actual activity by, using an activity code or give sufficient written information on the form about their activity so the trained district coder can indicate the appropriate activity code as defined in Chapter 2. RMS forms that use the actual school district staff's written description of the activity performed for the moment must be approved by the Medicaid office prior to use.

Districts using an approved electronic RMS time study will initially run one quarter of electronic and one quarter of the paper RMS questionnaires simultaneously. This will give the Monitors and Headquarters staff a chance to review and evaluate the new method and insure that all requirements in this Guide are followed. If there are significant differences between the two sample methods as determined by Headquarters staff or issues with electronic documentation for review, the districts must be ready to do another parallel sample the subsequent quarter. This parallel sample of paper and electronic time studies will continue until Medicaid is satisfied with the results of the electronic time study.

Time Study Requirements

A time study system that meets federal reporting and documentation requirements is designed to permit a level of precision of +/- 5% (five percent) with a 95% (ninety-five percent) confidence level.

The statistical formula is as follows:

$$n = \frac{Np(1-p) * [Z]^2}{p(1-p) * [Z]^2 + [N-1]e^2}$$

N = Total moments available for sampling.
p = proportion. For our purposes, .5 or fifty percent will be used.
Z = Z-score. For the 95 percent confidence level, a Z-score equals 1.96.
e = error. For our purposes, a plus or minus 5 percent error is used.
n = the required sampled size.

Time Study Participation

School district staff included in the sample pool and randomly selected to participate in the time study must make every attempt to complete and return any time study form. Failure of selected school district staff to return a time study form without sufficient cause for any three reimbursement periods will result in the permanent removal of that school district staff from the sample and cost pools. All districts must return at least 75% of all RMS forms, when selected, to be tabulated to be considered participating. If selected to participate in the time study and forms are not completed and returned at the 75% level, districts will be considered non-participating and will not be reimbursed for that quarter.

School districts should cooperate with the monitoring activities as required. School districts, consulting agents or group managers must be able to provide upon request, the sample pool participants, those initially selected for the time study and those who return a useable completed time study.

Multiple District Sampling

A number of school districts may contract with a lead school district to implement a SDAC Program. School districts may also elect to be represented by a single consulting contractor or other group to combine sample pools from each of the participating districts. In these situations, each lead district, consulting contractor or group must develop a master roster of personnel by school district who perform some level of Medicaid administrative activity as required in Chapter 3. It is from these master rosters that individuals will be randomly selected to participate in the quarterly time study. The documentation and identification of sample pool participants for multi-district sampling are the same as single district sampling.

Time Study Results

Upon completion of the time study forms (paper or electronic), they will be sent to their respective Medicaid Area Office School Specialist to be reviewed in accordance with Chapter 8, Monitoring and Quality Control. The forms or auditable screen shots should be maintained for a period of three years, per the requirements in Chapter 7 of this guide. Activity data recorded in the time study is the basis used in the cost allocation process for calculation of each quarter's claim.

Time Study Documentation

Each selected reimbursable activity, as described in Chapter 2, must have a written supporting description to justify the activity selected. This activity should be verifiable by school district records. Insufficient written records to substantiate the activity will result in an invalid response. Justification of the reimbursable activity must be sufficient enough for state or federal personnel to arrive at the same conclusion of activity that the sampled individual or district coder selected. This supporting documentation must be included on the sample form and may be a brief phrase or one line sentence. Reimbursable activities selected with incomplete or missing documentation will not be used for reimbursement purposes. Erroneous selections, as determined by state or federal personnel, based on the written documentation will also not be used for reimbursement. Changes of a selection or documentation sentence made by someone other than the original author will not be used for reimbursement. All changes, to be counted, must be initialed and dated by the individual who originally wrote the changed item. To insure the integrity of the sample, changes greater than 30 days past the quarter sampled cannot be changed.

Monitoring and Quality Control

The Agency for Health Care Administration (AHCA), Department of Education, administrative claiming contractors, group data managers and school district staff will be responsible for the following monitoring oversight and support/maintenance functions:

- Ongoing quarterly updates to the sample universe to reflect all current relevant personnel actions (school districts);
- Coordination of sample generation (school districts, contractors and group data managers);
- Ensure the 95 percent sampling validity of each quarterly sample (contractors and group data managers);
- Implementation of quality control reviews of completed observation forms (AHCA, school districts, group data managers and contractors);
- Analyzing and summarizing sample results to ensure appropriate application to various cost objectives (AHCA); and
- Provision of quarterly standardized and uniform sources of Medicaid eligibility rate data to be used by contractors and school districts in computing the discount factors (AHCA and school districts).

The analysis used to review the reliability of the sampling results includes the following: evaluating the distribution of staff selected from areas to be representative of the staff in the

sample universe, examining the results of the activity precision table for each sample, reviewing the results to check for data anomalies, and comparing the sampling results to prior reporting or case count systems.

Medicaid Area Office School Specialist will have the responsibility of monitoring the original sampled observations. The purpose of this review or monitoring is to provide means of validating the results of the sample.

Original sample forms should be used for tabulation after the monitoring process described in Chapter 8 is completed. Copies of the original non-monitored RMS and time study forms may be used for tabulation if properly identified as such as explained in Chapter 8. 7Having produced suitable documentation of how sampled employees spent their time during the sampling period, the next steps for capturing costs associated with those employees and allocating appropriate costs to the Medicaid program using the percentages that result from the sampling effort are facilitated.

CHAPTER 5

TRAINING FOR SCHOOL DISTRICT ADMINISTRATIVE CLAIMING (SDAC)

Overview

School district staff, as specified in Chapter 3, who are included in a sample pool are required to be knowledgeable of all of the activities listed in Chapter 2. In addition, staff must be familiar with the sampling methodology and understand how to complete the approved time study form used to collect claiming data. This will include detailed training on completing the time study form as well as the purpose of this program.

Agency for Health Care Administration (AHCA) Involvement

Notification of training sessions must be made by the school district or consultant(s) to the Medicaid Area Office School Specialist. This notification must be made in advance of the training so that the school services representatives are provided the opportunity to attend. Training, particularly in the area of correct use of activity codes, is critical to the success of the SDAC program. The attendance of the school services representatives can help ensure that consistent, accurate information is being generated to school district staff throughout the state. Training must be rescheduled in order to accommodate the schedule of the area office school services representatives, if requested.

Training Approach

Training must be provided either by consultants under contract with school districts that have experience in administrative claiming policy or by school district staff. All staff must be trained prior to their initial participation in a time study. Some districts use written descriptions of activities and have central coders assign codes from the written descriptions. In these districts, the central coders must be trained (training of time study participants in these districts is recommended but not mandated). In addition to initial training, staff must be provided an opportunity for regular training updates. In addition, all new or reassigned staff must be trained prior to their participation in the time study. Training must include a detailed review of all reimbursable and non-reimbursable categories of activities and instructions on completing the time study form. Examples of activities for each category must be presented and discussed. Trainees must present actual experiences and situations routinely encountered during the workday and discuss how their participation in these activities would be recorded on time study forms. Sign-in sheets for training sessions or other forms of proof that a time study participant or central coder was trained may be requested by an auditor. Thus, it is recommended that school districts maintain documentation of training attendance. Costs and time study results relating to untrained staff will be disallowed if the untrained staff participated in a time study.

Training Materials

Training materials consist of handouts that include: detailed definitions and examples of all categories of activities, the time study form, and any supporting documents that help explain the Medicaid program, such as eligibility for Medicaid, benefits of participation in the CHCUP program, Medicaid access and referral information, and direct service information. It is suggested that training techniques include use of different media formats. All trainings regardless of format must be approved by the Agency. Training materials are subject to review by Medicaid Area Office School Specialist and AHCA headquarters staff. Internet training programs may negate the use of handouts. However, all Internet training programs must be approved by AHCA headquarters. Federal review of Internet training programs is also strongly recommended for audit protection. AHCA will automatically forward any Internet training programs to the federal Medicaid office for approval unless instructed to do otherwise by a school district or consultant.

Training Content

The training program should include the following content areas:

- the purpose of the sampling system and activity codes;
- electronic or paper review of the time study form and instructions; and
- procedures for problem resolution.

The administrator, coordinators/sample takers and alternates training program should include these additional areas:

- instruction regarding initiation of the control listing and sample generation;
- sample execution, roles, and functions of the sample administrator and coordinator/sample taker and alternates;
- time study form completion and coding for staff participating in the time study;
- data management and data reporting with respect to appropriate staff; and
- problem resolution.

Follow-up and Retraining

All school district staff to be included in the sample must be provided the opportunity for retraining on a routine basis. Staff who have incorrectly completed time study forms should participate in retraining prior to participation in another time study or, at a minimum, be contacted for an explanation of why the error occurred. Training must be routinely provided on any changes and updates to administrative claiming categories and activities. All new and reassigned staff must participate in training prior to participating in a time study.

CHAPTER 6

TIME STUDY RESULTS AND THE COST ALLOCATION PROCESS

Overview

The sampled participants listed in Chapter 3 must have their activities summarized into the different categories for the sampled period. This will be the basis for the School District Administrative Claiming (SDAC) reimbursement process. These accumulations of activities must be converted to percentages and applied to the total costs of the identified participants listed in Chapter 3.

Sampled Results

The SDAC sampling results referred to in Chapter 4 could be similar to those found in Appendix 1 of this chapter. For purpose of illustration, Appendix 1 shows results from a quarterly RMS with one thousand forms being distributed and one hundred percent of the forms are accounted for. Invalid and missing forms will be added to activity 11 and do not count toward the 75% participation requirement. General administration time should be re-allocated back to the other eleven activities on the basis of the sample. An illustration of this re-allocation is shown on Appendix 2.

Sample Pool

The sample pool described in Chapter 3 is the list of all school district personnel and contracted personnel that do any of the reimbursable activities detailed in Chapter 2. All people listed in this pool will be included in the district's time study. Individuals who are not included for the entire quarter on the sample pool list given to the data manager before the quarter begins will not be reimbursed. Only those titles in chapter 3 and subsequent titles certified should be included on this list. Forms filled out by non-sample pool participants or non-certified personnel are invalid and will not count toward the 75 percent requirement.

District Quarterly Expenditures

Appendix 3 indicates the school district's total matchable funds for this program. Only funds expended from Fund 100 or the General Fund will be reimbursed. A portion of these costs will be claimed. Appendix 3 salaries and benefits will give the denominator of the 300-400-500 cost allocation fraction, the 300-400-500 amount and the total training cost to be allocated.

Allowable Costs

Allowable costs are those costs that relate solely to expenditures that benefit the personnel listed in the sample pool with their support staff. Prime examples of allowable costs would be salaries and benefits solely attributed to the specific personnel on the sample pool list and their support staff. Also included, if properly sampled, in these allowable costs would be contracted professional and technical services expensed in object code 310 or 390. Other allowable costs

would be allocated costs and the indirect cost component by percentage. Determination and inclusion of any costs ultimately rests with OMB Circular A-87.

Allowable DOE expenditure object codes to be included are:

Object	Description
100	Salaries
200	Employee Benefits
300	Purchased Services
400	Energy Services
500	Materials and Supplies

Allowable costs that can be claimed can be grouped into three general categories:

1. Direct Costs,
2. Indirect costs, and
3. Allocated Costs.

DIRECT COSTS

Personnel Costs

Appendix 4 lists all the district employees, excluding outside contracted personnel, with fund paid, job code, job title, name, sampled or non-sampled and their associated costs. This list will contain both the sampled and support or non-sampled support staff. Reimbursement cannot be obtained for anyone not included in this quarterly list. This list is not required to be filed with the claim, but must be made available if requested by state or federal officials. Total district staff costs for the quarter will be summarized by title in the Cost Pool Summary, Appendix 7.

. **Note:** the 75 percent rate will **not** be reimbursed for SPMP activities occurring on or after January 1, 2003.

Outside Contractors

Outside contractors are allowed for reimbursement only if they are specifically identified by name on the quarterly sample pool list given to the data managers. This requirement insures that outside contractors be subject to the same sampling requirements as district school staff. Appendix 5 is an example of outside contracted staff with associated expenses. Total contracted costs for the quarter will be summarized in the Cost Pool Summary, Appendix 7.

Support Staff

Also included as allowable personnel costs would be the costs attributed to the non-sampled supervisory (one level up) and clerical staff (one level down) that provides direct support exclusively to those who perform SDAC activities as identified in the sample pool. If this staff supports other personnel that do not perform the reimbursable activities, then their costs must be

allocated to all the people they support. Therefore, only the costs related to the sample pool personnel with the appropriate support staff costs should be shown on Appendix 7.

An example of allocated support staff would be ESE Directors who also oversee gifted students. Their costs should be allocated to the SDAC program in proportion to their time spent with personnel identified in the sample pool and issues concerning the SDAC program.

INDIRECT COSTS

Indirect Costs

Indirect costs for the purpose of this claim are the school district's general administrative costs that benefit and support the personnel identified in the cost pool.

The school district functions and cost centers that make up the school districts indirect costs are part of the annual Florida DOE Cost Allocation Plan (CAP). This CAP is submitted to the cognizant Florida and Federal (Federal Department of Education) agencies for annual approval. The resulting percentage will then be applied to allowable costs. Medicaid will allow this approved indirect rate percentage for claiming purposes. Indirect costs will be claimed on the administrative claim form on Appendix 1, Chapter 7.

ALLOCATED COSTS

Allocated Costs

Allocated costs for the SDAC program are defined as follows:

Object codes 300, (less contracted personnel) 400 and 500 costs will be allocated to the personnel contained in the claim by function. These costs that are accumulated from the District Quarterly Expenditures work sheet, Appendix 3, will be allocated to the personnel in the claim based on their salaries and benefits in comparison to the total salaries and benefits, Appendix 3 and 6.

Staff training, Function 6400 will be allocated on the bottom of the 300-400-500 work sheet, Appendix 6.

Other allocated costs would be the removal of supervisory and clerical support staff expenses for time spent supporting other people who are not listed in the claim. The allocation factor should be a percentage of time spent between the two groups. These reduced amounts should be accounted for on the School District Personnel, Appendix 4.

Federal Revenue Offsets

The following rules govern which revenues received by a program must be offset (i.e., subtracted from costs) before federal funds may be claimed under the SDAC program:

- All federal funds;

- All state revenues which have been previously matched by the federal government must be offset including state general revenues for the Medicaid services program;
- State general funds specifically earmarked solely for the delivery of services without an administrative component may not be used to draw down a federal match for administrative activities and must be offset; and
- Insurance and other fees collected from non-governmental sources must be offset.

Reimbursable Cost Pool

The reimbursable cost pool is the total allowable amount of direct and allocated costs of the participants in the sample pool. This will also include the allowable costs of their support staff to be claimed. The total reimbursable costs, excluding the indirect portion, will be found in the Cost Pool Summary, Appendix 7.

Billing Provider Costs (Optional)

Appendix 8, Billing Provider Costs, separates the billing personnel costs from the non-billing personnel costs. This work sheet with the three other quarterly amounts will give the district an indicator of how much fee-for-service they should be billing for the fiscal year.

QUARTERLY SAMPLE RESULTS

District: Any
For the Quarter Ending: 6/30/20XX

		Total	Percent
Activity			
1A	Outreach to Medicaid Program	2	0.2132%
1B	Outreach to Medicaid Program - Enhanced	0	0.0000%
2	Outreach to Non-Medicaid Program	1	0.1066%
3	Facilitate Medicaid Application	0	0.0000%
4	Facilitate Non-Medicaid Application	6	0.6397%
5A	Care Planning/Coordinating Medical Services	106	11.3006%
5B	Care Planning/Coordinating Medical Services - Enhanced	1	0.1066%
6	Client Assistance to Medicaid Services	0	0.0000%
7A	Child Health Checkup Training (CHCU)	7	0.7463%
7B	Child Health Checkup Training (CHCU) - Enhanced	0	0.0000%
8A	Coordination w ith ACHA/Contracted Provider	1	0.1066%
8B	Coordination w ith ACHA/Contracted Provider - Enhanced	0	0.0000%
9A	Program Planning, Development, and Monitoring	9	0.9595%
9B	Program Planning, Development, and Monitoring - Enhanced	0	0.0000%
10	Direct Medical/School Health Services	135	14.3923%
11	Non-Medicaid Other Services	573	61.0874%
	Subtotal	841	89.6588%
12	General Administration	97	10.3412%
	Subtotal	938	100.0000%
13	Not Scheduled to Work	62	
	Total	1000	

FILE WITH CLAIM

Release 12

MACS DATA MANAGEMENT GROUP

District:	
For the Quarter Ending:	

General Administration Allocation

Act.		Activity Count Sub Totals… Where the "General Administration Activity Count" (Activity 12) Has Not Been Allocated to	Activity Percentages For Activities 1 Through 11… Based on the Activity Count Total for Activities 1	Allocation of "General Administration Activity Count" (Activity 12)… to Activites 1 Through 11.	Activity Count Sub Totals Where the "General Administration Activity Count" (Activity 12) Has Been Allocated to Activites 1 Through 11.	Activity Percentages For Activities 1 Through 11… Based on the Activity Count Total for Activities 1 Through 11, After the "General Administration Activity Count" (Activity 12) Has Been Allocated to Activites 1 Through 11.
1A	Outreach to Medicaid Program	2	0.2378%	0.2307	2.2307	0.2378%
1B	Outreach to Medicaid Program - Enhanced	-	0.0000%	0.0000	0.0000	0.0000%
2	Outreach to Non-Medicaid Program	1	0.1189%	0.1153	1.1153	0.1189%
3	Facilitate Medicaid Application	-	0.0000%	0.0000	0.0000	0.0000%
4	Facilitate Non-Medicaid Application	6	0.7134%	0.6920	6.6920	0.7134%
5A	Care Planning/Coordinating Medical Services	106	12.6040%	12.2259	118.2259	12.6040%
5B	Care Planning/Coordinating Medical Services -	1	0.1189%	0.1153	1.1153	0.1189%
6	Client Assistance to Medicaid Services	-	0.0000%	0.0000	0.0000	0.0000%
7A	Child Health Checkup Training (CHCU)	7	0.8323%	0.8073	7.8073	0.8323%
7B	Child Health Checkup Training (CHCU) -	-	0.0000%	0.0000	0.0000	0.0000%
8A	Coordination with ACHA/Contracted Provider	1	0.1189%	0.1153	1.1153	0.1189%
8B	Coordination with ACHA/Contracted Provider -	-	0.0000%	0.0000	0.0000	0.0000%
9A	Program Planning, Development, and Monitoring	9	1.0702%	1.0381	10.0381	1.0702%
9B	Program Planning, Development, and Monitoring -	-	0.0000%	0.0000	0.0000	0.0000%
10	Direct Medical/School Health Services	135	16.0523%	15.5707	150.5707	16.0523%
11	Non-Medicaid Other Services	573	68.1332%	66.0892	639.0892	68.1332%
	Subtotal	841	99.9999%	97	938	99.9999%
12	General Administration	97				
	Sub-Total	938				
13	Not Scheduled to Work	62			62	
	Total	1,000		Total	1000	

Appendix 2

FILE WITH CLAIM

Release 012.

School District Quarterly Expenditures - General Fund 100 Only

District:
For the Quarter Ending:

		Reimbursable Expenditures							
Function	Title	Salaries 100	Benefits 200	Pro. & Tech. POS (1)	POS Other Allow. Costs	Energy 400	Mat. & Sup. 500	Allocated 300-400-500 (2)	Total
5000	Instruction	$ 530,087	$ 142,249	$ 1,284,922	$ 318,355	$ 441	$ 855,817	$ 1,174,613	$ 3,131,871
5100	K-12	$ 39,151,231	$ 12,220,177	$ 37,862	$ 126,416		$ 140,643	$ 267,059	$ 51,676,329
5200	ESE	$ 8,875,300	$ 2,939,558	$ 51,225	$ 18,225		$ 4,700	$ 22,925	$ 11,889,008
5300	Vo-Tec	$ 1,496,569	$ 446,195		$ 1,687		$ 8,496	$ 10,183	$ 1,952,947
5400	Adult General							$ -	$ -
5500	Prekindergarten							$ -	$ -
5900	Other Non FEFP							$ -	$ -
6000	Instruction Supp.							$ -	$ -
6100	PPS	$ 52,338	$ 16,383	$ 140,646	$ 1,495		$ 8,044	$ 9,539	$ 218,906
6110	Atten/SW	$ 191,526	$ 56,752	$ 194,034	$ 3,065			$ 3,065	$ 445,377
6120	Guidance	$ 1,760,258	$ 532,582		$ 1,084		$ 173	$ 1,257	$ 2,294,097
6130	Health	$ 382,877	$ 146,701	$ 61,798	$ 4,891		$ 1,099	$ 5,990	$ 597,366
6140	Psych.	$ 260,962	$ 72,812	$ 10,035	$ 1,477		$ 48	$ 1,525	$ 345,334
6150	PPS Other							$ -	$ -
6190	Other PPS							$ -	$ -
6200	Media	$ 947,840	$ 301,214		$ 1,372		$ 11,630	$ 13,002	$ 1,262,056
6300	Curr. Develop.	$ 639,285	$ 183,265	$ 7,425	$ 25,592		$ (16,998)	$ 8,594	$ 838,569
6400	Training	$ 375,908	$ 114,560	$ 64,466	$ 19,598		$ 6,833	$ 26,431	$ 581,365
6500	Inst. Rel Tech	$ 553,536	$ 167,337		$ 15,465		$ 1,321	$ 16,786	$ 737,659
7000	General Support							$ -	$ -
7100	Board	$ 116,418	$ 38,571	$ 142,309	$ 6,295		$ 2,475	$ 8,770	$ 306,068
7200	General Admin.	$ 338,844	$ 96,844		$ 2,812		$ 649	$ 3,461	$ 439,149
7300	School Admin.	$ 5,438,851	$ 1,811,818		$ 36,700		$ 17,991	$ 54,691	$ 7,305,360
7400	Fac. Acquisition			$ 765	$ 5,979		$ 613	$ 6,592	$ 7,357
7500	Fiscal Services	$ 353,772	$ 117,002	$ 2,550	$ 7,077	$ 561	$ 2,664	$ 10,302	$ 483,626
7600	Food Serv.	$ (72)	$ (13)					$ -	$ (85)
7700	Central Serv.	$ 7,353	$ 802					$ -	$ 8,155
7710	Planning/Research	$ 8,693	$ 3,184		$ 492		$ 190	$ 682	$ 12,559
7720	Information Serv							$ -	$ -
7730	Staff Services	$ 406,178	$ 332,118	$ 32,778	$ 43,621		$ 4,036	$ 47,657	$ 818,731
7740	Statistical Serv.							$ -	$ -
7750	Data Processing							$ -	$ -
7760	Internal	$ 171,775	$ 61,419		$ 14,106	$ 4,114	$ 8,124	$ 26,344	$ 259,538
7790	Other							$ -	$ -
7800	Transportation	$ 2,617,162	$ 1,447,016	$ 6,885	$ 76,567	$ 640,883	$ 346,980	$ 1,064,430	$ 5,135,493
7900	Plant Oper.	$ 2,460,985	$ 1,165,595	$ 6,445	$ 1,496,389	$ 4,224,649	$ 246,740	$ 5,967,778	$ 9,600,803
8100	Plant Maint.	$ 1,333,949	$ 455,590	$ 16,116	$ 354,847	$ 1,225	$ 323,904	$ 679,976	$ 2,485,631
8200	Admin Tech Serv	$ 385,727	$ 118,798	$ 217,617	$ 130,488		$ 3,834	$ 134,322	$ 856,464
9100	Comm. Serv.	$ 135,480	$ 43,575		$ 23,299		$ 6,736	$ 30,035	$ 209,090
9200	Debt Service							$ -	$ -
9700	Transfers							$ -	$ -
	Total	$ 68,992,832	$ 23,032,104	$ 2,277,878	$ 2,737,394	$ 4,871,873	$ 1,986,742	$ 9,596,009	$ 103,898,823
								Total Check	CORRECT

FILE WITH CLAIM

SCHOOL DISTRICT PERSONNEL ALPHA

FUNC	JOBCD	TITLE	NAME	Employee Id	N/S	GROSS	TAXES	INSURANCE	RETIREMENT	MISC	BENEFITS	TOTAL
5200	52000	Teacher Exceptiona		00951		$ 13,843	$ 888	$ 1,364	$ 1,687	$ 43	$ 3,982	$ 17,825
7300	91	Secretary		00952	N/S	$ 5,020	$ 358	$ 494	$ 1,687	$ 11	$ 2,551	$ 7,571
6120	61233	Counselor High		00953		$ 16,246	$ 1,217	$ 1,773	$ 1,687	$ 69	$ 4,745	$ 20,992
6120	61233	Counselor High		00954		$ 19,873	$ 1,506	$ 1,958	$ 1,687	$ 69	$ 5,219	$ 25,092
5200	52000	Teacher Exceptiona		00955		$ 10,874	$ 823	$ 1,071	$ 1,687	$ 18	$ 3,599	$ 14,474
5200	52000	Teacher Exceptiona		00956		$ 5,154	$ 371	$ 508	$ 844	$ 6	$ 1,728	$ 6,882
5200	52000	Teacher Exceptiona		00957		$ 1,803	$ 137	$ 178	$ -	$ -	$ 315	$ 2,118
5200	52000	Teacher Exceptiona		00958		$ 9,988	$ 759	$ 984	$ 1,687	$ 15	$ 3,446	$ 13,433
6120	61233	Counselor High		00959		$ 13,295	$ 1,018	$ 1,310	$ -	$ 105	$ 2,432	$ 15,728
5200	52000	Teacher Exceptiona		00960		$ 10,467	$ 791	$ 1,031	$ 1,687	$ 15	$ 3,524	$ 13,991
6130	61320	School Board Nurse		00961		$ 13,443	$ 1,030	$ 1,324	$ -	$ 118	$ 2,472	$ 15,915
6120	61233	Counselor High		00962		$ 18,005	$ 1,379	$ 1,774	$ 1,687	$ 44	$ 4,883	$ 22,888
7300	73008	Assistant Principa		00963		$ 12,817	$ 975	$ 1,263	$ 1,687	$ 20	$ 3,945	$ 16,762
7300	73001	Principal Elementa		00964		$ 22,178	$ 1,707	$ 2,410	$ 1,687	$ 238	$ 6,042	$ 28,219
6130	61320	School Board Nurse		00965		$ 6,684	$ 511	$ 658	$ -	$ 40	$ 1,210	$ 7,894
6140	63102	Specialist Staffin		00966		$ 3,445	$ 263	$ 336	$ 422	$ (7)	$ 1,014	$ 4,459
6120	61232	Counselor Middle		00967		$ 13,131	$ 996	$ 1,293	$ 1,687	$ 22	$ 3,998	$ 17,129
5200	52000	Teacher Exceptiona		00968		$ 8,308	$ 615	$ 818	$ 1,687	$ 14	$ 3,134	$ 11,442
6120	61232	Counselor Middle		00969		$ 13,131	$ 999	$ 1,293	$ 1,687	$ 28	$ 4,007	$ 17,137
7300	91	Secretary		00970	N/S	$ 3,440	$ 218	$ 339	$ 1,687	$ 11	$ 2,255	$ 5,695
7730	91	Secretary		00971	N/S	$ 500	$ 34	$ -	$ -	$ -	$ 34	$ 534
5200	52000	Teacher Exceptiona		00972		$ 11,957	$ 912	$ 1,178	$ 1,406	$ 12	$ 3,508	$ 15,464
5200	52000	Teacher Exceptiona		00973		$ 10,165	$ 778	$ 1,001	$ -	$ -	$ 1,779	$ 11,943
7300	73001	Principal Elementa		00974		$ 20,670	$ 1,589	$ 2,245	$ 1,687	$ 121	$ 5,642	$ 26,312
6120	61231	Counselor Elementa		00975		$ 7,830	$ 595	$ 782	$ 1,294	$ 12	$ 2,682	$ 10,511
6120	61231	Counselor Elementa		00976		$ 10,885	$ 830	$ 1,065	$ 1,265	$ 12	$ 3,172	$ 14,057
5200	52018	Speech Language Pa		00977		$ 8,923	$ 683	$ 879	$ 1,687	$ -	$ 3,249	$ 12,172
5200	52000	Teacher Exceptiona		00978		$ 12,188	$ 933	$ 1,201	$ 1,687	$ 31	$ 3,852	$ 16,039
5200	52000	Teacher Exceptiona		00979		$ 13,186	$ 1,009	$ 1,299	$ 1,687	$ 21	$ 4,016	$ 17,202
5200	52000	Teacher Exceptiona		00980		$ 5,626	$ 415	$ 554	$ 1,687	$ 11	$ 2,667	$ 8,294
6140	63102	Specialist Staffin		00981		$ 3,238	$ 246	$ 317	$ 422	$ 5	$ 989	$ 4,227
6110	61131	School Social Work		00982		$ 7,743	$ 529	$ 763	$ 1,265	$ 10	$ 2,567	$ 10,310
7300	73001	Principal Elementa		00983		$ 16,974	$ 1,299	$ 2,215	$ 1,687	$ 30	$ 5,232	$ 22,206
5200	52000	Teacher Exceptiona		00984		$ 17,603	$ 1,338	$ 1,734	$ 1,687	$ 53	$ 4,813	$ 22,415
5200	52000	Teacher Exceptiona		00985		$ 14,642	$ 1,122	$ 1,442	$ 1,687	$ 44	$ 4,295	$ 18,937
6400	52000	Teacher Exceptiona		00986		$ 374	$ 29	$ 37	$ -	$ -	$ 66	$ 440
5200	52000	Teacher Exceptiona		00987		$ 6,611	$ 491	$ 651	$ 1,406	$ 12	$ 2,561	$ 9,172
		FUND 100 TOTAL				$ 9,578,207	$ 713,059	$ 980,680	$ 1,239,708	$ 24,722	$ 2,958,173	$ 12,536,374

Purchased Services -- Professional and Technical Services (Object 310) Detail **Appendix 5**

District:	
For the Quarter Ending:	

Group and Total each Service (Therapies, Psychological, Social, Nursing, and Augmentative Devices).

Contractor Name or Payee	Service Type	Method of Payment	Amount Paid	Contract Period
Children's Psycological Service	Psy	T	$ 13,305	07/01/09 - 06/30/10
Smith Therapy Services	OT	T	$ 4,576	07/01/07 - 06/30/08
McGee, Angelia	S/L	T	$ 3,663	07/01/07 - 06/30/08
		Total	$ 21,544	

(1) Method of Payment: Enter "T" for Time (Hourly), "E" per Evaluation, "S" per Student or Case.
(2) If several paymnets with the same method of payment are paid to the same payee during the quarter, then only one line with the total amount paid is required.
(3) Contract period is the period of the contract with the vendor, not the claiming period.

FILE WITH CLAIM

Release 012

District:
For the Quarter Ending:

District Cost Allocation, Object 300 Less 310, 400, and 500 Costs

Personnel Claimed by Function	Salaries Claimed	Benefits Claimed	Total Claimed	Total Function Salaries	Total Function Benefits	Function Total	Percent Claim to Function	Object 300-400-500	Allocated 300-400-500
5000			$ -	$ 530,087	$ 142,249	$ 672,336	0.00%	$ 1,174,613	$ -
5100			$ -	$ 39,151,231	$ 12,220,177	$ 51,371,408	0.00%	$ 267,059	$ -
5200	$ 5,562,811	$ 1,732,803	$ 7,295,614	$ 8,875,300	$ 2,939,558	$ 11,814,858	61.75%	$ 22,925	$ 14,156
5300			$ -	$ 1,496,569	$ 446,195	$ 1,942,764	0.00%	$ 10,183	$ -
5400			$ -			$ -	0.00%	$ -	$ -
5500			$ -			$ -	0.00%	$ -	$ -
5900			$ -			$ -	0.00%	$ -	$ -
6000			$ -			$ -	0.00%	$ -	$ -
6100			$ -	$ 52,338	$ 16,383	$ 68,721	0.00%	$ 9,539	$ -
6110	$ 171,636	$ 50,705	$ 222,341	$ 191,526	$ 56,752	$ 248,278	89.55%	$ 3,065	$ 2,745
6120	$ 1,576,067	$ 466,495	$ 2,042,562	$ 1,760,258	$ 532,582	$ 2,292,840	89.08%	$ 1,257	$ 1,120
6130	$ 367,970	$ 137,037	$ 505,007	$ 382,877	$ 146,701	$ 529,578	95.36%	$ 5,990	$ 5,712
6140	$ 250,872	$ 75,857	$ 326,729	$ 260,962	$ 72,812	$ 333,774	97.89%	$ 1,525	$ 1,493
6150			$ -			$ -	0.00%	$ -	$ -
6190			$ -			$ -	0.00%	$ -	$ -
6200			$ -	$ 947,840	$ 301,214	$ 1,249,054	0.00%	$ 13,002	$ -
6300	$ 197,789	$ 60,058	$ 257,847	$ 639,285	$ 183,265	$ 822,550	31.35%	$ 8,594	$ 2,694
6400 (1)	$ 3,821	$ 658	$ 4,479	$ 375,908	$ 114,560	$ 490,468	0.91%	$ 26,431	N/A
6500			$ -	$ 553,536	$ 167,337	$ 720,873	0.00%	$ 16,786	$ -
7000			$ -			$ -	0.00%	$ -	$ -
7100			$ -	$ 116,418	$ 38,571	$ 154,989	0.00%	$ 8,770	$ -
7200			$ -	$ 338,844	$ 96,844	$ 435,688	0.00%	$ 3,461	$ -
7300	$ 1,442,556	$ 434,245	$ 1,876,801	$ 5,438,851	$ 1,811,818	$ 7,250,669	25.88%	$ 54,691	$ 14,154
7400			$ -			$ -	0.00%	$ 6,592	$ -
7500			$ -	$ 353,772	$ 117,002	$ 470,774	0.00%	$ 10,302	$ -
7600			$ -	$ (72)	$ (13)	$ (85)	0.00%	$ -	$ -
7700			$ -	$ 7,353	$ 802	$ 8,155	0.00%	$ -	$ -
7710			$ -	$ 8,693	$ 3,184	$ 11,877	0.00%	$ 682	$ -
7720			$ -			$ -	0.00%	$ -	$ -
7730	$ 4,750	$ 341	$ 5,091	$ 406,178	$ 332,118	$ 738,296	0.69%	$ 47,657	$ 329
7740			$ -			$ -	0.00%	$ -	$ -
7750			$ -			$ -	0.00%	$ -	$ -
7760			$ -	$ 171,775	$ 61,419	$ 233,194	0.00%	$ 26,344	$ -
7790			$ -			$ -	0.00%	$ -	$ -
7800			$ -	$ 2,617,162	$ 1,447,016	$ 4,064,178	0.00%	$ 1,064,430	$ -
7900			$ -	$ 2,460,985	$ 1,165,595	$ 3,626,580	0.00%	$ 5,967,778	$ -
8100			$ -	$ 1,333,949	$ 455,590	$ 1,789,539	0.00%	$ 679,976	$ -
8200			$ -	$ 385,727	$ 118,798	$ 504,525	0.00%	$ 134,322	$ -
9100			$ -	$ 135,480	$ 43,575	$ 179,055	0.00%	$ 30,035	$ -
9200			$ -			$ -	0.00%	$ -	$ -
9700			$ -			$ -	0.00%	$ -	$ -
Total	$ 9,578,272	$ 2,958,199	$ 12,536,471	$ 68,992,832	$ 23,032,104	$ 92,024,936		$ 9,596,009	$ 42,403
	CORRECT	CORRECT		CORRECT	CORRECT			CORRECT	

(1) IF Reimbursement is claimed here, then put the POSITIVE amount of salaries and benefits claimed in cells D54 and E54 The formulas in D55 and E55 will subtract these previously claimed amounts above from Total 6400 salaries and benefits that are to be allocated. This is necessary to avoid both claiming the costs above and being included in J55

FILE WITH CLAIM

Function 6400 Staff Training Allocation

	Salaries	Benefits	Prof & Tech	ther Allowabe 30	400	500	Total
Total 6400 Costs	$ 62,149	$ 9,958	$ 12,634	$ 10,066		$ 398	$ 95,205
CLAIMED 6400 7	$ 3,821	$ 658					$ 4,479
Net Costs	$ 58,328	$ 9,300	$ 12,634	$ 10,066	$ -	$ 398	$ 90,726
							CORRECT

Salaries / Benefits Claimed	$ 12,536,471	13.62%
District Salaries and Benefits-Fund 100	$ 92,024,936	

Claimed $ 12,357

Release 012

Cost Pool Summary

District:						
For the Quarter Ending:						
	Expenditures					
Job Classification	Salaries 100	Benefits 200	Pro. & Tech. 310	300-400-500	Training	Total
Adm ESSS Area	$ 91,510	$ 24,016				$ 115,526
Assistant Clinic 1	$ 141,187	$ 70,060				$ 211,247
Assistant Principa	$ 491,948	$ 144,422				$ 636,370
Counselor Elementa	$ 482,737	$ 142,123				$ 624,860
Counselor High	$ 653,941	$ 190,961				$ 844,902
Counselor Middle	$ 408,066	$ 118,654				$ 526,720
Educ Interpreter	$ 45,275	$ 19,602				$ 64,877
Principal Elementa	$ 747,608	$ 211,525				$ 959,133
Principal ESE Cent	$ 42,669	$ 12,412				$ 55,081
School Board Nurse	$ 211,526	$ 59,056				$ 270,582
School Psychologis	$ 189,316	$ 57,866	$ 13,305			$ 260,487
School Social Work	$ 171,636	$ 50,705				$ 222,341
Specialist Augment	$ 26,922	$ 8,132				$ 35,054
Specialist Staffin	$ 61,556	$ 17,991				$ 79,547
Speech Language Pa	$ 868,107	$ 269,410	$ 3,663			$ 1,141,180
Teacher Exceptiona	$ 4,461,520	$ 1,393,495				$ 5,855,015
Teacher Homebound	$ 29,857	$ 6,912				$ 36,769
Therapist Occupati	$ 121,748	$ 34,300	$ 4,576			$ 160,624
Therapist Physical	$ 39,105	$ 9,401				$ 48,506
Vision Assistant	$ 16,757	$ 8,027				$ 24,784
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
Supervisory and Clerical Support	$ 275,281	$ 109,129				$ 384,410
Allocated 300-400-500 Costs				$ 42,403		$ 42,403
						$ -
6400 Costs					$ 12,357	$ 12,357
Total Program Costs	$ 9,578,272	$ 2,958,199	$ 21,544	$ 42,403	$ 12,357	$ 12,612,775
			CORRECT	CORRECT	CORRECT	OKAY, ROW AND COLUMN TOTALS MATCH

FILE WITH CLAIM
Release 012

Note: List and group sampled school district personnel by actual primary school district title.

Billing Provider Costs
OPTIONAL

District:	
For the Quarter Ending:	

Billing Providers	Salaries	Benefits	Purchased Services	Total Salaries, Benefits and Contract	Indirect % 3.55%	Act 10 Elig.	16.05% 24.20%	FMAP 67.64%	State Matching Share
Augmentative Specialist	$ 26,922	$ 8,132		$ 35,054	$ 36,298		$ 1,410	$ 954	$ 456
Counselor	$ 1,544,744	$ 451,738		$ 1,996,482	$ 2,067,357		$ 80,298	$ 54,314	$ 25,984
Health Aides	$ 141,187	$ 70,060		$ 211,247	$ 218,746		$ 8,496	$ 5,747	$ 2,749
Occupational Therapist / COTA	$ 121,748	$ 34,300	$ 4,576	$ 160,624	$ 166,326		$ 6,460	$ 4,370	$ 2,090
Physical Therapist / PTA	$ 39,105	$ 9,401		$ 48,506	$ 50,228		$ 1,951	$ 1,320	$ 631
Psychologist	$ 189,316	$ 57,866	$ 13,305	$ 260,487	$ 269,734		$ 10,477	$ 7,087	$ 3,390
RN / LPN / Nurse Assistant	$ 211,526	$ 59,056		$ 270,582	$ 280,188		$ 10,883	$ 7,361	$ 3,522
Social Worker	$ 171,636	$ 50,705		$ 222,341	$ 230,234		$ 8,943	$ 6,049	$ 2,894
Speech-Language Pathologist	$ 868,107	$ 269,410	$ 3,663	$ 1,141,180	$ 1,181,692		$ 45,898	$ 31,045	$ 14,853
				$ -	$ -		$ -	$ -	$ -
				$ -	$ -		$ -	$ -	$ -
				$ -	$ -		$ -	$ -	$ -
				$ -	$ -		$ -	$ -	$ -
Total Billing Providers	$ 3,314,291	$ 1,010,668	$ 21,544	$ 4,346,503	$ 4,500,803		$ 174,816	$ 118,247	$ 56,569
Non-billing Providers									
Assistant Principal, Elementary	$ 491,948	$ 144,422		$ 636,370					
ESE Administrators	$ 91,510	$ 24,016		$ 115,526					
ESE Center Principals	$ 42,669	$ 12,412		$ 55,081					
ESE Teachers	$ 4,461,520	$ 1,393,495		$ 5,855,015					
ESE Teacher Homebound	$ 29,857	$ 6,912		$ 36,769					
Interpreter	$ 45,275	$ 19,602		$ 64,877					
Principal, Elementary	$ 747,608	$ 211,525		$ 959,133					
Program/Staffing Specialist	$ 61,556	$ 17,991		$ 79,547					
Vision Assistant	$ 16,757	$ 8,027		$ 24,784					
				$ -					
				$ -					
				$ -					
Total Non-billing Personnell	$ 5,988,700	$ 1,838,402	$ -	$ 7,827,102					
Supervisory and Clerical Support	$ 275,281	$ 109,129		$ 384,410					
Salaries, Benefits and Pro & Tech 310	$ 9,578,272	$ 2,958,199	$ 21,544	$ 12,558,015			$ 174,816	$ 118,247	$ 56,569
	CORRECT	CORRECT	CORRECT	$ 12,558,015	CHECK				

Quarterly Summary	Federal	State	Total
July September	$ 37,106	$ 17,753	$ 54,859
October December	$ 175,845	$ 84,127	$ 259,972
January March	$ 148,452	$ 71,020	$ 219,472
April June	$ 95,260	$ 45,573	$ 140,833
State Fiscal Year Total	$ 456,663	$ 218,473	$ 675,136

Medicaid Administrative Claiming System (MACS) Claim Component, Release 012.

CHAPTER 7

PREPARING A CLAIM FOR MEDICAID PAYMENT

Overview

The sampling percentages for staff identified in Chapter 3 and compiled as shown in Chapter 6 along with the total costs for activities detailed in Chapter 6 Cost Pool Summary will be the basis for a school district to receive reimbursement under the School District Administrative Claiming (SDAC) program.

The following is a general outline of costing factors and considerations necessary for completion of quarterly invoices.

- Enhanced reimbursement, if allowed, for medical professionals and their direct support staff will be available only when these qualified individuals are specifically identified by the sampling techniques described in Chapter 4. It should be noted that the 75 percent enhanced FFP is not allowed by CMS effective January 1, 2003 forward.

- Total SDAC program costs or cost pool will have four categories determined by the resultant time study activity codes and type of personnel who performed them:

    1. Non-discounted activities that qualify for 50 percent reimbursement;
    2. Discounted activities that qualify for enhanced or 75 percent reimbursement;
    3. Non-discounted activities that qualify for enhanced or 75 percent reimbursement; and
    4. Discounted activities that qualify for 50 percent reimbursement.

Note: While the SPMP (Skilled Professional Medical Personnel) funding-75% categories are still shown on the claim, the school districts are not reimbursed at the 75% level.

SDAC Invoice

Appendix 1 is the sample invoice for reimbursement purposes. The net cost from the cost Pool Summary (Appendix 7, Chapter 6) will be multiplied by the percentages from reimbursable activities listed in Chapter 6, Appendix 2. The categories listed above will be created by those reimbursable activities that either need discounting by Medicaid eligibility or don't need this factoring. Once those two categories are created, then those activities that qualify for the enhanced FFP, if allowed, can be calculated with the sampled percentages. It should be noted that the 75 percent enhanced funding is not available for claiming periods after January 1, 2003.

Medicaid Eligibility

Certain sampled activities must be factored by the percentage of Medicaid eligible students in the total student population in each school district or special school. Calculation of the Medicaid student population can be accomplished by one of the following two procedures:

1. The following method of eligibility (Appendix 2) is prepared quarterly by AHCA and made available to each participating school district:

a. For all Florida counties, perform a query with the Agency's DSS (Decision Support System) database to count the number of Medicaid eligible individuals between the ages of 3 and 19 for each month in a quarter,
b. Total the months and derive the county monthly average for the months in the quarter, and
c. Calculate Medicaid eligibility by dividing the monthly averaged Medicaid eligibles by the total county PK through 12 student population from the most recent Florida Department of Education publication.

2. A school district may calculate the Medicaid eligibility of its exceptional student population by determining eligibility for each ESE enrolled student through the state's fiscal agent. Examples could be charter and specialty schools enrolled in the program or other districts with these capabilities. Any district or special school using this method must have prior Headquarters approval.

Certification Forms

All invoices submitted must include the local share certification form. A copy of this form is included as Appendix 3 in this chapter.

Appendix 4 is a direct services billing certification that is required for each district to retain the reimbursement from the sampling percentage derived from Activity 5, Care Planning and Coordination for Medical/Mental Health Services. A school district or special school needs to certify that referrals for direct services on campus by district or special school staff is done to a participating Medicaid provider. School districts, must present documentation that the billing requirements are met through a community participating Medicaid provider. Refer to the "note" under activity code 5 in Chapter 2 for definition of "participating provider."

Invoice Back-up

Each invoice will need the following data attached when submitted for reimbursement:

1. A summary of the time studies. (Chapter 6, Appendix 1)
2. General administration allocation. (Chapter 6, Appendix 2)
3. District quarterly expenditures. (Chapter 6, Appendix 3)
4. Personnel costs by person and job category. (Chapter 6, Appendix 4) Does not need to be submitted with claim, but available upon request.
5. Purchase of service, object 310 list of claimable contract costs. (Chapter 6, Appendix 5)
6. 300-400-500 Allocation. (Chapter 6, Appendix 6)
7. Cost Pool Summary. (Chapter 6, Appendix 7)
8. Administrative claiming invoice. (Chapter 7, Appendix 1)
9. A copy of all financial allocations with written explanations available upon request.
10. A signed and dated quarterly certification of state expenditures. (Chapter 7, Appendix 3)
11. A signed and dated quarterly certification of direct services billing. (Chapter 7, Appendix 4)
12. A cover letter on the school districts letterhead.

Mailing Instructions

The completed invoice with the above mentioned back-up should be signed and mailed to the following address:

Agency for Health Care Administration
Medicaid Program Analysis
School Based Services
Medicaid Program Finance
2727 Mahan Drive, Mail Stop 23
Tallahassee, Florida 32308-5403

Timely Filing Requirements

Implementing Federal regulations for timely filing of quarterly claims are specifically provided for by 45 CFR 95.1-34, Subpart A. Per the regulation, Federal reimbursement is available if the state (AHCA) files a claim for expenditures within two years after the calendar quarter in which the district made the expenditure. The expenditure is not considered filed until it is received by CMS on the CMS-64 Expenditure Report, due within thirty days after any quarter has ended. Therefore, in order to meet the two-year timely filing limit for a claim, a district or special school must submit the claim to the Agency in such a timely manner so that it can be received by CMS within two years from the last day of the last month in the claimed quarter. Adjustments or revisions to a previously paid claim have the same two-year timely filing requirement as an original paid claim.

Audit File

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

1. Sample pool participants by function, job code, title, name, unique number, location or phone number or equivalent electronic record
2. Signed original time study forms
3. A copy of the summary of time study 4. Any computations or allocations used in reimbursement calculation
5. A detailed listing of all revenues offset from the claim, by source
6. A copy of the eligibility percentage computation if a district chooses to use the calculated Medicaid eligible ESE population divided by ESE population
7. Copies of all training materials given to staff
8. Names of attendees and instructors for the training session given for that quarter
9. A completed quarterly claim
10. A copy of the warrant and remittance
11. Approved Chapter 3, Appendix 3 Job Title/Job Code form.

Records Retention

The above audit files should be retained by each school district for a period of three years after each quarterly claim is filed to Medicaid, unless an ongoing audit or resolution of an audit exception is in process.

Technical Support

Questions concerning costing methodology, allowance of costs, eligibility calculation, and other claim preparation concerns should be directed to:

Jim Robinson
School Based Services
Medicaid Program Finance
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 23
Tallahassee, Florida 32308
(850) 412-4109, Fax 850 922-5172
Jim.Robinson@AHCA.MyForida.com

SCHOOL DISTRICT ADMINISTRATIVE CLAIMING INVOICE

School District	
For the quarter ending	

IDEA Indirect Rate in Effect: 3.55%

Medicaid Eligibility	24.20%

	CORRECT Salaries	CORRECT Other Costs	Total	Reimb. To Costs %
Total Costs	$ 9,578,272	$ 3,034,503	$ 12,612,775	2.01%
	75.94%	24.06%	100.00%	

Non-Discounted, NON-SPMP, Reimbursed at 50 %

	%	Salaries Gross Claimable	Other Gross Claimable	Total
(1A) Medicaid Outreach	0.2378%			
(1B) Enhanced Medicaid Outreach at 50 %*	0.0000%			
(3) Facilitate Medicaid Application	0.0000%			
(8A) Coordination AHCA/Contractors	0.1189%			
Sub-Total	0.3567%	$ 34,166	$ 10,824	$ 44,990

Non-Discounted, SPMP, Reimbursed at 75 %***

	%	Salaries Gross Claimable	Other Gross Claimable	Total
(8B) Enhanced Coordination AHCA/Contract	0.0000%			
Sub-Total	0.0000%	$ -	$ -	$ -

Discounted, NON-SPMP, Reimbursed at 50 %

	%
(5A) Care Planning/Coordinating	12.6040%
(6) Client Assistance	0.0000%
(7A) CHCU Training **	0.8323%
(7B) Enhanced CHCU Training ***	0.0000%
(9A) Program, Planning and Development	1.0702%
Sub-Total	14.5065%
Medicaid Eligibilty %	24.20%
Claimable %	3.5106%

	Salaries Gross Claimable	Other Gross Claimable	Total
Total Non-SPMP	$ 336,255	$ 106,529	$ 442,784
	$ 370,421	$ 117,353	$ 487,774

Discounted, SPMP Reimbursed at 75 %***

	%
(5B) Enhanced Care Planning/Coordinating	0.1189%
(9B) Enhanced Program Plannning and Devel	0.0000%
Sub-Total	0.1189%
Medicaid Eligibilty %	24.20%
Claimable %	0.0288%

	Salaries Gross Claimable	Other Gross Claimable	Total
	$ 2,759	$ 874	$ 3,633
Total SPMP	$ 2,759	$ 874	$ 3,633

SUMMARY

	50%	75%	TOTAL
GROSS CLAIMABLE	$ 491,407		$ 491,407
INDIRECT	$ 17,445		$ 17,445
TOTAL	$ 508,852		$ 508,852
NET CLAIMABLE	$ 254,426		$ 254,426

INDIRECT CALCULATION

GROSS CLAIM. COSTS	INDIRECT RATE	GROSS INDIRECT
$ 491,407	3.55%	$ 17,445

TOTAL CLAIMED	$ 254,426

Signature of Fiscal Officer: _____ Release 012

* Activities 1b and 7 b not enhanced per CMS
** Activities 7 a and 7 b discounted per CMS
*** Per CMS, 75% cannot be claimed effective Jan 1, 2003.

NUMBER OF MEDICAID ELIGIBLES AGES 3 TO 19 BY COUNTY
FOR THE JANUARY THROUGH MARCH 2011 QUARTER

		JANUARY	FEBRUARY	MARCH	TOTAL	AVG	2010 MEMBERSHIP	MEDICAID PER CENT
01	ALACHUA	14,372	14,426	14,445	43,243	14,414	27,495	52.42%
02	BAKER	2,422	2,398	2,425	7,245	2,415	5,004	48.26%
03	BAY	13,208	13,279	13,244	39,731	13,244	25,943	51.05%
04	BRADFORD	2,338	2,332	2,332	7,001	2,334	3,278	71.20%
05	BREVARD	29,889	30,067	30,265	90,221	30,074	71,866	41.85%
06	BROWARD	111,184	111,827	112,516	335,527	111,842	256,474	43.61%
07	CALHOUN	1,114	1,095	1,105	3,313	1,104	2,249	49.09%
08	CHARLOTTE	7,920	7,934	7,936	23,790	7,930	16,640	47.66%
09	CITRUS	8,756	8,768	8,772	26,296	8,765	15,676	55.91%
10	CLAY	10,947	10,935	10,955	32,836	10,945	35,812	30.56%
11	COLLIER	20,109	20,271	20,305	60,684	20,228	42,919	47.13%
12	COLUMBIA	6,381	6,398	6,408	19,186	6,395	9,810	65.19%
13	MIAMI-DADE	218,039	218,871	219,221	656,131	218,710	347,406	62.96%
14	DESOTO	3,610	3,605	3,640	10,855	3,618	4,938	73.27%
15	DIXIE	1,372	1,379	1,387	4,138	1,379	2,044	67.47%
16	DUVAL	72,279	72,446	72,715	217,440	72,480	123,995	58.45%
17	ESCAMBIA	25,599	25,498	25,456	76,553	25,518	40,227	63.44%
18	FLAGLER	6,446	6,492	6,508	19,446	6,482	12,931	50.13%
19	FRANKLIN	797	789	794	2,379	793	1,350	58.74%
20	GADSDEN	5,400	5,384	5,410	16,194	5,398	6,300	85.68%
21	GILCHRIST	1,333	1,338	1,336	4,007	1,336	2,636	50.68%
22	GLADES	483	478	477	1,437	479	1,439	33.29%
23	GULF	1,020	1,023	1,035	3,078	1,026	2,014	50.94%
24	HAMILTON	1,511	1,533	1,542	4,586	1,529	1,799	84.99%
25	HARDEE	3,757	3,774	3,770	11,301	3,767	5,036	74.80%
26	HENDRY	5,399	5,427	5,425	16,250	5,417	6,821	79.42%
27	HERNANDO	13,272	13,305	13,243	39,820	13,273	22,711	58.44%
28	HIGHLANDS	7,776	7,854	7,870	23,499	7,833	12,128	64.59%
29	HILLSBOROUGH	103,816	104,047	104,777	312,640	104,213	194,353	53.62%
30	HOLMES	2,188	2,195	2,202	6,585	2,195	3,374	65.06%
31	INDIAN RIVER	8,145	8,152	8,225	24,521	8,174	17,740	46.08%
32	JACKSON	3,920	3,961	3,950	11,831	3,944	7,161	55.08%
33	JEFFERSON	995	990	990	2,974	991	1,104	89.76%
34	LAFAYETTE	520	541	539	1,599	533	1,157	46.07%
35	LAKE	21,040	21,103	21,075	63,218	21,073	41,110	51.26%
36	LEE	42,999	43,239	43,742	129,980	43,327	81,965	52.86%
37	LEON	15,355	15,310	15,375	46,039	15,346	33,326	46.05%
38	LEVY	3,450	3,451	3,444	10,345	3,448	5,737	60.10%
39	LIBERTY	681	689	692	2,062	687	1,462	46.99%
40	MADISON	2,007	2,017	1,995	6,018	2,006	2,720	73.75%
41	MANATEE	21,286	21,328	21,444	64,058	21,353	44,249	48.26%
42	MARION	26,794	26,856	26,860	80,509	26,836	41,961	63.95%
43	MARTIN	6,699	6,702	6,769	20,169	6,723	18,170	37.00%
44	MONROE	2,766	2,743	2,765	8,273	2,758	8,356	33.01%
45	NASSAU	4,269	4,266	4,291	12,826	4,275	11,100	38.51%
46	OKALOOSA	10,050	10,071	10,118	30,239	10,080	28,695	35.13%
47	OKEECHOBEE	4,374	4,379	4,391	13,144	4,381	6,789	64.53%
48	ORANGE	90,310	91,041	91,314	272,664	90,888	175,986	51.65%
49	OSCEOLA	29,605	29,824	29,936	89,365	29,788	53,466	55.71%
50	PALM BEACH	77,975	78,337	78,681	234,992	78,331	174,659	44.85%
51	PASCO	30,434	30,398	30,419	91,250	30,417	66,994	45.40%
52	PINELLAS	51,338	51,528	51,599	154,464	51,488	104,001	49.51%
53	POLK	53,671	53,895	53,978	161,544	53,848	95,178	56.58%
54	PUTNAM	8,744	8,704	8,718	26,166	8,722	11,244	77.57%
55	SAINT JOHNS	6,529	6,500	6,601	19,629	6,543	30,708	21.31%
56	SAINT LUCIE	22,015	22,095	22,208	66,317	22,106	39,259	56.31%
57	SANTA ROSA	8,395	8,388	8,428	25,210	8,403	25,533	32.91%
58	SARASOTA	17,533	17,563	17,616	52,711	17,570	40,899	42.96%
59	SEMINOLE	20,360	20,439	20,568	61,367	20,456	64,228	31.85%
60	SUMTER	3,795	3,832	3,861	11,488	3,829	7,626	50.21%
61	SUWANNEE	4,234	4,269	4,246	12,748	4,249	6,172	68.84%
62	TAYLOR	2,028	2,024	1,987	6,039	2,013	3,153	63.84%
63	UNION	1,179	1,185	1,198	3,562	1,187	2,281	52.04%
64	VOLUSIA	34,112	34,184	34,276	102,572	34,191	61,559	55.54%
65	WAKULLA	1,934	1,943	1,944	5,820	1,940	5,151	37.66%
66	WALTON	2,995	3,021	3,045	9,060	3,020	7,343	41.13%
67	WASHINGTON	2,185	2,174	2,135	6,494	2,165	3,491	62.02%
	TOTAL	1,347,442	1,352,295	1,356,925	4,056,679	1,352,225	2,636,401	51.29%

Quarterly Certification of State Expenditures
By Schools and School Districts

Agency for Health Care Administration
Medicaid Program Finance
School Based Services
2727 Mahan Drive, Bldg. 3, Mail Stop 23
Tallahassee, FL 32308

To whom it may concern,

As financial officer of the _____, I am
(Name of School or School District)
charged with the duties of supervising the administration of the school district's accounting system for the school district claiming activities and services provider under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school or school district has expended the state share of public, non-federal funds needed to match the federal share of Medical claims billed to the state Medicaid agency for School District services provided to and on behalf of eligible Medicaid students during the _____ quarter.
(Month/Year Certified)

I also certify that the school or school district's certified expenditures were incurred in accordance with provisions of Florida's policies for the services. These certified expenditures are separately identified and supported in our accounting system.

_____
Name

_____
Signature

_____
Title

_____
Date

Direct Services Billing Certification

Federal guidelines effective October 1, 2003, require that for reimbursement for administrative activities relating to referral and coordinating activities, the district or special school must ensure that the service is referred to a participating Medicaid provider. This applies to referrals for services rendered on campus by district staff. Service referrals for physician or other care not rendered on campus are automatically covered under federal rules since all Medicaid recipients are either HMO or MediPass enrolled or in some other form of Medicaid covered health care. October 1, 2003, revisions to the Florida School District Administrative Program Claiming Guide (Guide) require that each school district or special school participating in the administrative claiming program must be enrolled as a Medicaid fee for service provider in the fee for service program for referrals to district or special school staff to be reimbursed for . Claims referred to a participating Medicaid provider for therapies, behavioral, and nursing services must be for dates of service in the administrative claiming quarter being claimed. A district or special school that is not a participating fee for service provider for district or special school referrals or does not refer eligible students to a community participating Medicaid provider will not be reimbursed for any Activity Code 5 involvement.

I certify that _____
(School District or Special School Name)

is a participating Medicaid provider and will submit fee for service therapy, behavioral and nursing claims for dates of service during the _____ quarter
(Quarter Claimed)

in compliance with the CMS-1500 claiming handbook or refer eligible Medicaid students to a participating Medicaid provider.

This signature also ensures that there is no duplication between the SDAC program and the Medicaid Certified School Match program.

_____
Name (please print)

_____
Signature

_____
Title

_____
Date

CHAPTER 8

AHCA MONITORING AND QUALITY CONTROL

Overview

Ongoing evaluation of the School District Administrative Claiming (SDAC) program is a federal requirement. Medicaid Area Office School Specialist will have certain responsibilities for monitoring and quality control functions as defined earlier in Chapter 4. AHCA headquarters staff will provide direct supervision, necessary monitoring tools and other needed assistance for these functions.

Monitoring Activities

Medicaid Area Office School Specialist will need to review the contents of the quarterly audit files that contain the approved job title certifications and original time study questionnaires for each participating school district in their respective area. Districts that use an electronic time study will be required to provide the functional equivalent documentation as required by the paper RMS time study. The method of acquiring time study information (either paper or electronic RMS) will not change the requirements in this guide.

Medicaid Area Office School Specialist will perform the following duties each quarter:

- Review the district's quarterly master list of sample pool personnel and support personnel to verify district job title certification forms are completed and approved when requested by headquarters staff,
- Review FMMIS files to ensure that fee for service participation for therapies, nursing, and behavioral services are occurring during the administrative quarter being claimed,
- Review the original RMS questionnaires or electronic RMS records to determine whether any discrepancies exist,
- Report monitoring findings to AHCA headquarters and each school district,
- Tabulate activities by district and submit to Headquarters staff,
- Additional school district review deemed necessary by headquarters staff to maintain program compliance as required by this guide, and
- Attend and monitor all training sessions..

Place and Time of Review

Medicaid Area Office School Specialist will have the option of either reviewing the RMS questionnaires or time study logs at the school district or at the representative's area office. The original samples must be made available by the school districts for review by the end of the second month following the quarter under review.

Monitoring Time Frames

Medicaid Area Office School Specialist must complete their review and return each district's RMS questionnaires or other electronic data requested by the end of the third month of the quarter under review (e.g. Quarter: January to March; review should be completed by March). For larger districts, this review may be done monthly.

Original Sample Forms

Medicaid Area Office School Specialist will review only the original RMS questionnaires or appropriate electronic information after the completed sample data has been provided by either the Data Manager or a District Contact district coder. Sample forms cannot be tabulated for reimbursement until this review has been completed. RMS questionnaires that are lost may be duplicated from a master copy, if it exists, and re-sent to the individual. This copy must be suitably marked, as "Lost Original-Copy is Original." School districts that do not produce the original sample forms for monitoring purposes to the area office school services representatives will have future invoices deferred until reviewed. Copies of the completed forms are not acceptable for review. Only copies of the blank form with the proper labeling as discussed above will be accepted for reimbursement.

School District Notification

Medicaid Area Office School Specialist must notify each school district contact person with the results of each monitoring no later than 30 days after the review of time study logs or RMS forms have been reviewed. Deficiencies disclosed and discussed should show significant improvement on subsequent monitoring. Repetitive deficiencies may result in withholding of or a reduction in Medicaid payments.

School District Administrative Claiming (SDAC) Sample Universe

As a general rule, school district staff spending time on any of the Medicaid reimbursable SDAC activities described in Chapter 2 of the SDAC guide may be included in the SDAC sample pool. (3-1)

LEA Tip: Using the appropriate quarter date range, a query should be run utilizing district employee management software. The query should include positions likely to perform outreach activities as identified by the district or certified through the Medicaid office. Employees who are fully funded by federal sources must be excluded from this report. Please note: The query may include contracted personnel as well as vacant positions likely to be filled during the quarter. Reviewing the list of outreach activities in Chapter 2 of the SDAC guide with leadership and department heads is key to ensuring the sample pool is comprehensive.

***Examples* of Job Categories that Might be Included in the SDAC Sample Pool**

Employed or contract school district staff within the following job categories could reasonably be expected to perform SDAC reimbursable activities without certification. (3-1)

1. Speech-Language Pathologists and Speech-Language Pathology Assistants
2. Audiologists and Audiology Assistants
3. Occupational Therapists and Occupational Therapist Assistants
4. Physical Therapists and Physical Therapist Assistants
5. Behavior Analysts
6. Social Workers
7. Psychologists and Interns
8. Counselors
    a. Guidance
    b. Marriage and Family Therapist
    c. Mental Health
9. Diagnosticians
10. Physicians
11. Nurses
    a. Advanced Registered Nurse Practitioner
    b. Registered Nurse
    c. Licensed Practical Nurse
    d. School Health Aides
    e. Health Specialists
12. Interpreters
13. Orientation and Mobility Specialists
14. Bilingual Specialists
15. Program and Staffing Specialists
16. Substance Abuse Specialist
17. Administrators for Exceptional Student Education (ESE)
18. Augmentative Specialists
19. Dietitians
20. Respiratory Therapists
21. Liaisons and Related ESE Teachers

*In addition to the list above, a district may include Paraprofessionals, School Resource Officers, Supervisors, Coordinators, Directors, Administrators, Elementary Principals, Center School Principals, or other positions likely to perform outreach activities.

Please refer to **"Who Should Not be Included in the SDAC Sample Pool"** (3-2) to determine if a Job Title Certification Form, District Job Description, and Outreach Activities Checklist must be emailed to SDAC@ahca.myflorida.com for approval.

JOB TITLE CERTIFICATION

SCHOOL DISTRICT: _____

DISTRICT JOB TITLE: _____

FLDOE JOB CODE: _____

Please select one:
SAMPLED STAFF (YES) _____ SUPPORT STAFF (YES) _____

This is to certify for the job title identified above, that the personnel on the attached list perform the Medicaid administrative claiming reimbursable duties or provide clerical support to those that perform Medicaid administrative activities in accordance with Chapter 3 of the federally approved School District Administrative Claiming (SDAC) Guide. District job title refers to the title the district has given or assigned to the title in question and is used by the district to report expenditures to the Florida Department of Education (FLDOE). The district job code equivalent is not acceptable for this certification. It must be the assigned FLDOE job code. The district is asked to identify the source of the job title and code.

I am aware that further review of the title and listed participants in either the sample pool or support staff by appropriate federal or state officials may disallow the inclusion of these personnel with their associated costs and adjust reimbursement claims for the disallowance as claimed. Said judgment as to non-inclusion of this job title class or specific personnel within this class for reimbursement purposes from federal and state officials will be in compliance with specific existing federal policies or the guide. Tests for allowability may be evaluation of this title's sampling results for reimbursable utilization, direct interview of the listed personnel by Medicaid staff, or other tests deemed necessary by appropriate federal or state officials to insure compliance with the guide.

Attached are the official job duties and responsibilities as they relate to reimbursable activities identified in Chapter 2 of the SDAC guide for this job title and a list of personnel with this job title currently being claimed under the School District Administrative Claiming Program. Also attached is additional school district documentation substantiating the job titles inclusion in the sample pool or as support staff included in the claim's cost pool. These documents, after AHCA approval, are to be filed in the school district audit file.

_____
Name (Print)

_____
Signature

_____
Title

_____
Date

AHCA Headquarters School-Based Medicaid Staff

_____ _____
Signature/Approval Date

Job Title _____

Job Code Number _____

Examples of Outreach Activities

Circle or highlight those activities that apply to this job title.

- Reviewing a student's medical history for the purpose of placement in a special needs program,
- Determining if a student needs a medical referral,
- Participating health or behavioral care planning and coordination for a student population,
- Developing strategies to improve the coordination and delivery of health and behavioral services to students,
- Developing and maintaining tracking systems to assess the effectiveness of health and behavioral programs and services,
- Assisting in early identification of children with special medical or mental health needs through various child find activities,
- Encouraging families to access medical/mental health services provided by health plans,
- Informing eligible or potentially eligible students on the range of covered Medicaid services and how to access those services,
- Assisting a student or family in applying for a health or behavioral program covered by Medicaid,
- Assisting a student or family in completing a Medicaid application, or referring them to the local assistance office.
- Coordinating or monitoring the delivery of health or behavioral services for an individual,
- Coordinating medical/mental health services for a student with special needs in the least restrictive environment,
- Gathering and providing any information that maybe required for health/behavioral referrals or evaluations,
- Monitoring and evaluating the medical components of a student's IEP,
- Participating in IEP meetings or student staffing meetings to coordinate or review a student's need for health or behavioral services,

- Providing information about health and developmental screenings at school that would help in identifying medical conditions that can be corrected by services covered by Medicaid,
- Verifying a student's Medicaid eligibility status,
- Coordinating or monitoring the delivery of health or behavioral services of a program,
- Synchronizing or linking the health or behavioral services for a student or family to carry out and maintain a health service plan,
- Arranging for support services such as translation assistance and transportation to help a student or family access health or behavioral services,
- Conducting, coordinating or participating in training events or seminars designed to assist district staff in performing health and behavioral outreach activities,
- Conducting, coordinating or participating in training events or seminars designed to inform staff about how to find, screen and refer students with special needs for health and behavioral services,
- Participating in training that improves the quality of identification, referral and coordination of care for children with special needs,
- Working with Medicaid resources to make an effort to locate and develop health service referral relationships.

SDAC RMS REVIEW SUMMARY

School District:

Quarter (Month to Month, Year):

Date Review Completed:

Random Moment Sample (RMS) Count	
RMS Forms Received	
RMS Forms Accepted	
Discrepancies	
Errors	
Invalid Forms	

Discrepancies Resulting in an Updated Code

Activity Description	Participant Name	Job Title	District Code	Updated Code	Guide Reference
1.					*Choose an item.*
2.					*Choose an item.*
3.					*Choose an item.*

Non-Reimbursable RMS Form Errors

Participant Name	Job Title	District Code	Error Description

Invalid RMS Forms

Participant Name	Job Title	District Code	Reason Form was Voided
			Choose an item.

Additional Comments:

SDAC RMS REVIEW SUMMARY

COUNT OF RMS SAMPLING ACTIVITIES

District	Baker

Quarter	Quarter 3 (July – September) 2023

Code	Activity	Count
1	Outreach to the Medicaid Program	
2	Outreach to Non-Medicaid Programs	
3	Facilitating an Application for Medicaid	
4	Facilitating an Application for Non-Medicaid Programs	
5	Care Planning and Coordination for Medical/Mental Health Services	
6	Client Assistance to Access Medicaid Services	
7	Child Health Check-Up (CHCUP) Training	
8	Coordination with AHCA and Contracted Medicaid Providers	
9	Program Planning, Development, and Monitoring	
10	Direct Medical and School Health-Related Services	
11	Non-Medicaid, Other Educational and Social Activities	
	Subtotal	
12	General Administration	
	Subtotal	
13	Not Scheduled to Work	
	Final Count of Approved RMS Forms	

Additional Comments: The table above represents the final, approved form count with respect to changes in codes.

SDAC RMS RECONSIDERATION REQUEST FORM

School District:

Quarter (Month to Month, Year):

Date Request Submitted:

Instructions: *Reconsideration requests must be received by the Agency 14 calendar days (2 weeks) from the date the SDAC RMS Review Summary was sent. To complete this form, begin by filling out the district information in the table above. Then, paste information from the original SDAC RMS Review Summary into the tables below* ***and write a detailed explanation in your own words of why the discrepancy should be reconsidered****; if there is additional documentation to support the claim, please attach it to the email requesting the reconsideration. Save this form as a Word document and submit to the monitor and Program Administrator to start the reconsideration process; the Agency will use the same form to complete the reconsideration and results will be sent back as a PDF document, along with the finalized SDAC RMS Review Summary if changes were made during the Reconsideration.*

Please note: All reconsiderations are considered final.

Discrepancies Resulting in an Updated Code

Activity Description	Participant Name	Job Title	District Code	Agency Updated Code	District Reconsideration Request	Final Agency Determination
1.						
2.						
3.						

Invalid RMS Forms

Participant Name	Job Title	District Code	Reason Form was Voided	District Reconsideration Request	Final Agency Determination

[AGENCY-USE ONLY]

Additional Comments:

OVERVIEW OF THE FLORIDA MEDICAID WEB PORTAL

Karen Mayden-Samanamud
Provider Field Services Team Lead
Gainwell Technologies

DIFFERENCE BETWEEN AHCA AND GAINWELL

Gainwell Technologies

Fiscal Agent for AHCA

Claim Status

Claims Processing

Remittance Advice

Provider Enrollment

Provider File Maintenance

AHCA (Agency for Health Care Administration)

Policy Clarification

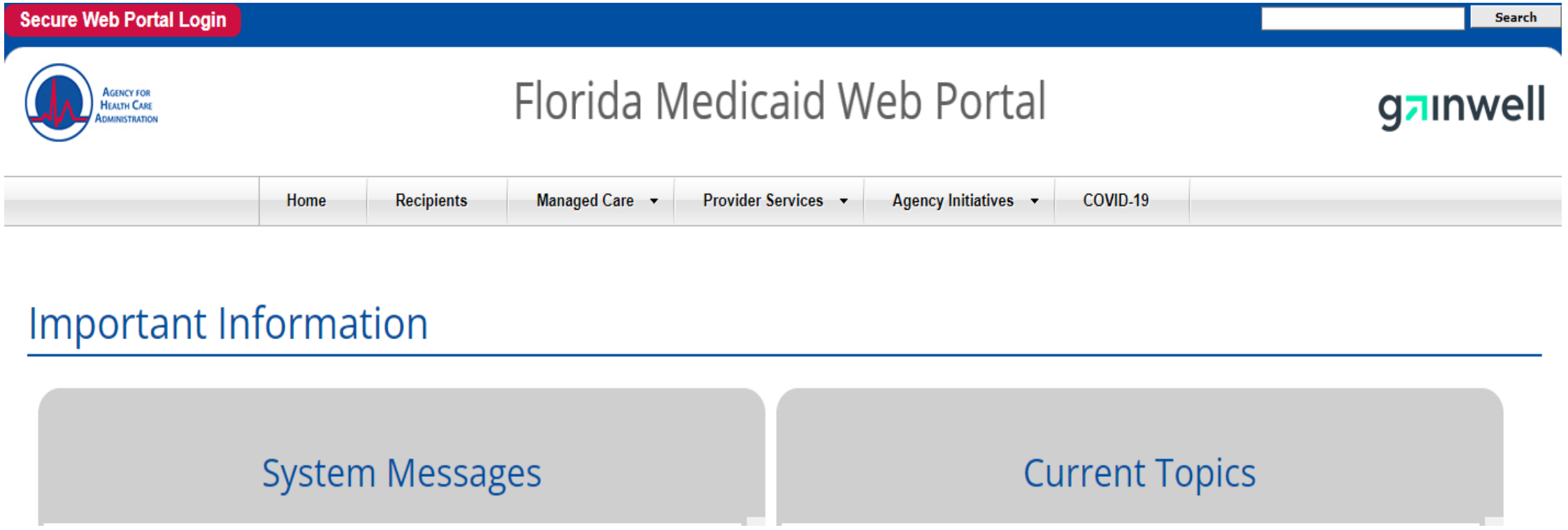
Claims past timely filing deadline

Information Resource

Fee Schedules, Forms, Handbooks

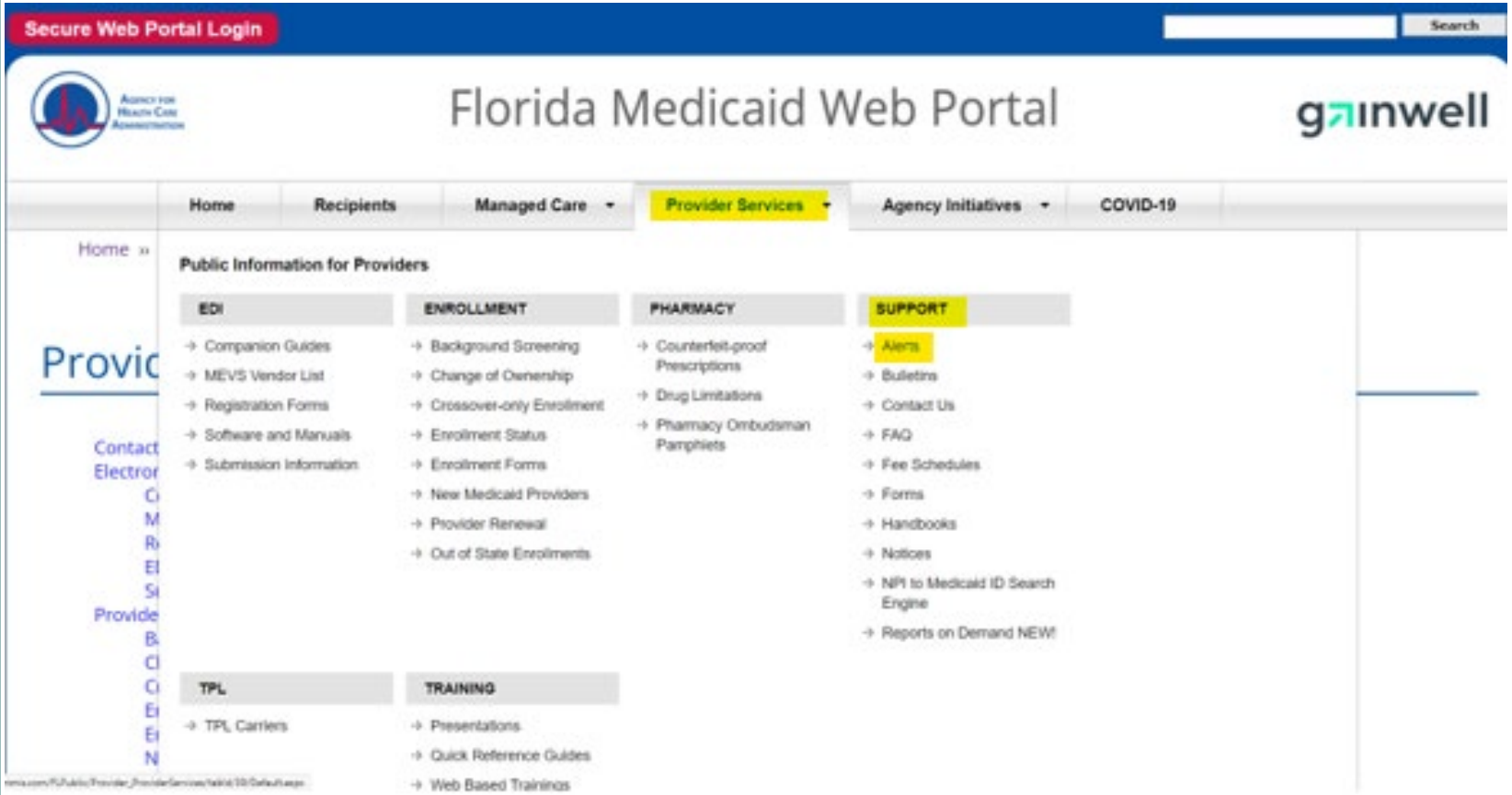
FLORIDA PUBLIC WEB PORTAL

- System Messages
- Health Care Alerts
- Fee Schedule Look-Up Tool
- Training Presentations and Quick Reference Guides (QRG)
- Provider Enrollment
- Contact Us
- AHCA (Agency for Health Care Administration
- Secure Web Portal


Secure Web Portal Login
Search
Agency for Health Care Administration
Florida Medicaid Web Portal
gainwell
Home
Recipients
Managed Care
Provider Services
Agency Initiatives
COVID-19
Important Information
System Messages
Current Topics

HOW TO SIGN UP FOR ALERTS

- Go to Provider Services
  - Support
    - Alerts
      - Florida Medicaid Health Care Alerts



Florida Medicaid Web Portal

Home | Recipients | Managed Care | Provider Services | Agency Initiatives | COVID-19

Home ›› Provider Services ›› Support ›› Alerts

Provider Message Archive

Periodically, the state Medicaid office will communicate to the provider community via provider alert messages. Provider alerts typically contain new policies and/or pertinent Medicaid information relevant to the provider community. This page contains recent and historical Medicaid provider alerts.

Archived messages may contain links to websites or documents that no longer exist at the linked URL. Documents referenced in the messages that are maintained by the fiscal agent can be found within the public pages of the Gainwell Technologies Web Portal.

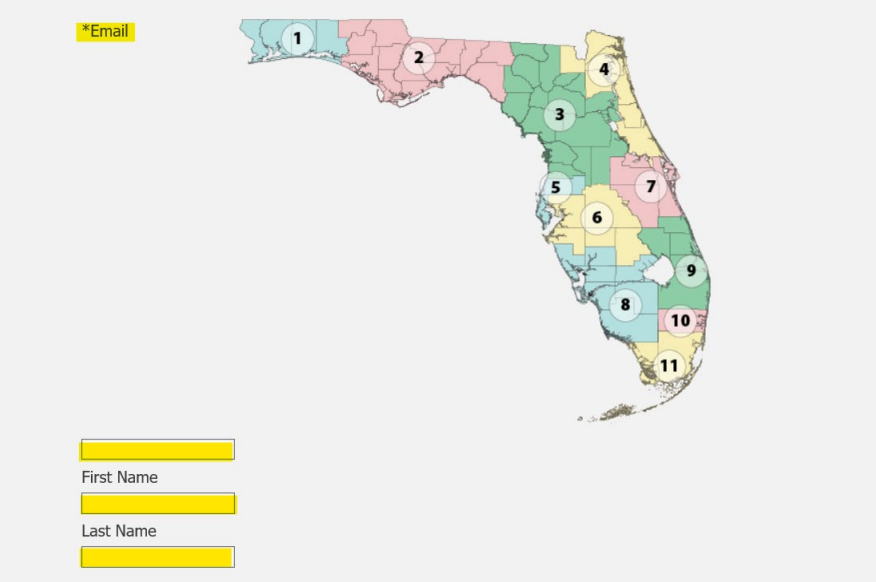
NOTE: Managed Care Alerts sent on March 1, 2015 and later are available on the Managed Care Alerts page.

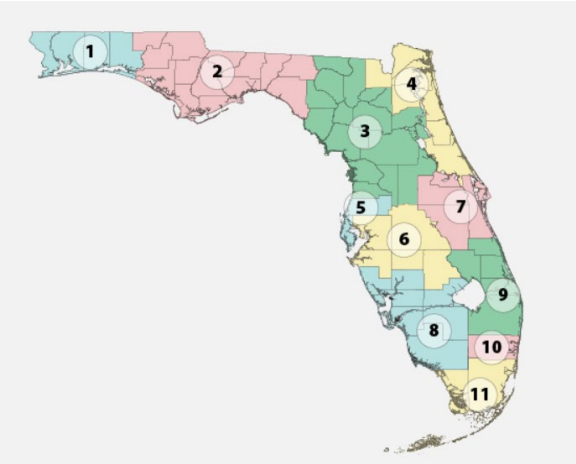
To subscribe to receive Provider Alerts, complete the online form on the Florida Medicaid Health Care Alerts page.

To search for a specific alert, enter a keyword and click the "search" button. To view all alerts, click the "search" button below.

Field entry is:

- E-mail
- First Name
- Last Name





*Region

- All Regions
- Region 1
- Region 2
- Region 3
- Region 4

*Provider Type

- 00 - All Messages/Provider Types
- 01 - General Hospital
- 04 - State Mental Hospital
- 05 - Community Behavioral Health Services
- 06 - Ambulatory Surgical Center
- 07 - Mental Health Practitioner
- 08 - District Schools
- 09 - Skilled Nursing Unit
- 10 - Skilled Nursing Facility/Nursing

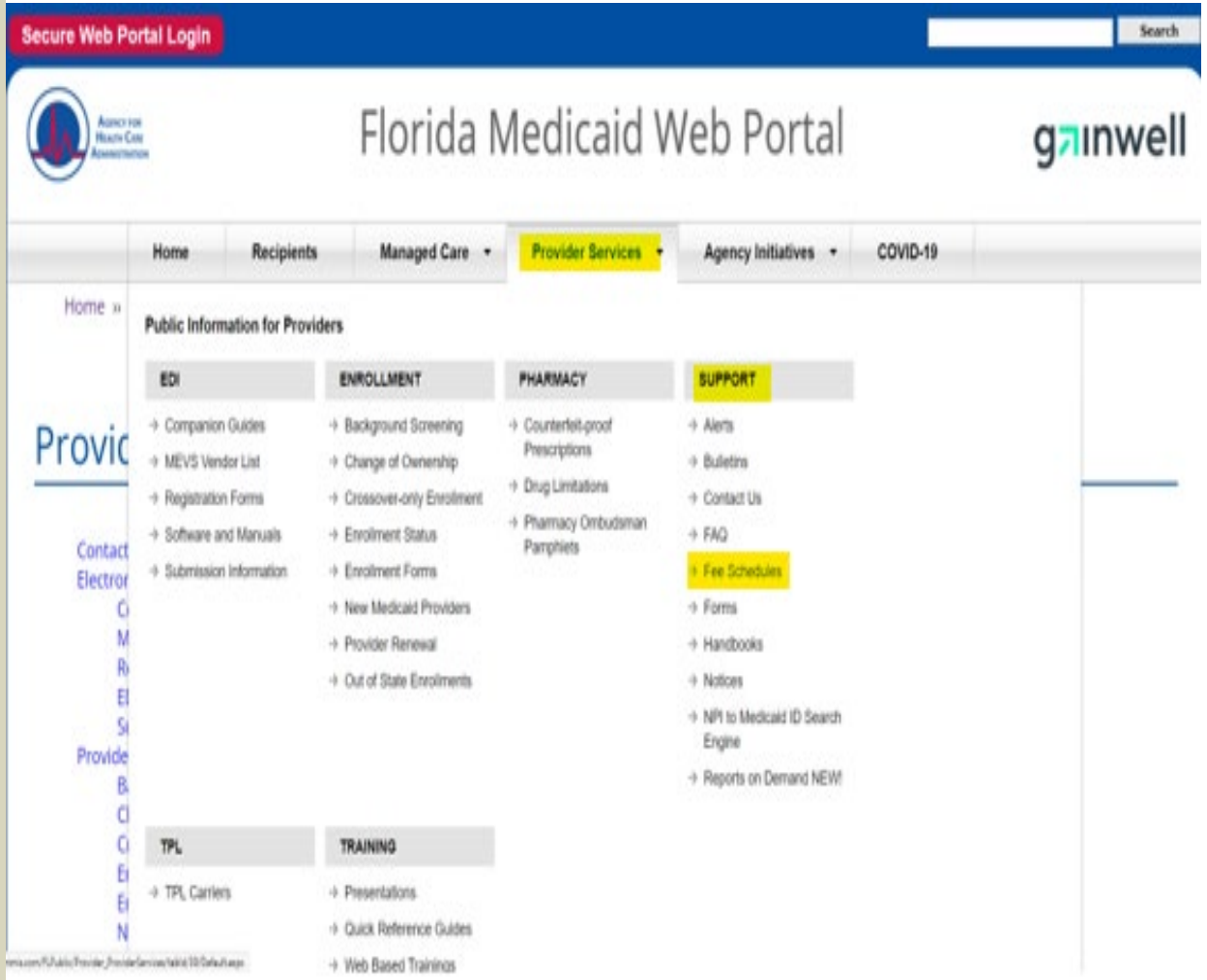
* = Required Field

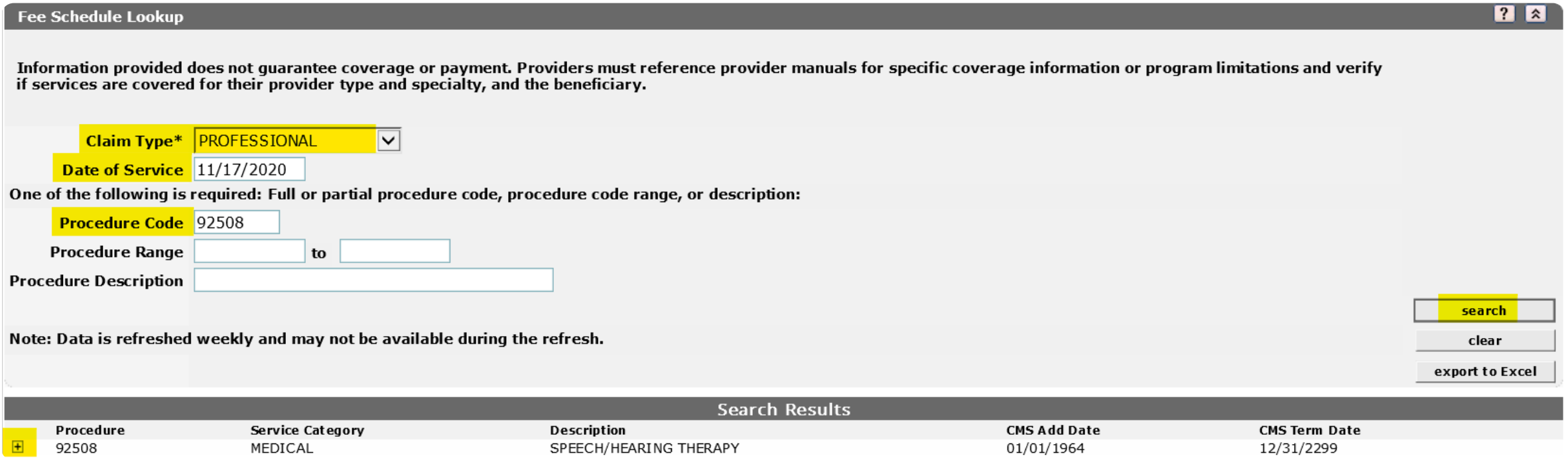
Submit

The REGION to choose is based upon the school district where services are provided

After you click Submit, an e-mail will be sent to the e-mail address provided to complete the setup. If you do not receive the e-mail, please check your junk or spam folder

- The Fee Schedule Look-Up Tool is a valuable resource to check reimbursement rates, allowed modifiers, and other service limitations. Note, this is only a tool and does not include all policy and restrictions





- Complete the fields:
- Claim Type: Professional
- Date of Service:
- Procedure Code and Search
- Then click on the + sign to expand

Here you will see that the reimbursement rate is $3.47 and then under

Contracts will display:

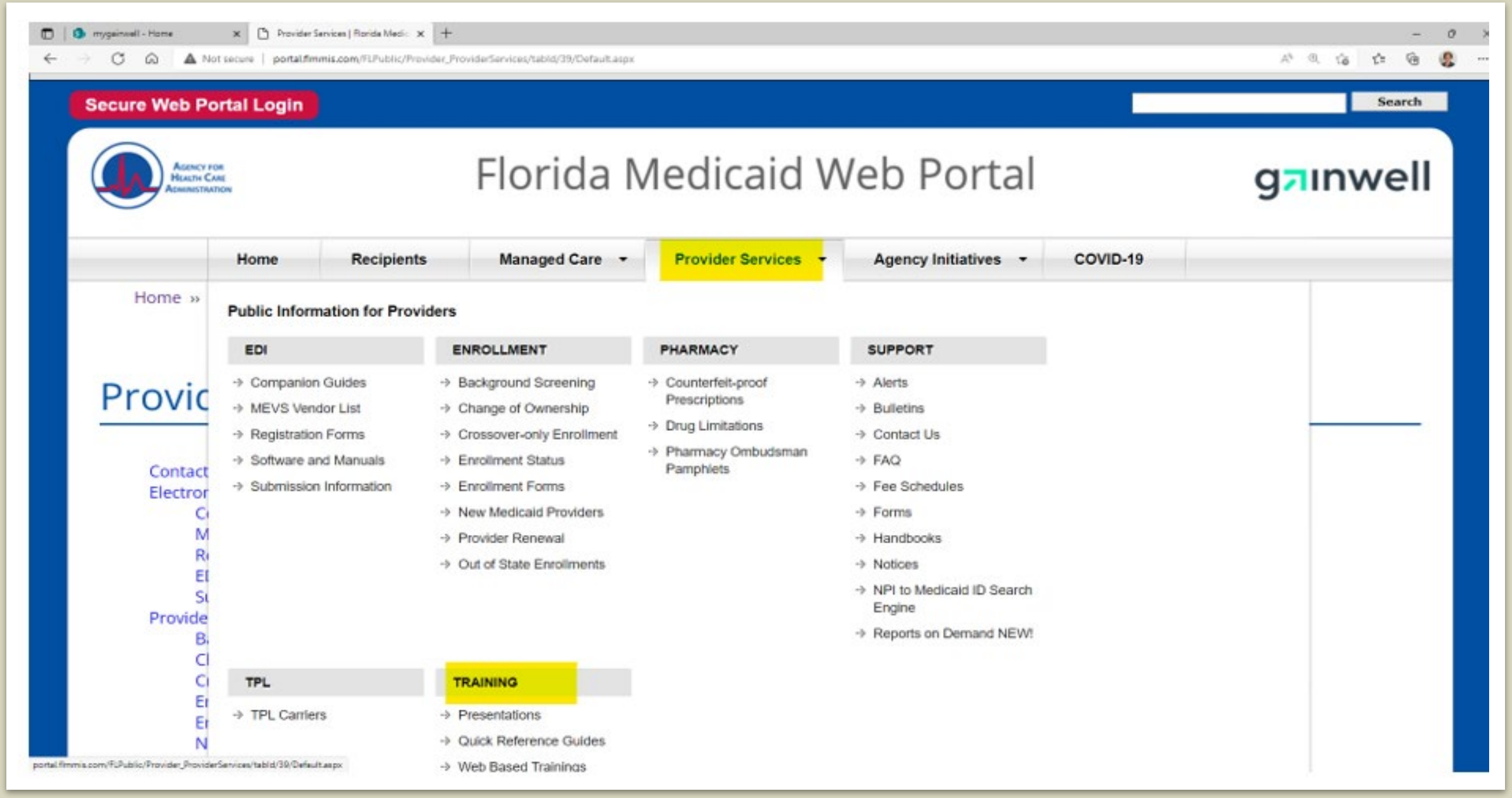
- -Allowed Modifiers
- -Minimum-Maximum Units
- -Age Restrictions
- -Place of Service (POS)

Search R

Service Category	Description
IEDICAL	SPEECH/HEARING THERAPY

Rate Type	Pricing Indicator	Date Of Service	Fee Schedule Amount
FEE SCHEDULE	MAX FEE	04/26/2022	$13.49
THERAPY	MAX FEE	04/26/2022	$3.47
SCHOOL	MAX FEE	04/26/2022	$3.47
HOME HEALTH	MAX FEE	04/26/2022	$6.60
FEE SCHED INCREASE	MAX FEE	04/26/2022	$14.03
FEE SCHEDULE	MAX FEE	04/26/2022	$3.74

x	Allowed Modifiers	PA Required	Attachment Required	Gender	Min/Max Age	Allowed POS
9	22,99	NO	NO	BOTH	0 - 999	
4		YES	NO	BOTH	0 - 20	03,11,12,18,1
9		YES	NO	BOTH	0 - 17	21
4	HM	NO	NO	BOTH	0 - 20	03,11,12,18,1
4		YES	NO	BOTH	0 - 20	02,03,11,12,1


Secure Web Portal Login
Search
Florida Medicaid Web Portal
gainwell
Home
Recipients
Managed Care
Provider Services
Agency Initiatives
COVID-19
Home »
Public Information for Providers
EDI
Companion Guides
MEVS Vendor List
Registration Forms
Software and Manuals
Submission Information
ENROLLMENT
Background Screening
Change of Ownership
Crossover-only Enrollment
Enrollment Status
Enrollment Forms
New Medicaid Providers
Provider Renewal
Out of State Enrollments
PHARMACY
Counterfeit-proof Prescriptions
Drug Limitations
Pharmacy Ombudsman Pamphlets
SUPPORT
Alerts
Bulletins
Contact Us
FAQ
Fee Schedules
Forms
Handbooks
Notices
NPI to Medicaid ID Search Engine
Reports on Demand NEW!
TPL
TPL Carriers
TRAINING
Presentations
Quick Reference Guides
Web Based Trainings

The Professional Claim Form Presentation is a step-by-step guide to the Web Portal

	State providers only.
Enhanced Ambulatory Patient Grouping (EAPG) Presentations	Hospital (Provider Type 01) Training Presentation ASC (Provider Type 06) Training Presentation
Institutional Claim Form Presentations	Direct Data Entry (DDE) on the Web UB-04 Paper Claim Submission - Paper submissions applicable to Out-of-State providers only.
Long Term Care Claim Form Presentations	Direct Data Entry (DDE) on the Web Long Term Care UB-04 Paper Claim Submission - Paper submissions applicable to Out-of-State providers only.
Medicaid Behavior Analysis Enrollment Webinar	Medicaid Behavior Analysis (Provider Type 39) Enrollment Webinar
Professional Claim Form Presentations	Direct Data Entry (DDE) on the Web CMS-1500 Paper Claim Submission - Paper submissions applicable to Out-of-State providers only.
Professional Waiver Claim Form Presentations	Direct Data Entry (DDE) on the Web CMS-1500 Waiver Paper Claim Submission - Paper submissions applicable to Out-of-State providers only.
ROPA Enrollment Presentation	ROPA Provider Enrollment Initiative
Sandata Transition Webinar	Telephonic Home Health Services DMV Project: Transition Webinar
Streamlined Credentialing (Limited Enrollment)	Streamlined Credentialing (Limited Enrollment)

Quick Reference Guides

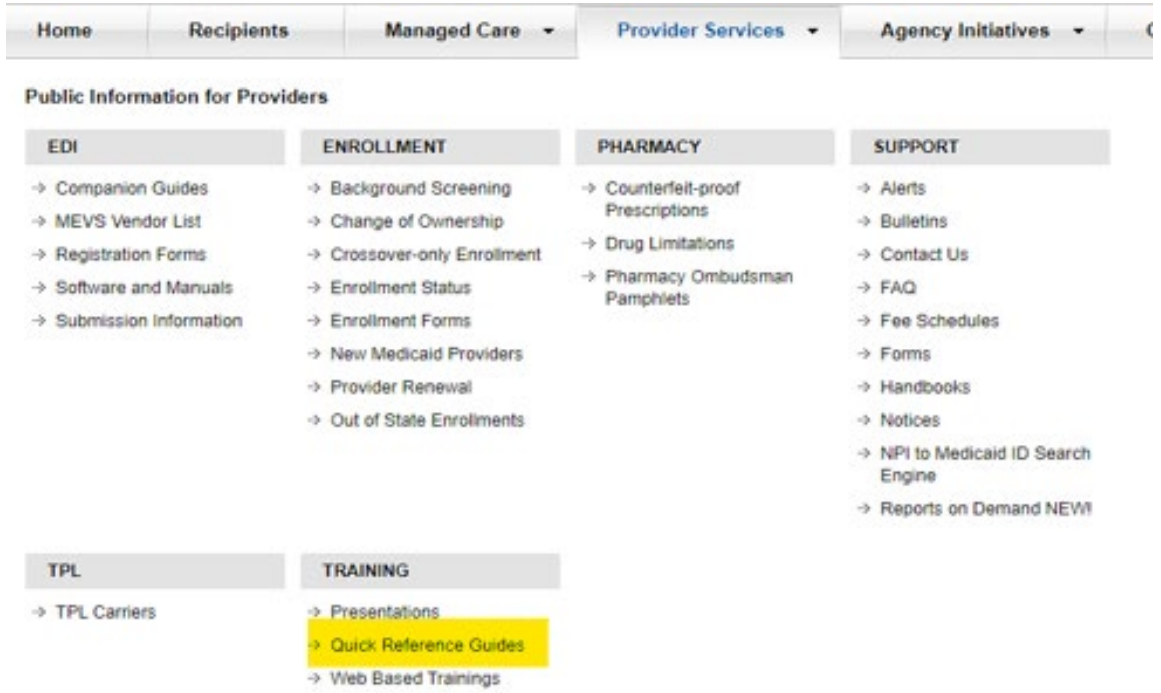
Self-Service

The following Quick Reference Guides (QRGs) provide helpful information on automation changes for providers. More Self-Service QRGs to come. Please visit this page periodically to stay up-to-date as changes occur.

Secure Web Portal Maintenance	Provides information on secure Web Portal user accounts that become locked due to inactivity and how to perform password resets.
Address Maintenance Wizard	Provides information on how to successfully perform a change of address via the secure Web Portal.
EFT Designation Wizard	Provides information on how to initiate an electronic funds transfer information change via the secure Web Portal.
Electronic EDI Agreements	Informs providers and billing agents on how to complete the EDI agreement via the secure Web Portal.
Electronic Exceptional Claim Submission	Informs providers and billing agents on how to submit a Medicaid exceptional claim through a secure Web Portal account.
Interactive Enrollment Checklist	Informs enrolling providers how to effectively use this new feature when enrolling with Florida Medicaid via the secure Web Portal.
Provider File Maintenance	Provides information on how to upload file maintenance documents successfully via the secure Web Portal.
Electronic IRS Form 1099	Provides information on how to access electronically delivered 1099 forms via the secure Web Portal.
Fee Schedule Lookup Tool	Informs providers on how to effectively use this new, user friendly feature to search for current rates and fee schedules via the secure Web Portal.

226305 EOB'S PHARM REMOVED PDF.PDF (FLMMIS.COM)

EOB Message Codes and Descriptions



EOB Message Codes and Descriptions

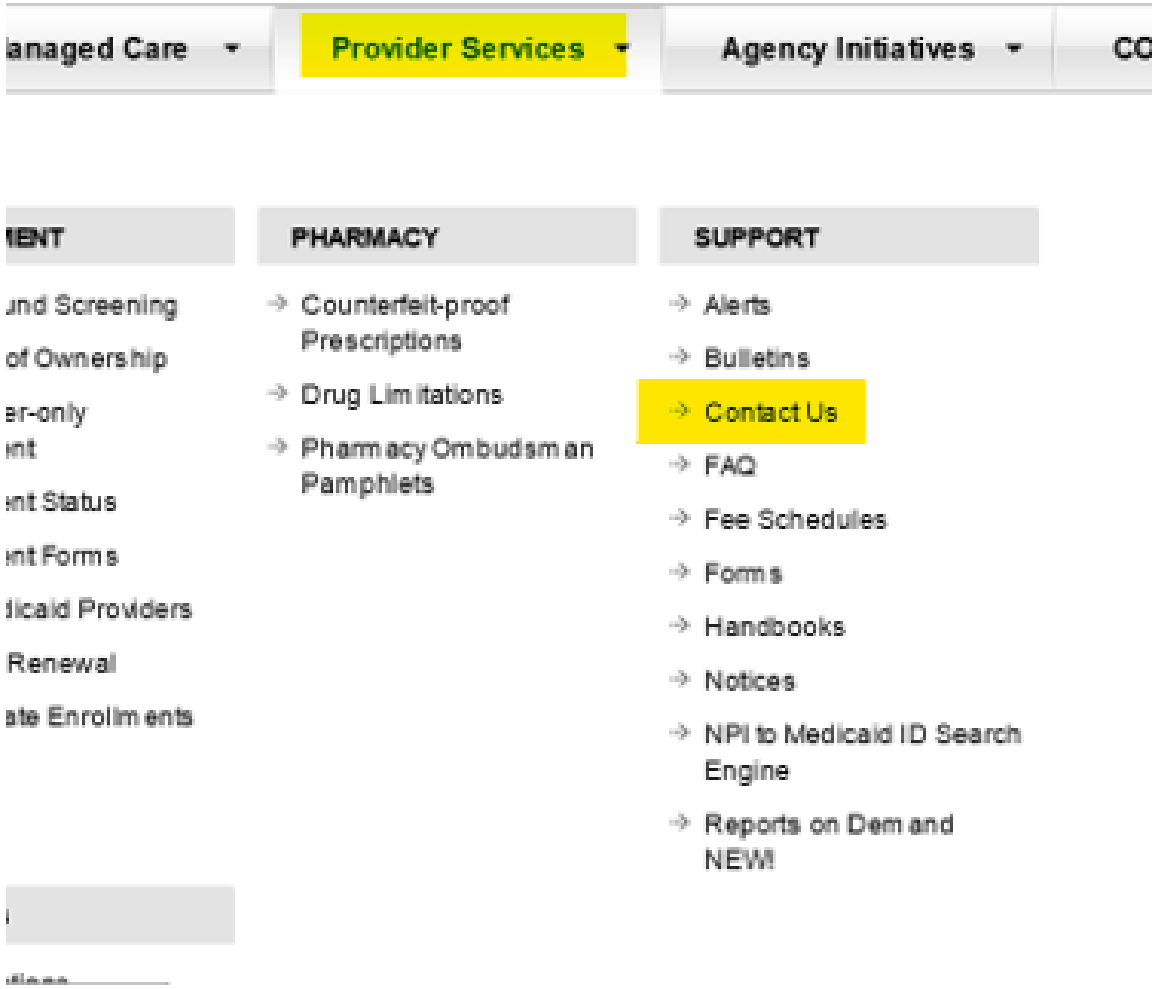
Provides a current version of the Explanation of Benefits (EOB) codes and associated messages that are used in the new FMMIS. These codes are provided as a reference and may periodically be revised.

Finding your Provider Field Service Representative

Provider Services

Support

Contact Us



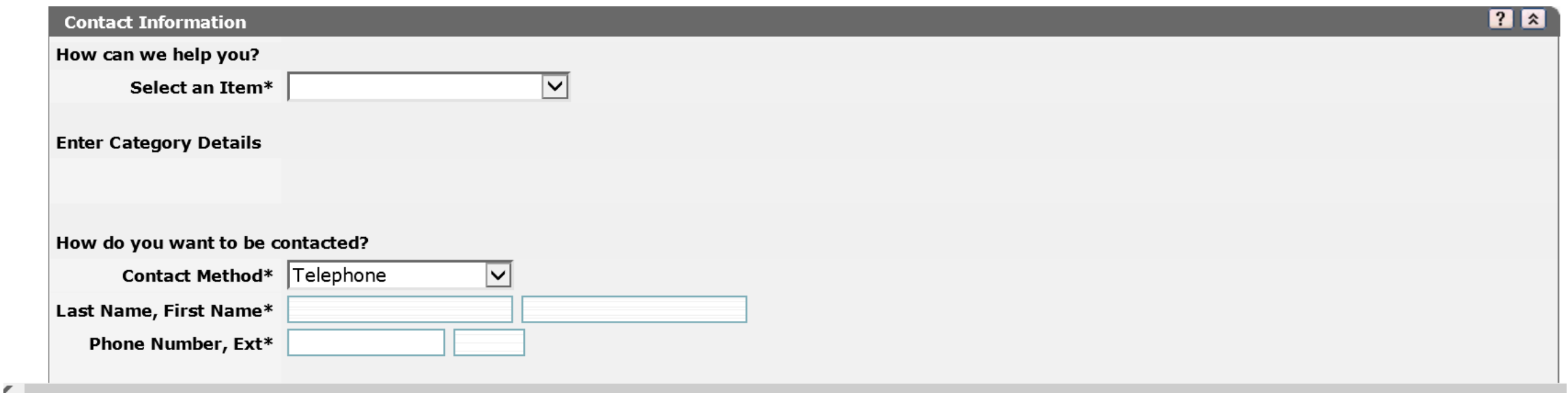
Contact Us

The following is important contact information applicable to all Florida Medicaid providers:

Contact Information Sheet
Recipient and Provider Assistance (formerly Florida Medicaid Field Offices)
Gainwell Technologies Provider Services Field Representative Map

Questions?

If you have questions you would like a response to, please use the Contact Information form below to send us an e-mail.



Provider Field Services Map

Territories

1 **Eric Anderson**
Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun and Gulf.

2 **Cedric Brown**
Liberty, Franklin, Gadsden, Leon, Wakulla, Jefferson, Taylor and Madison.

3 **Edwin Alexander**
Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Levy, Lafayette, Putnam, Suwanee and Union.

Angie Brands
Citrus, Hernando, Lake, Marion and Sumter.

4 **Brandy Dudley**
Nassau, Baker and Duval.

Karen Mayden-Samanamud
St. John's, Flagler, Volusia and Clay.

5 **Cheryl Rizzo**
Pasco County and Pinellas County.

6 **Lucinda Wagner**
Hillsborough (providers with last names A-J) Manatee, Sarasota, Polk and Highlands.

Yen Keomany
Hillsborough (providers with last names K-Z) Hardee, DeSoto, Charlotte and Lee.

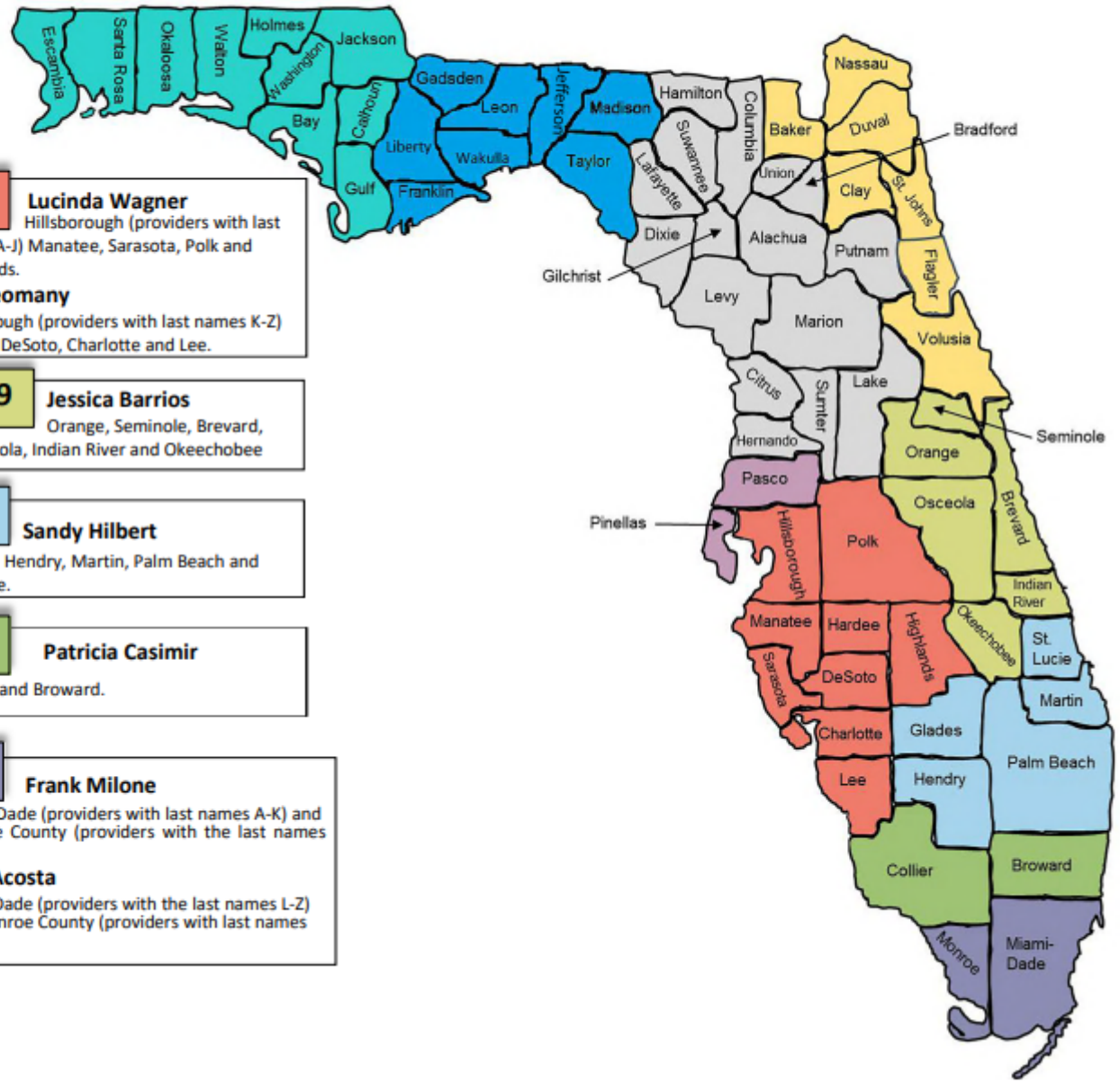
7/9 **Jessica Barrios**
Orange, Seminole, Brevard, Osceola, Indian River and Okeechobee

9 **Sandy Hilbert**
Glades, Hendry, Martin, Palm Beach and St. Lucie.

10 **Patricia Casimir**
Collier and Broward.

11 **Frank Milone**
Miami-Dade (providers with last names A-K) and Monroe County (providers with the last names A-K).

Jerry Acosta
Miami-Dade (providers with the last names L-Z) and Monroe County (providers with last names L-Z).

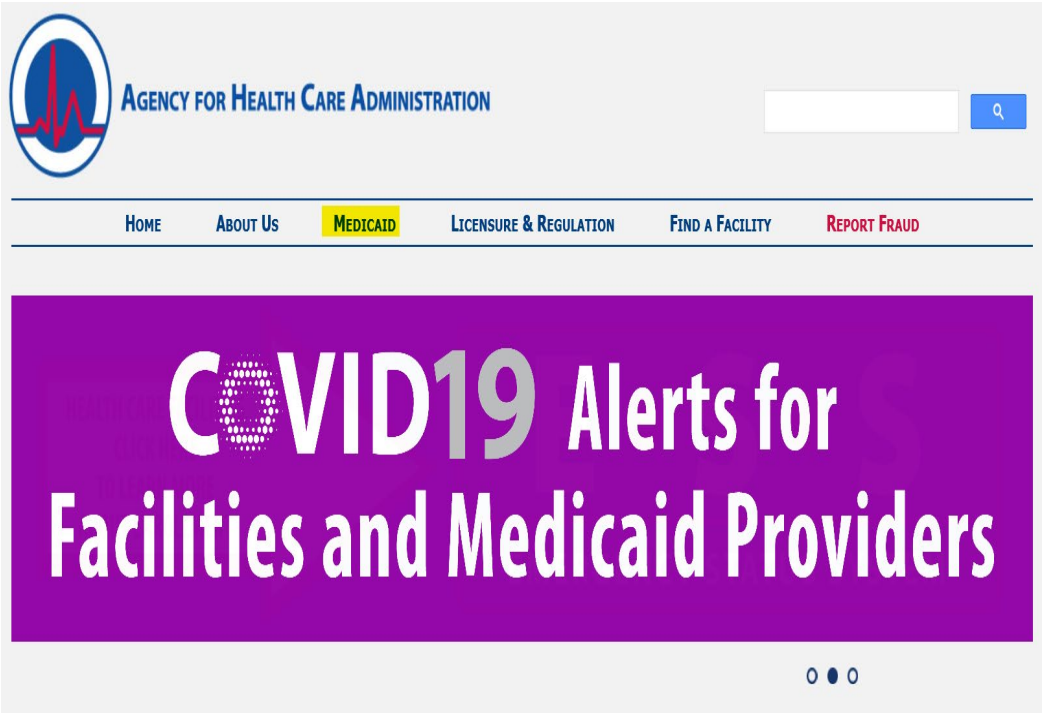


Updated: 11/10/2021

ACCESSING THE AHCA WEBSITE

Click on the link (highlighted in yellow)

Click on Medicaid to reach the Medicaid page



Looking for information on:	Go to:
Accessing Long-Term Care Services	Statewide Medicaid Managed Care
Accessing Telehealth Through the Florida Medicaid Program	Telehealth
View Recent Medicaid Health Care Alerts	Medicaid Program Coordination
Behavior Analysis Services Information	Bureau of Medicaid Policy
Health Plan Contracts and Information	Statewide Medicaid Managed Care
Health Plan Enrollment	Bureau of Medicaid Data Analytics
Health Plan Rates	Bureau of Medicaid Data Analytics
HEDIS Performance Measures	Bureau of Medicaid Quality
Housing Assistance Pilot Program	Statewide Medicaid Managed Care
Institutional Rates	Bureau of Medicaid Program Finance
LIP/DSH/GME Operations	Bureau of Medicaid Program Finance
Medicaid Eligibles	Bureau of Medicaid Data Analytics
Pharmacy Policy	Bureau of Medicaid Policy
Provider Fee Schedules and Provider Handbooks	Bureau of Medicaid Policy
Quality Management and Research and Evaluation Contracts	Bureau of Medicaid Quality
Recent Presentations and Reports	Medicaid Program Coordination
Recipient Support and Provider Services	Bureau of Medicaid Recipient and Provider Assistance
State Plan	Bureau of Medicaid Policy

- Click on Provider Fee Schedules and Provider Handbooks to locate the Medicaid Certified School Match Program handbook.

- This handbook is the written policy of AHCA

Rules

The Rules Unit is responsible for coordinating and providing support to Florida Medicaid staff related to administrative rules promulgated in the Florida Administrative Code.

Below you can access rule information about adopted rules and rules currently in the promulgation process including, any incorporated reference material such as coverage policies (formally handbooks), fee schedules, forms and drafts.

Rules in Process

- Draft Florida Medicaid rule reference materials, if available, for the public to access during the rule promulgation process. These documents are not final until they are adopted into rule. Agendas for the public meetings/workshops/hearings are available on this page.

Adopted Rules

- General Policies - Rules that are universally applicable to the Florida Medicaid program.
- Service-Specific Policies - Rules for individual Florida Medicaid covered services and waiver programs.
- Other Policies - Rules pertaining to other aspects of the Florida Medicaid program.
- Reimbursement Policies and Fee Schedules - Rules pertaining to submitting claims for reimbursement and reimbursement methodologies.
- Fee Schedules and Billing Codes - Florida Medicaid fee schedules and billing codes
- Florida Medicaid Forms - Forms pertaining to the Florida Medicaid program.

59G-13.075	Home and Community Based Services Settings	12/25/2018	FAR
59G-4.130	Home Health Services	11/17/2016	FAR
59G-4.132	Home Health Electronic Visit Verification Program	2/22/2017	FAR
59G-4.140	Hospice Services	6/2/2016	FAR
59G-4.150	Inpatient Hospital Services	7/11/2016	FAR
59G-4.032	Integumentary Services	6/29/2016	FAR
59G-4.170	Intermediate Care Facility for Individuals with Intellectual Disabilities Services	7/11/2016	FAR
59G-4.180	Intermediate Care Services	2/28/1995	FAR
59G-4.190	Laboratory Services	6/29/2016	FAR
59G-4.035	Medicaid Certified School Match Program [1.34MB]	1/10/2006	FAR
59G-4.058	Medicaid County Health Department Certified Match Program	12/25/2018	FAR
59G-4.197	Medical Foster Care	1/16/2020	FAR
59G-4.199	Mental Health Targeted Case Management [1.14MB]	1/2/2008	FAR
59G-4.201	Neurology Services	10/15/2018	FAR
59G-4.330	Non-Emergency Transportation Services	11/19/2019	FAR
59G-4.200	Nursing Facility Services	5/3/2016	FAR
59G-4.318	Occupational Therapy Services	11/29/2016	FAR

ACCESSING THE SECURE WEB PORTAL

Click on the red “Secure Web Portal” link

SECURE WEB PORTAL

USE INTERNET EXPLORER/MICROSOFT EDGE

- Log-In
- Reset Password
- Web Portal User Guide
- Provider Information-Demographic Maintenance
- Address Maintenance
- Eligibility
- Trade Files
- Claims
- Reports/Remittance Advice

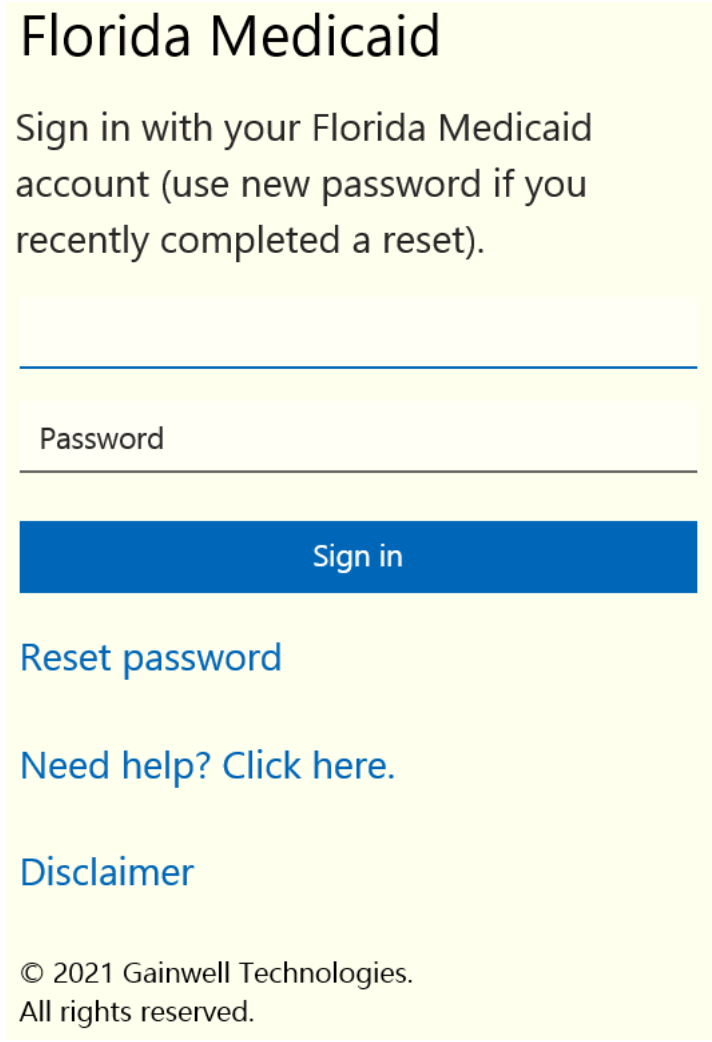
When logging in, it is IMPERATIVE

to use the Username for the service and account that you want to bill for.

You will have several different log-in Usernames depending on the service.

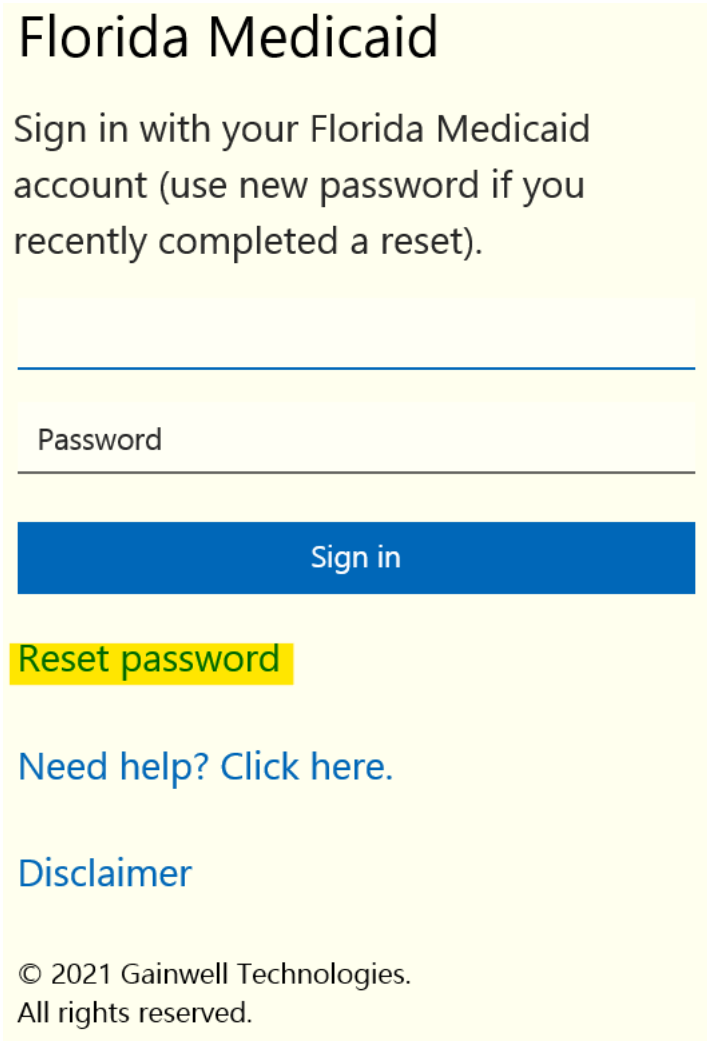
There will be a Username for

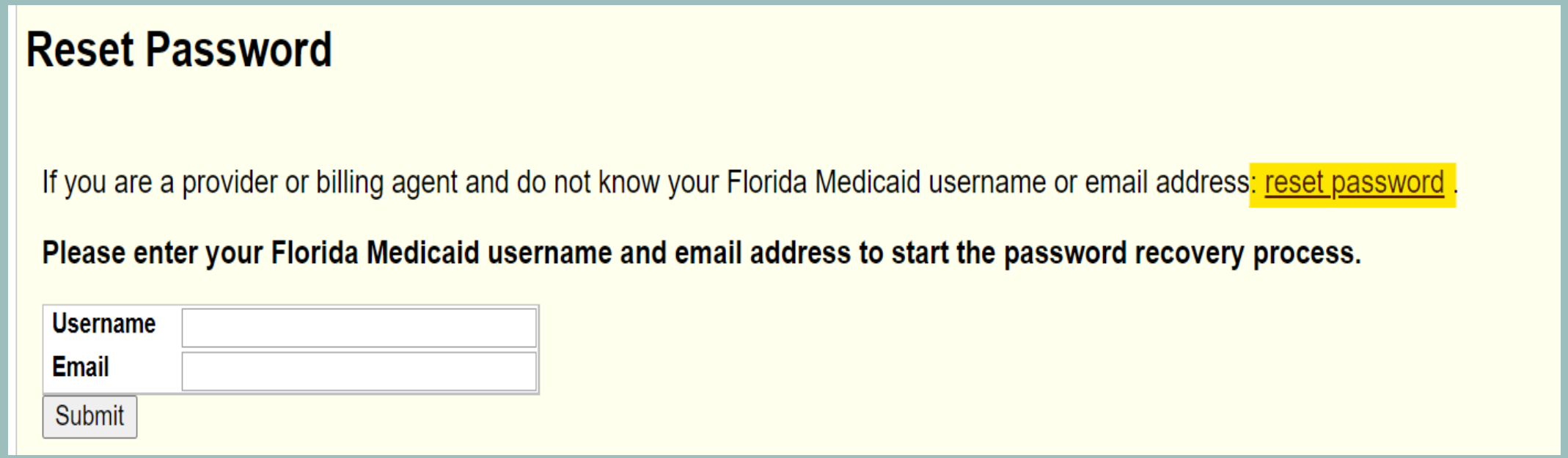
Therapy, Behavioral, Transportation, Nursing, etc.



- On this page if you do not remember your password, you can click the RESET PASSWORD link.

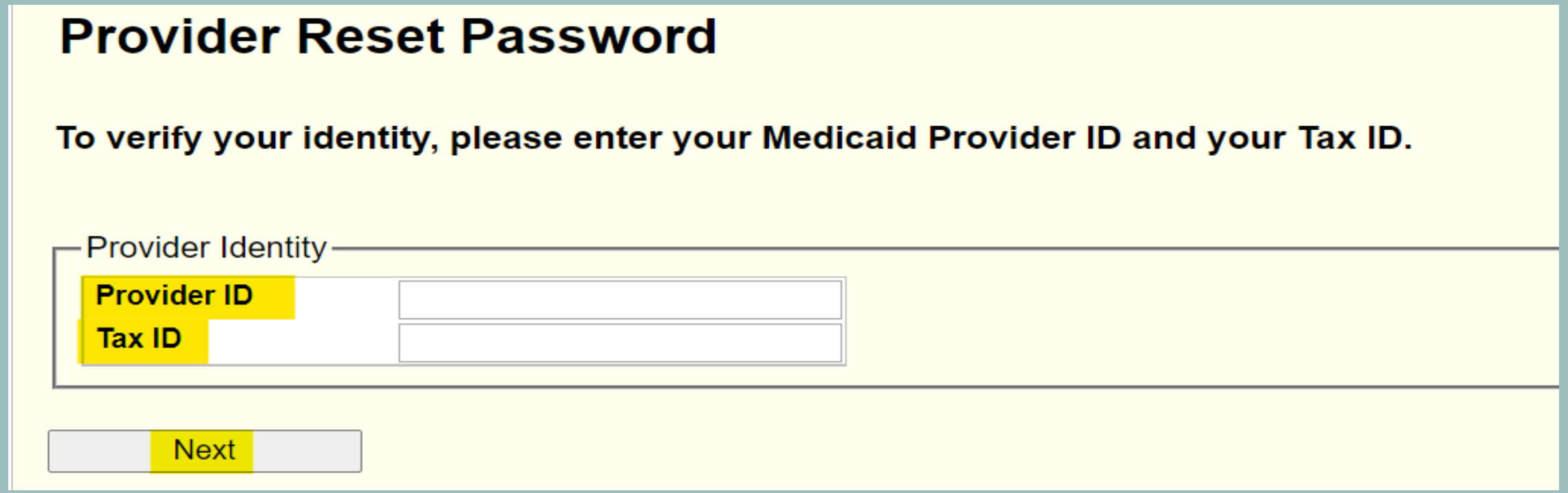
- This link will send you an e-mail to the e-mail on file and you can reset your password on your own. You will also need to remember your response to the security question that is on file.





IF YOU DO NOT KNOW YOUR USERNAME AND EMAIL, CLICK **RESET PASSWORD**

Florida Medicaid - Reset Password (flmmis.com)

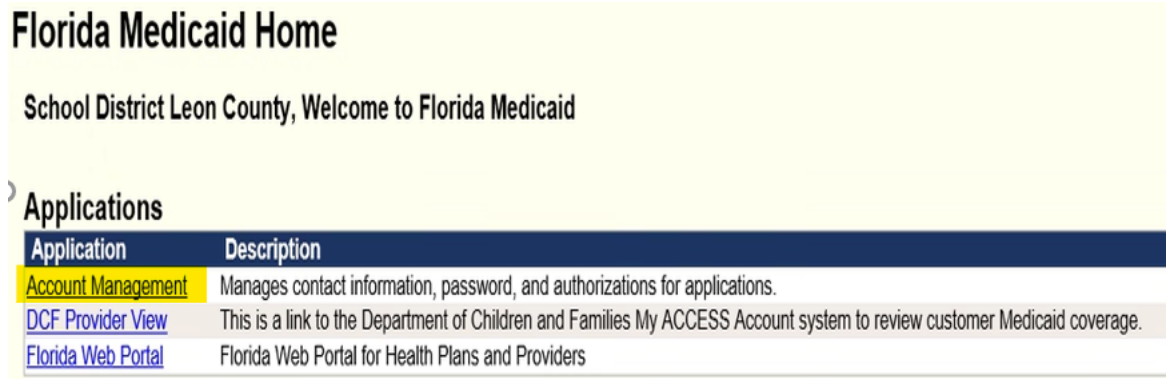


THIS WILL RESET ONLY THE ADMINISTRATOR ACCOUNT

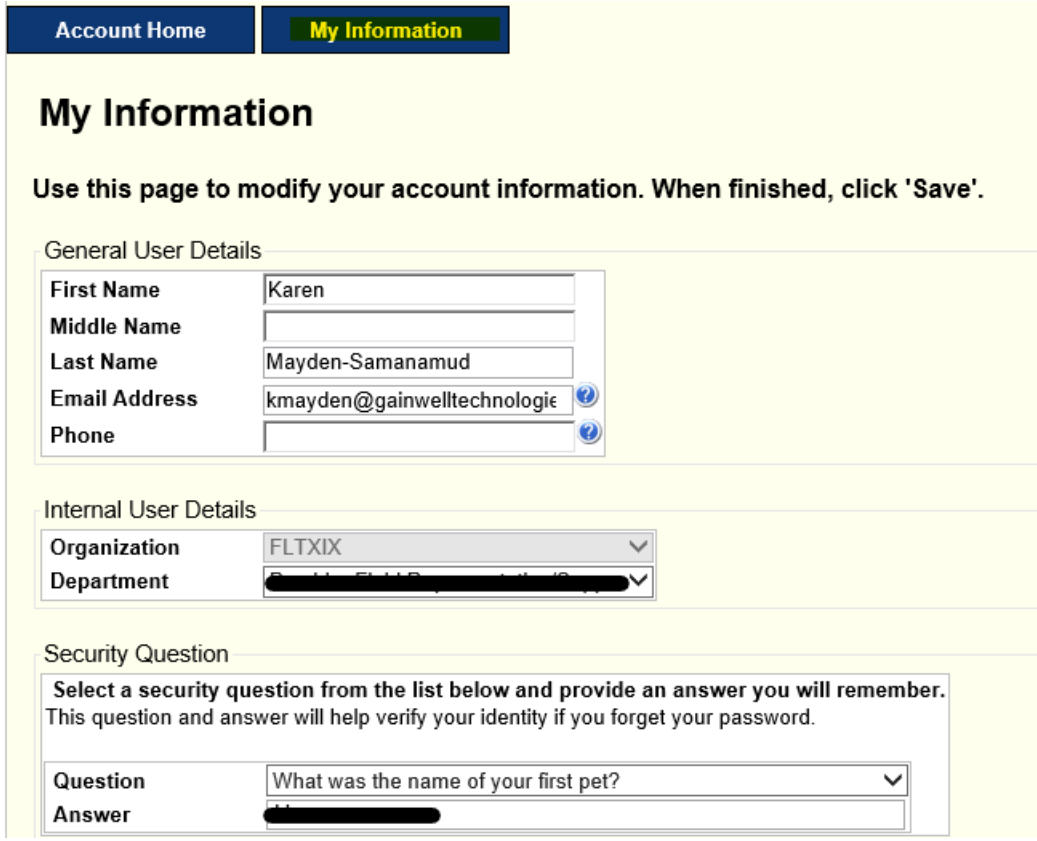
You will need the Medicaid Provider Id for the account and the TIN (Tax Id Number) used to enroll

RESETTING
E-MAIL ADDRESS ON FILE
SECURITY QUESTION AND ANSWER

Once logged into the secure web portal, if you need to update the e-mail or Security Question click **Account Management**



Then click on **My Information** and from here you can update the **Name** on account, **E-mail address**, **Security Question** and **Answer**. Then click **Save**



State Staff ONLY
Password Resets
Monday - Friday
7:30 AM - 6 PM ET
850-298-7123

Providers and Agents
Refer to the Secure Web Portal Maintenance Quick Reference Guide for assistance.

Health Plan Portal User Manual

Secure Web Portal User Guide

Reset an Account Password Quick Reference Guide

Account Management-where you can change your password prior to it expiring OR if you are a Super Agent this is where you will add new agents. This is where you will update your E-mail and Security Question and Answer

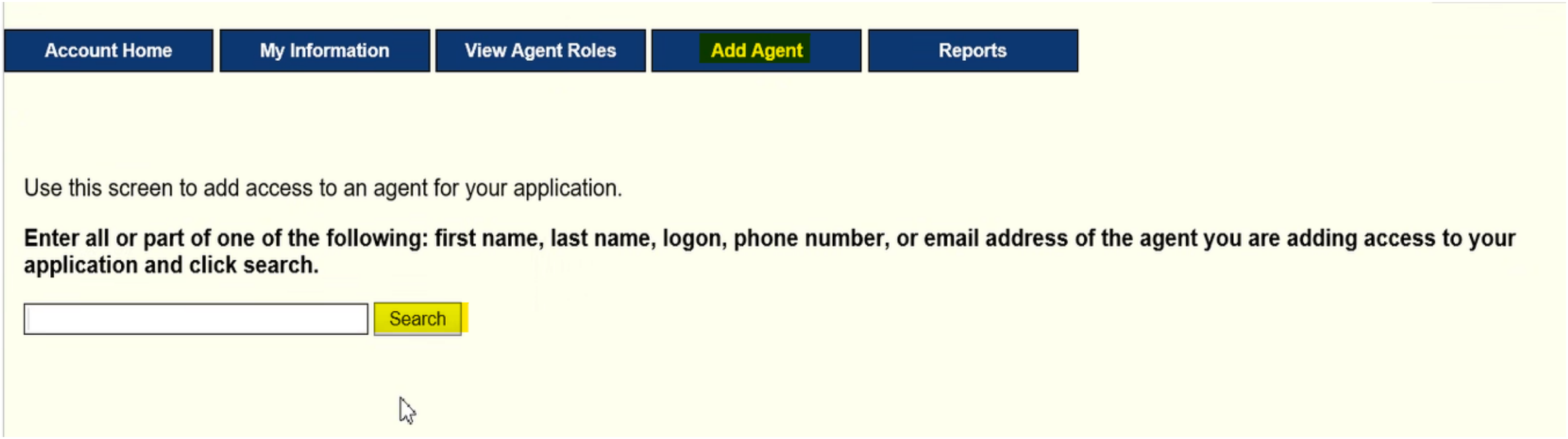
Florida Web Portal-this is the secure web portal where you will look at claims, check eligibility, obtain Remittance Advice (RA or a Remittance Voucher), and pull electronic eligibility

DCF Provider View-which you should not have to utilize. Gainwell Technologies does not maintain this site and I cannot train on it.

The Secure Web Portal User Guide found on the left-hand side (highlighted) is a user guide that will take you through the entire web portal. You will discover how to add agents in this handbook.

- **Setting up multiple locations under one Username**
-
- After the portal is set up and you are logged in with your **Administrator Account**
- Go to: **Account Management**
- **Add Agent**
- Type in a **new** Username
- **Search**
  - **Add Agent**
  - **Select**
  - **Yes, I agree**
  - **Manage Roles**
-
- Log into Florida Web Portal using the username, **Accounts**, toggle between locations.
- Each location will have its Login, and you will add agents from this point. You must go into each portal (location) that you want to add to the log-in.

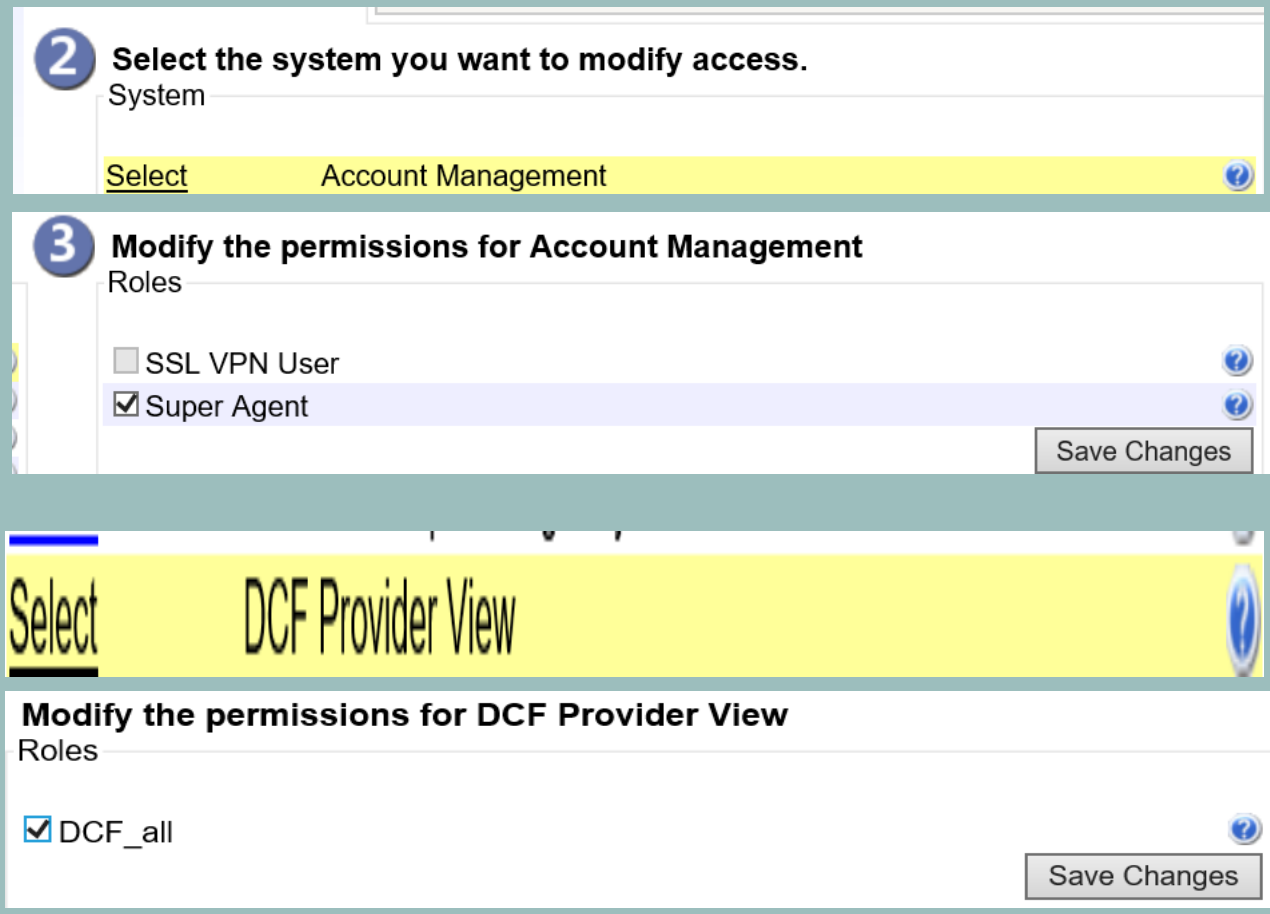
ADD AGENT
TYPE IN A NEW USERNAME
SEARCH

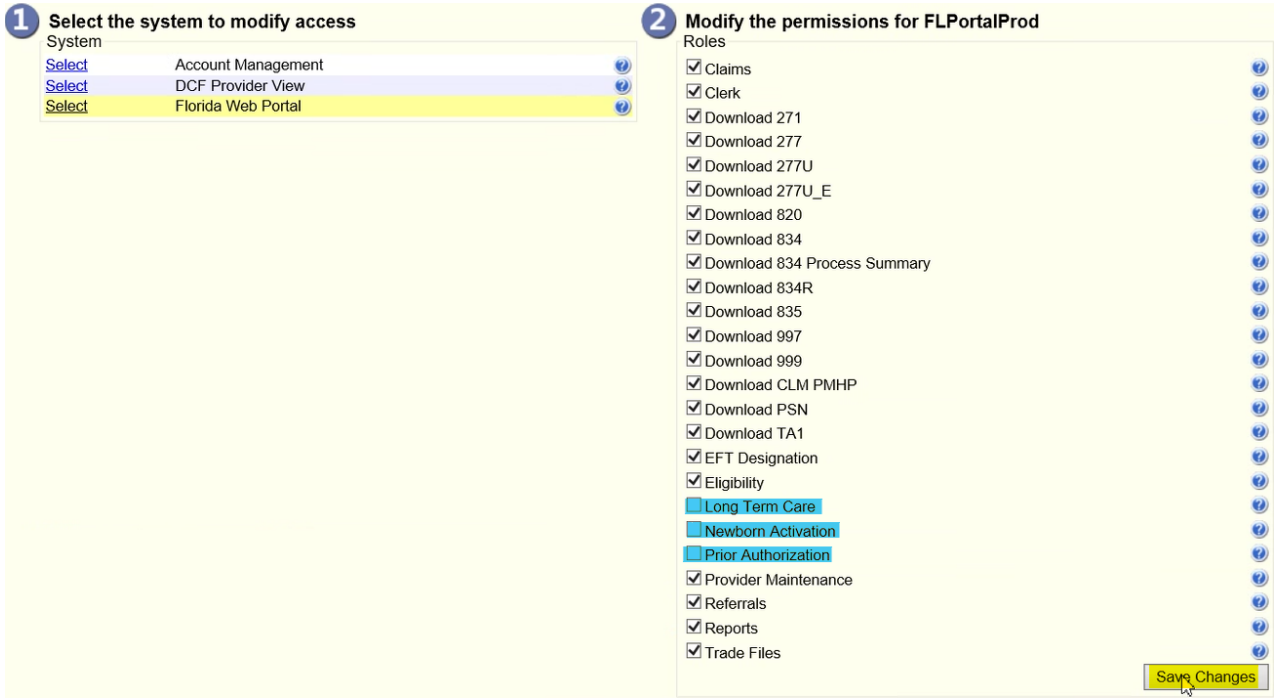


You will then enter the user's information and Manage Roles

Account Management:
Super Agent and Save Changes

DCF Provider View:
"DCF All" and Save Changes





FLORIDA WEB PORTAL

Check all boxes except
Long Term Care
Newborn Activation
Prior Authorization

YOU WILL LOG INTO YOUR NEXT PROVIDER ID

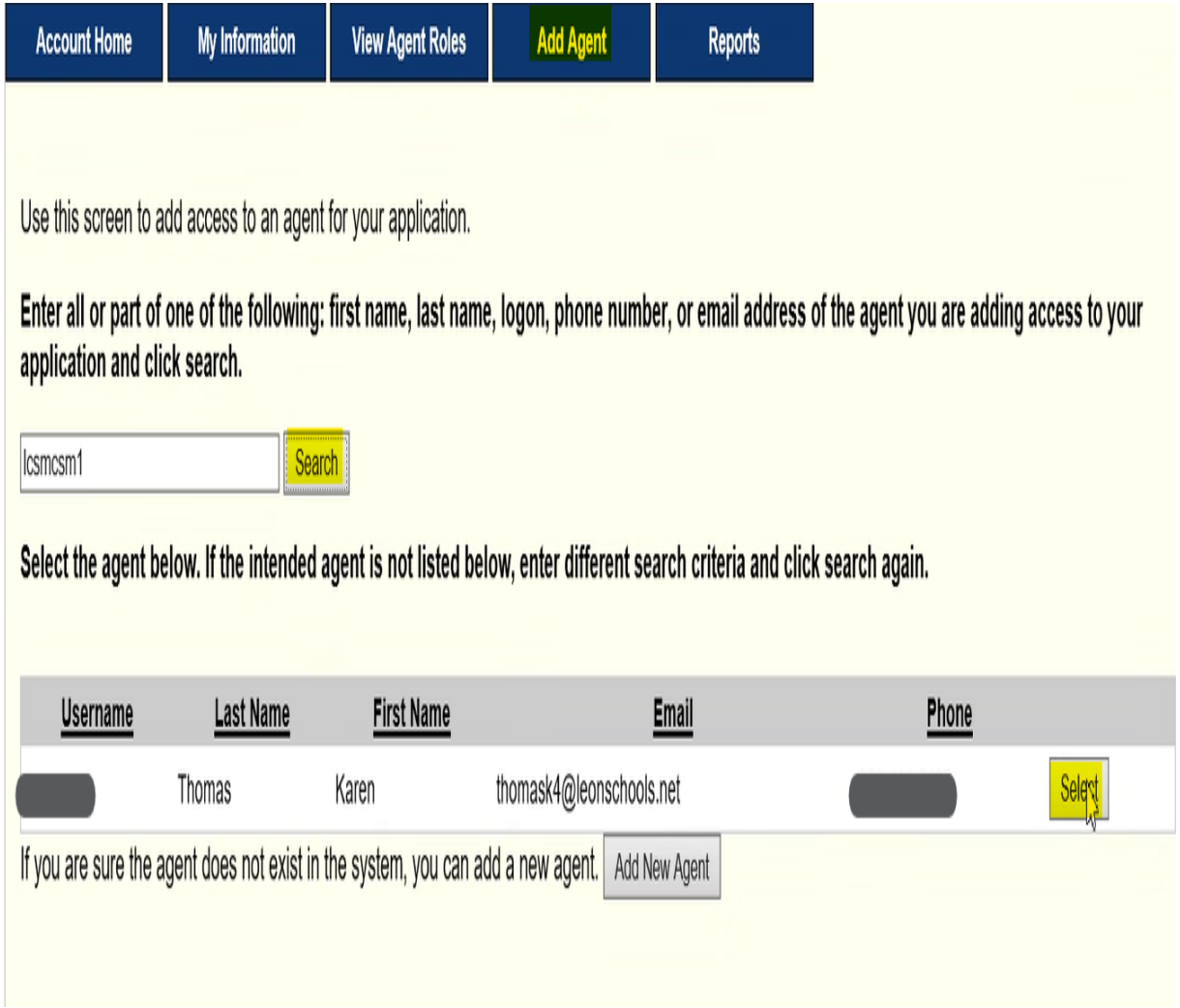
Click **Add Agent**

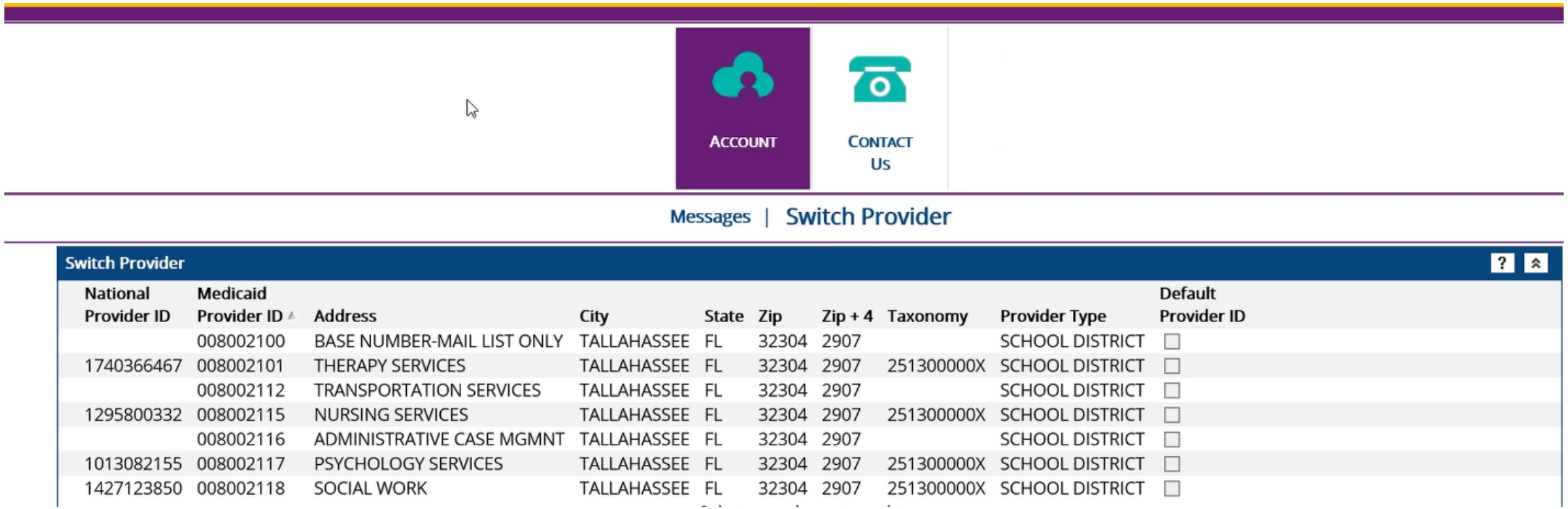
Enter the same username that you created in the previous step

Search

Select

Repeat these steps for each Medicaid Provider Id that you have



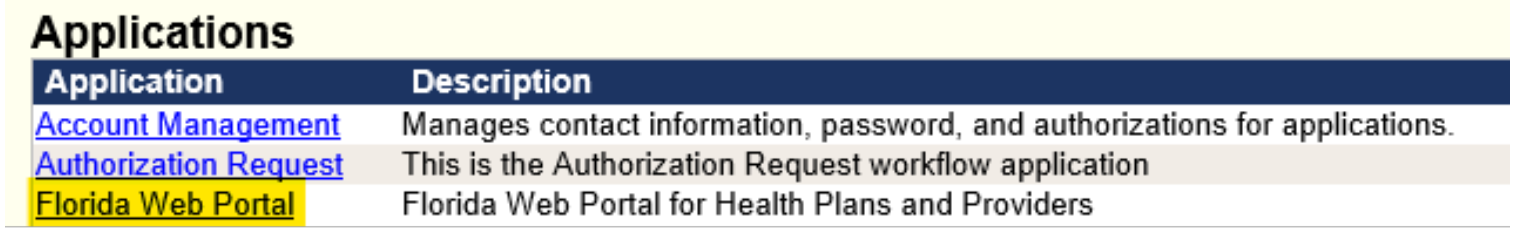


National Provider ID	Medicaid Provider ID	Address	City	State	Zip	Zip + 4	Taxonomy	Provider Type	Default Provider ID
	008002100	BASE NUMBER-MAIL LIST ONLY	TALLAHASSEE	FL	32304	2907		SCHOOL DISTRICT	☐
1740366467	008002101	THERAPY SERVICES	TALLAHASSEE	FL	32304	2907	251300000X	SCHOOL DISTRICT	☐
	008002112	TRANSPORTATION SERVICES	TALLAHASSEE	FL	32304	2907		SCHOOL DISTRICT	☐
1295800332	008002115	NURSING SERVICES	TALLAHASSEE	FL	32304	2907	251300000X	SCHOOL DISTRICT	☐
	008002116	ADMINISTRATIVE CASE MGMNT	TALLAHASSEE	FL	32304	2907		SCHOOL DISTRICT	☐
1013082155	008002117	PSYCHOLOGY SERVICES	TALLAHASSEE	FL	32304	2907	251300000X	SCHOOL DISTRICT	☐
1427123850	008002118	SOCIAL WORK	TALLAHASSEE	FL	32304	2907	251300000X	SCHOOL DISTRICT	☐

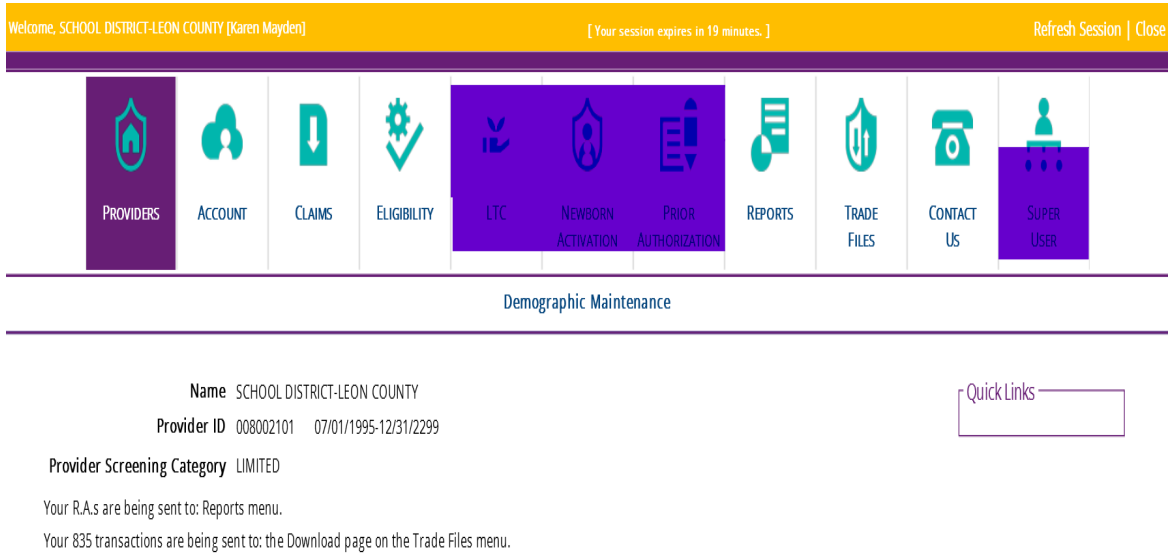
YOU WILL LOG IN WITH THE NEW USERNAME CREATED AND THE VIEW WILL LOOK LIKE THIS

Click on the Application Florida Web Portal

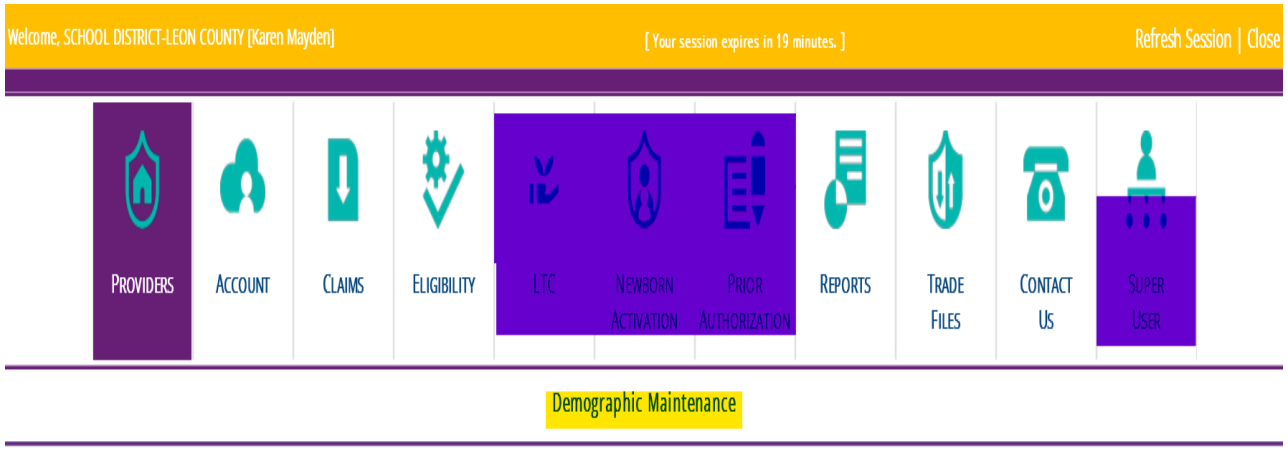
For the purpose of this training presentation, I am going to use Leon County's Medicaid Provider Id.



You will **never** have to use the LTC, Newborn Activation, or Super User applications

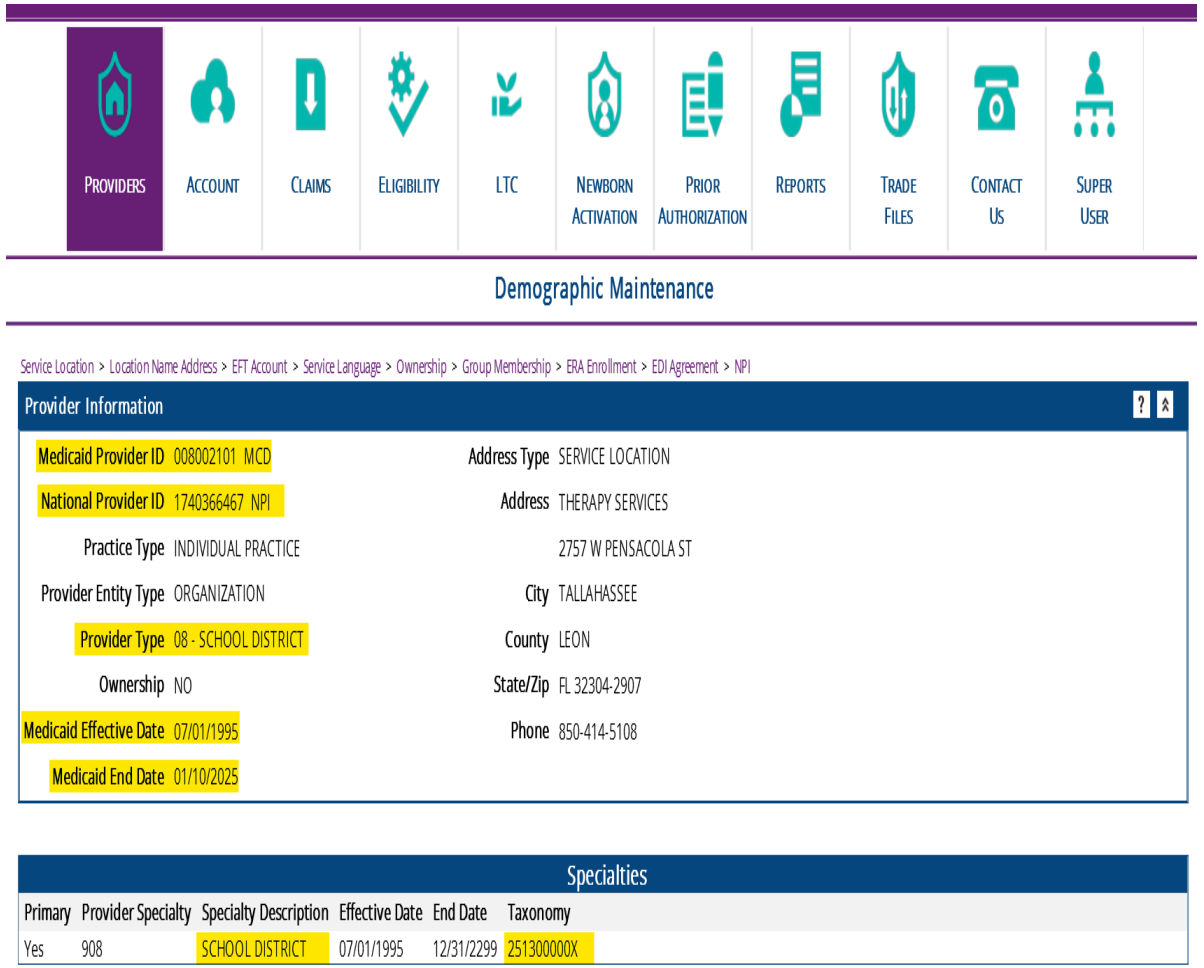


Clicking on **Demographic Maintenance** will show you the information including the practice type for the Medicaid Provider ID that you are in



The information here is important to know.

- Medicaid Provider ID, NPI (National Provider Identifier), Specialty, and Taxonomy
- Provider Type-School District
- Medicaid Effective and End Dates



- Under the Demographic Maintenance application, you will see several sub-tabs. Today, we will look at the Location Name Address

There are four different locations:

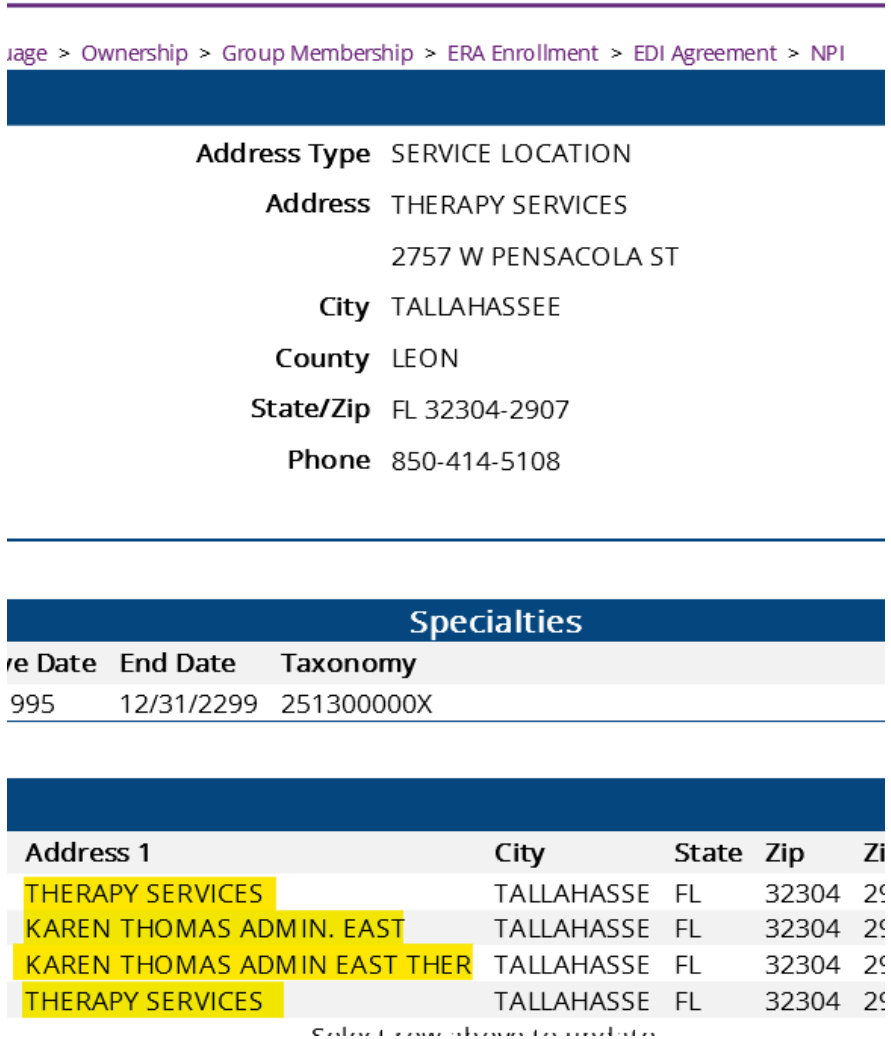
Home/Corporate Office

Mail To/Correspondence

Pay To Address

Service Location.

All these addresses do not have to be the same.



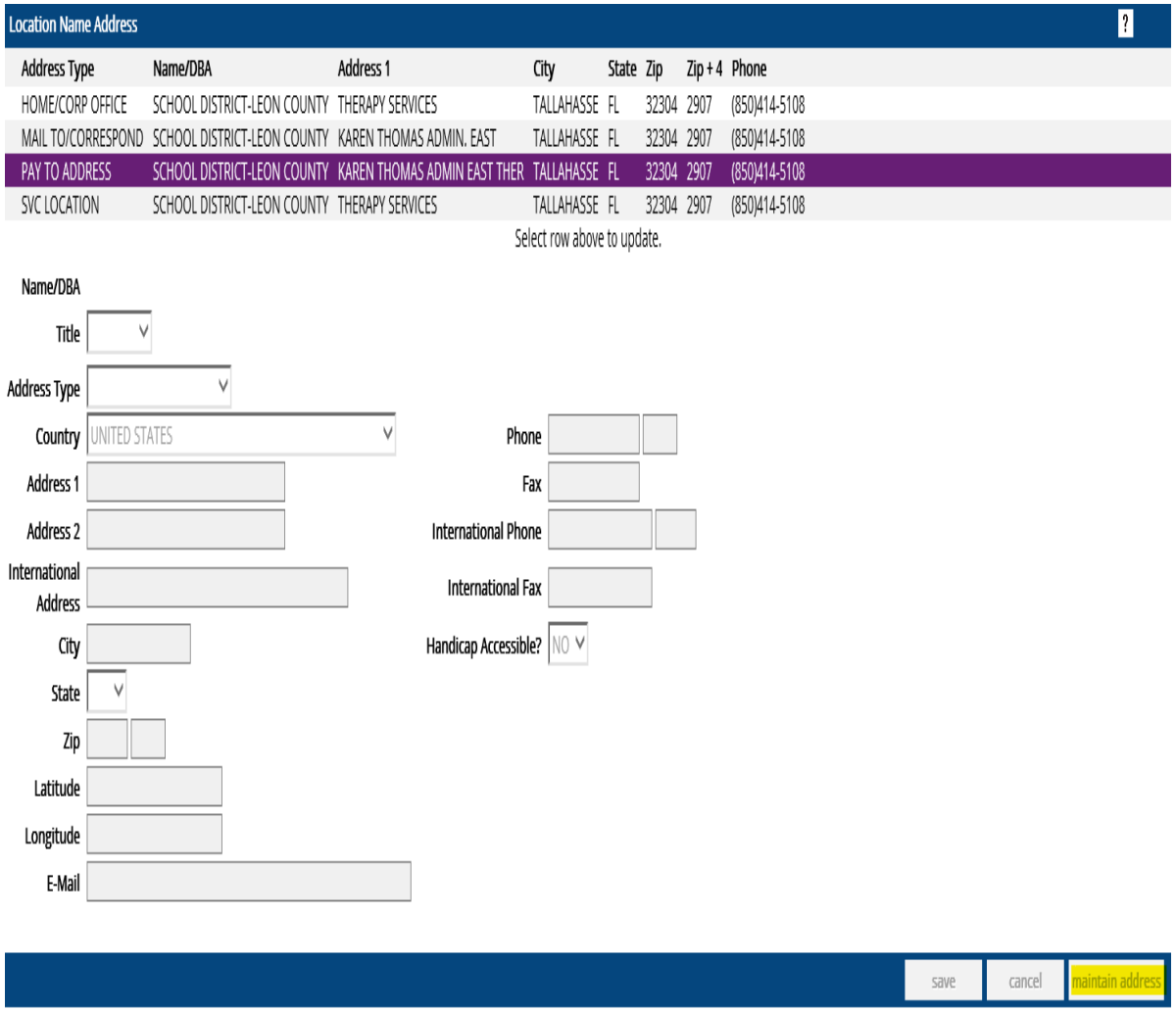
uage > Ownership > Group Membership > ERA Enrollment > EDI Agreement > NPI

Address Type	SERVICE LOCATION
Address	THERAPY SERVICES
	2757 W PENSACOLA ST
City	TALLAHASSEE
County	LEON
State/Zip	FL 32304-2907
Phone	850-414-5108

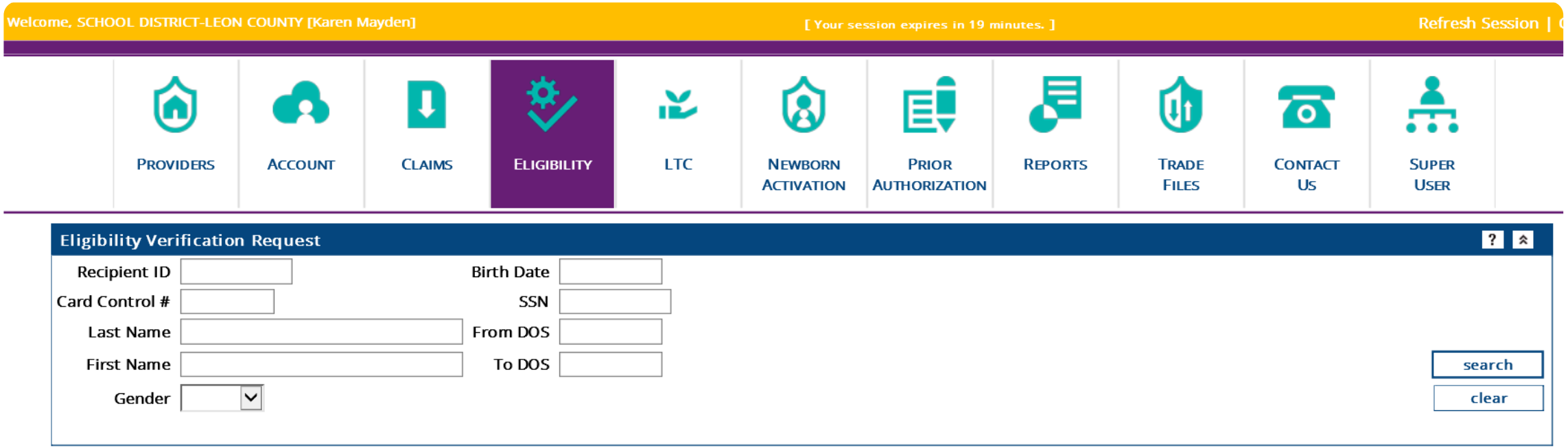
Specialties

ve Date	End Date	Taxonomy
995	12/31/2299	251300000X

Address 1	City	State	Zip	Zi
THERAPY SERVICES	TALLAHASSE	FL	32304	29
KAREN THOMAS ADMIN. EAST	TALLAHASSE	FL	32304	29
KAREN THOMAS ADMIN EAST THER	TALLAHASSE	FL	32304	29
THERAPY SERVICES	TALLAHASSE	FL	32304	29



- The Maintain Address in the bottom-right will direct you through changing and address. You will click on Maintain Address and follow the prompts. The system will go through each location, and you can mark no change or make an update. In the end, you will be e-mailed a passcode and have 10 minutes to enter the passcode to finalize the changes.



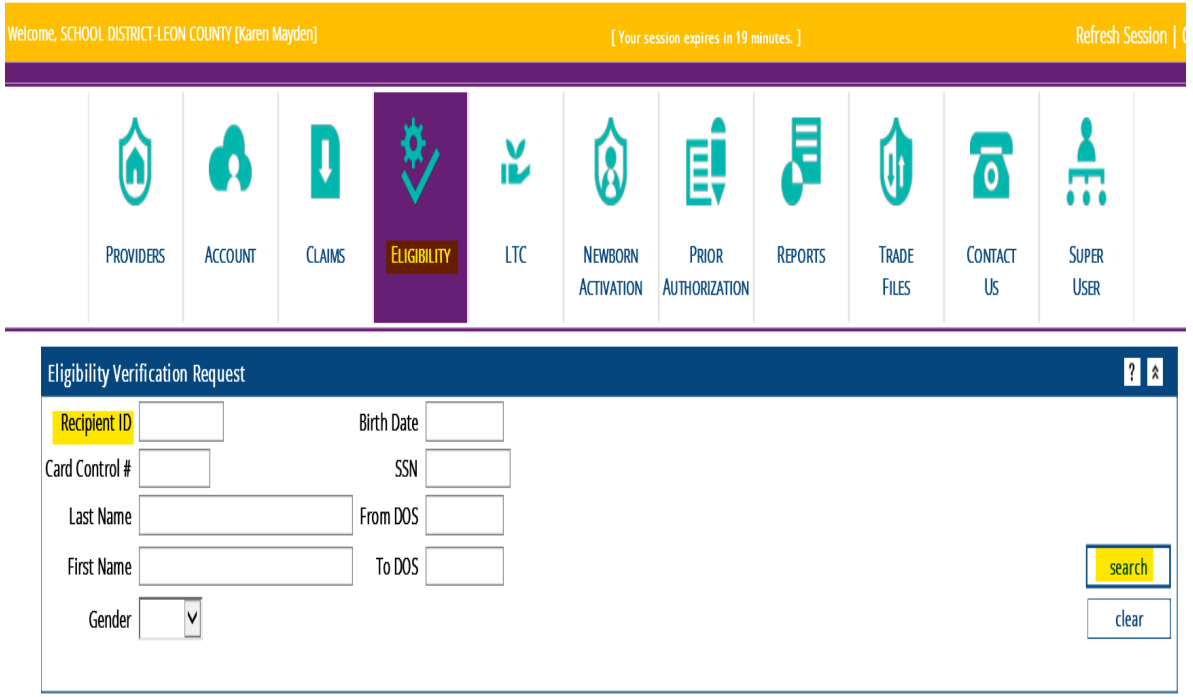
Eligibility

This is where you will check a student's Medicaid eligibility

When checking a student/recipient's Medicaid eligibility, keep in mind:

- The system will not go into the future
- You can check12 months into the past
- You can only check a single month at a time; for example, 08/01/2021-08/31/2021
- If you do not enter a date in the From DOS (date of service) To DOS, the system will look at eligibility for the current date only

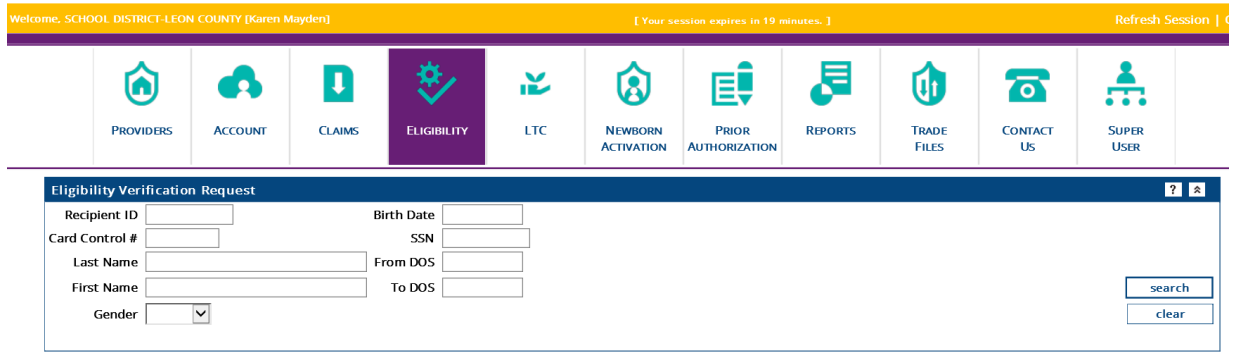
- Due to HIPAA and PHI laws, I cannot demonstrate an actual eligibility check.

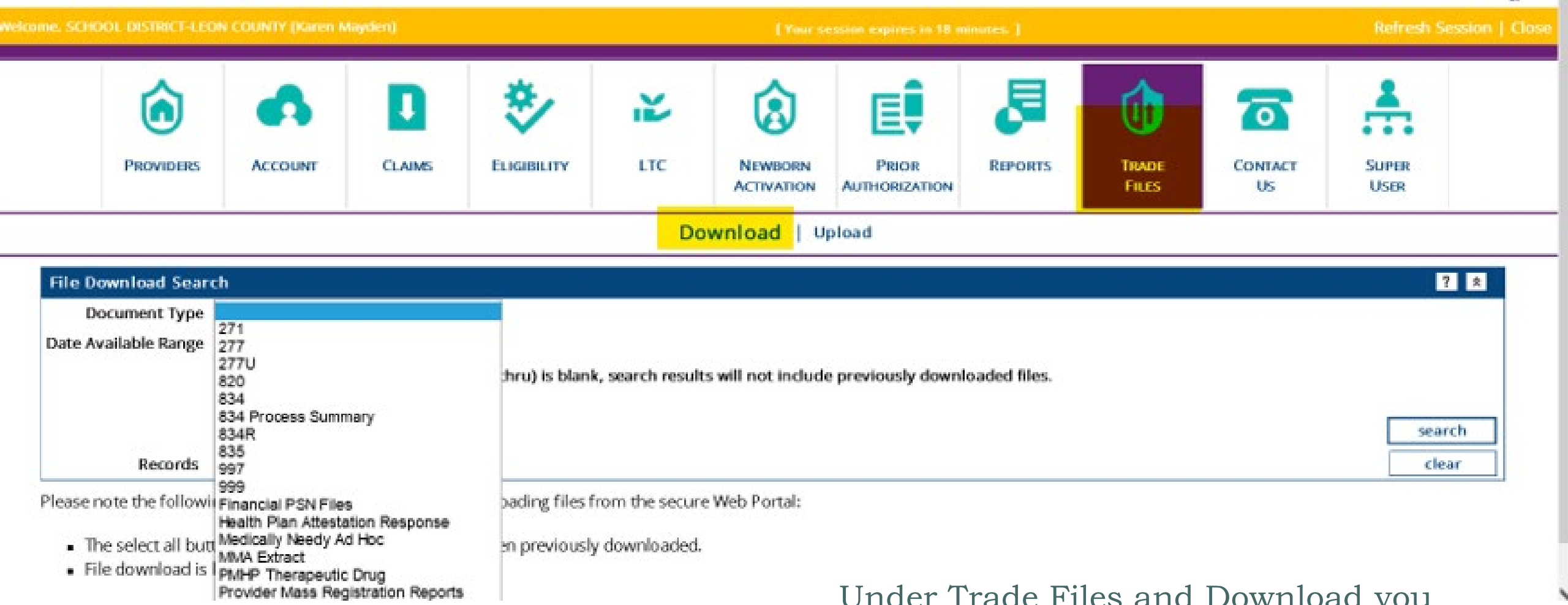


If you know the recipient's Medicaid ID, enter that in the Recipient ID field and press search. If you do not have the Medicaid ID, you can enter the other demographical information

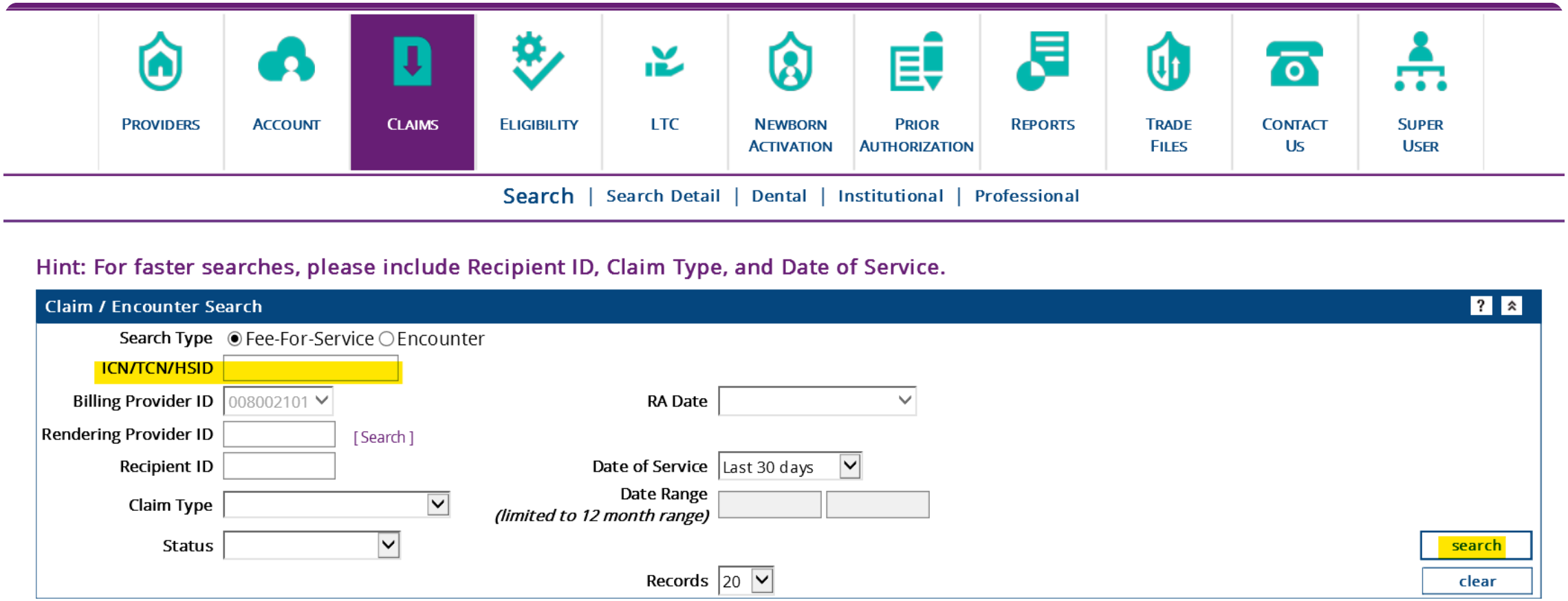
Last Name, First Name, Gender, Birthdate and or Social Security Number (SSN)

NOTE: Gender is determined by what is listed on a recipient's birth certificate or government-issued identification not what one identifies as





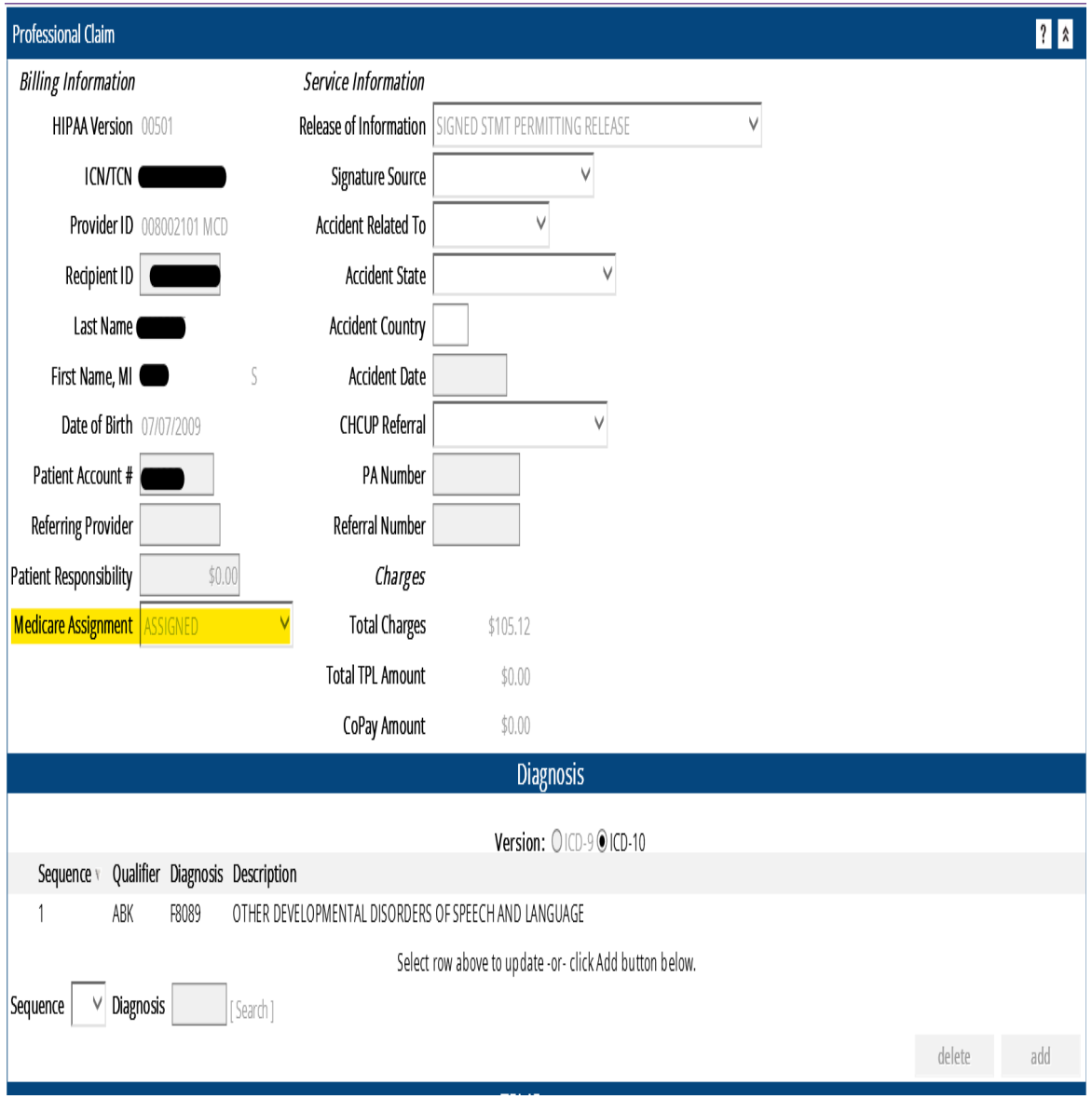
Under Trade Files and Download you can download the electronic batch files to check for Recipient eligibility. You can discuss further with your system administrator when and how to complete this task



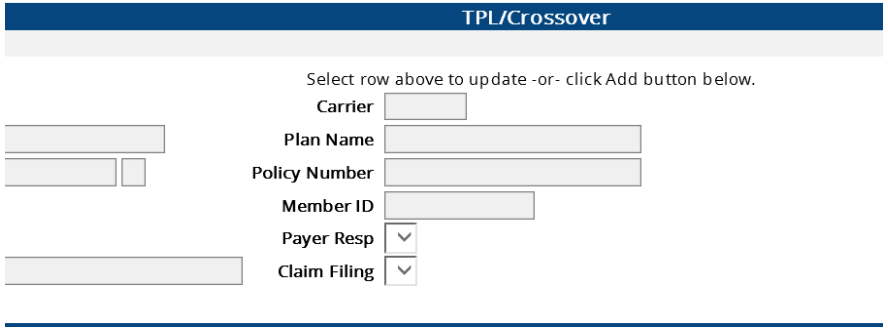
- To check a claim, you will need to enter the claim ICN and Search. If you do not have the claim ICN, enter the Recipient ID, Claim Type (Professional), Date Range, and Search

This is an actual claim that is redacted. The Medicare Assignment should always be NOT ASSIGNED, having it marked as Assigned *could* create billing issues

Diagnosis is always alpha-numeric and does not include the decimal



- Do not complete this panel as it is not applicable to school services



Detail

Item	From DOS	Procedure	M1	M2	M3	M4	Units	Charges	Status	Allowed Amount
11	12/15/2020	92508					2.00	$6.94	PAID	$4.73
10	11/24/2020	92508					2.00	$6.94	PAID	$4.73
9	11/04/2020	92507					2.00	$35.72	PAID	$24.35
8	12/08/2020	92508					2.00	$6.94	PAID	$4.73
7	11/03/2020	92508					2.00	$6.94	PAID	$4.73
6	11/05/2020	92508					2.00	$6.94	PAID	$4.73
5	11/18/2020	92508					2.00	$6.94	PAID	$4.73
4	12/09/2020	92508					2.00	$6.94	PAID	$4.73
3	11/10/2020	92508					2.00	$6.94	PAID	$4.73
2	11/12/2020	92508					2.00	$6.94	PAID	$4.73

1 2 Next >

Detail

Item	From DOS	Procedure	M1	M2	M3	M4	Units	Charges	Status	Allowed Amount
1	11/17/2020	92508					2.00	$6.94	PAID	$4.73

< Previous 1 2

- Detail Panel is where the services are entered. Each line will show whether it is paid or denied; in this instance, each line is paid. You can also see the date of service, units billed, and charge; as well as the allowed amount that was paid

1	11/17/2020	92508	2.00	$6.94	PAID	$4.73

< Previous 1 2

Type changes below.

Item 1

Line Control Number [redacted]

Rendering Provider 008002101 MCD

From DOS 11/17/2020

To DOS 11/17/2020

POS* 03

Procedure* 92508

Modifiers

Diagnosis Pointer* 1

Units 2.00

Charges $6.94

TPL Amount

TPL Paid Date

Emergency

CHCUP/Fam Plan

Ordering Provider

Referring Provider

Drug Rebate Information

NDC

Medicare Information

Paid Date

Paid Amount $0.00

Allowed Amount $0.00

Coinsurance Amount $0.00

Deductible Amount $0.00

Copay Amount $0.00

Medicaid Information

Status PAID

Allowed Amount $4.73

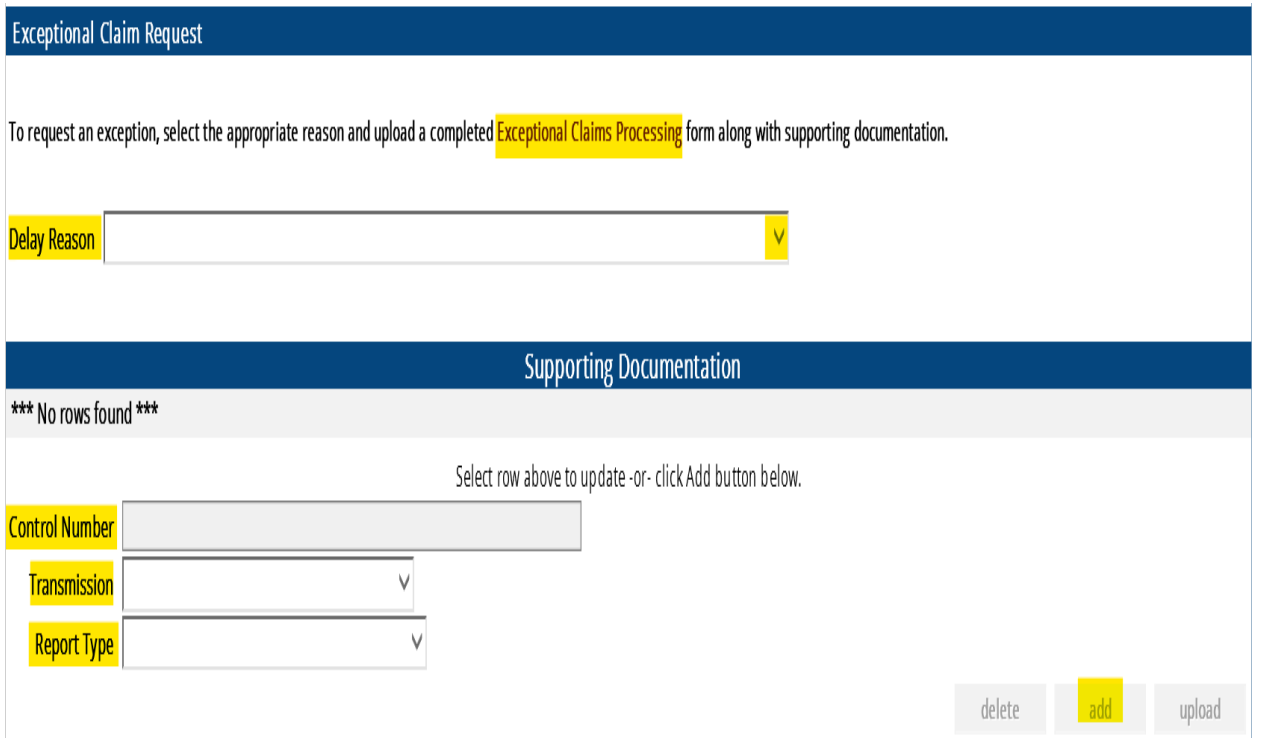
Copay Amount $0.00

delete add copy

- The information highlighted in the previous screen must be completed.

- **Rendering Provider**: who is providing the services
- **From DOS** (Date of Service)
- **To DOS**
- **POS** (Place of Service)-where the services were provided
- **Procedure Code**-code for service
- **Modifier**-provides additional information regarding service. Only certain modifiers are allowable
- **Diagnosis Pointer**-which diagnosis code points to that procedure
- **Units**-how much time spent providing the services
- **Charge**-You do the Math, multiply your units by the unit charge. The system will not do the math.

- To file an Exceptional Claim for whatever reason, the purple hyperlink “Exceptional Claims Processing” (highlighted) will send you to the PDF link for the Exceptional Claim Form
- The form must be completed and uploaded.
- An Exceptional Claim is requested when needing a system override for various reasons like timely filing



Request for Exceptional Claims Processing

Provider Name: _____

Contact: _____ Phone number: _____

Provider Number: _____

I am requesting an exception to the timely filing limit. The claim meets the exception criteria checked below:

Section I (Claim more than 12 months old.)

___(1) Eligibility file was not updated timely. Claim is within 12 months from the date of the recipient's file update.

___(2) Eligibility is the result of an administrative hearing or court decision. A copy of that decision is attached.

___(3) This claim is within 12 months of the Medicare payment or denial dated ___ ___ ___. A copy of the Medicare EOMB is attached.

___(4) This claim is within 6 months of a third party insurance payment or denial, dated ___ ___ ___. Documentation is attached.

___(5) Fiscal agent error caused my claim to deny erroneously, and my claim is submitted within 12 months of the adjudication date.

___(6) This claim was voided on ___ ___ ___. This claim is over 12 months from the date of service and within 6 months of the void date. Documentation is attached.

Section II (Claim less than 12 months old.)

___(1) Medicare does not cover the procedure listed on the claim, and Medicaid does cover this procedure. Medicare EOMB is attached.

___(2) Claim is approaching the 12 month timely filing limit.

___(3) Service limit exception is requested. (Examples: Recipient went to two hospitals or multiple pregnancies within one year.)

___(4) A Full or Limited provider, Referring, Ordering, or Attending provider enrolled after claim date of service.

___(5) Referring, Ordering, or Attending provider not on file. Order/referral prior to recipient eligibility, submit written referral.

Section III

Other reason: _____

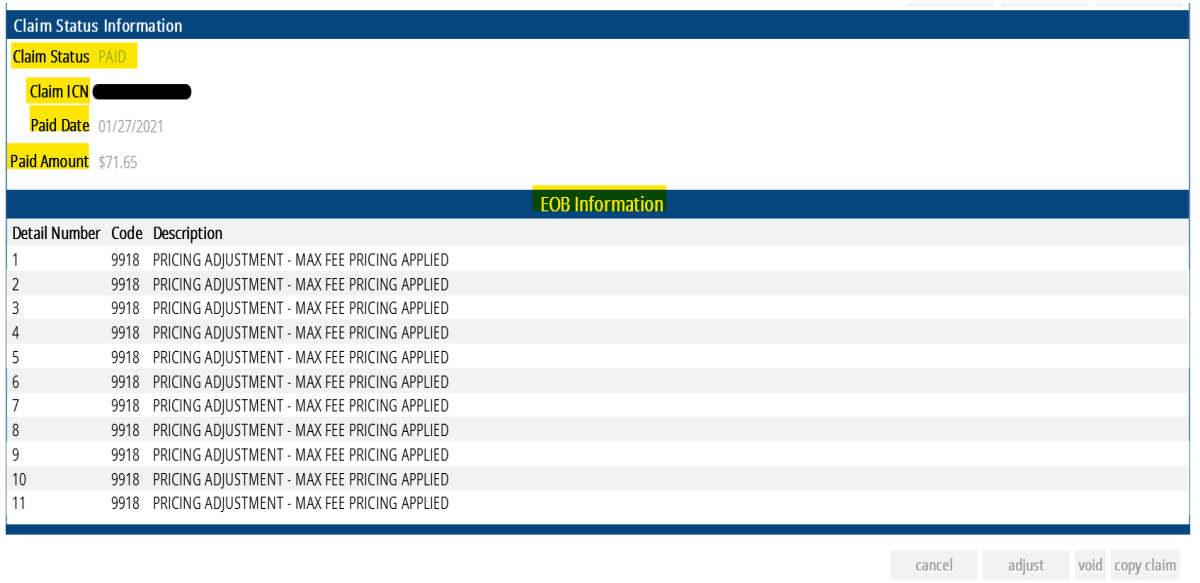
_____ _____

Signature **Date**

A separate completed Request for Exceptional Claims Processing form is required for each claim.

10/01/2021

- This claim has a status of Paid, the paid date, and the paid amount. If the claim had any denial reasons the denial code and description would be listed under EOB Information
- This EOB code will align with the Remittance Advice later in this presentation



Claim Status Information

Claim Status PAID

Claim ICN [redacted]

Paid Date 01/27/2021

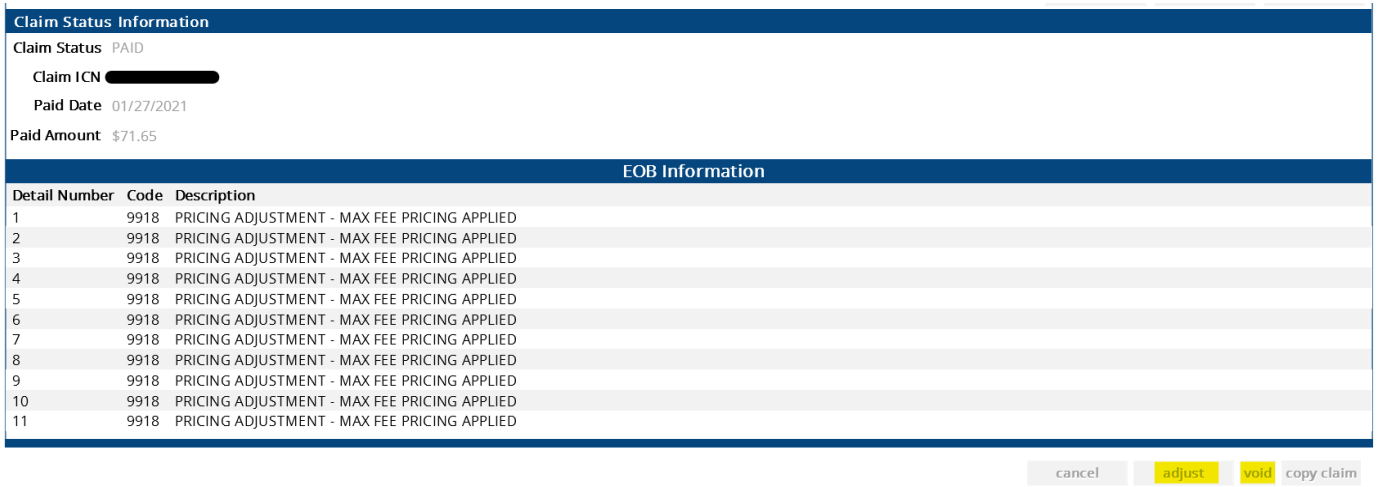
Paid Amount $71.65

EOB Information

Detail Number	Code	Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
2	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
3	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
4	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
5	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
6	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
7	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
8	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
10	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
11	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED

cancel adjust void copy claim

- If a claim has a detail line that needs to be adjusted, click on the detail line adjust the information and scroll to the bottom of the screen and click **Adjust**



If the entire claim needs to be voided, then scroll down to the bottom of the claim and click **Void**.

If there is no option to Adjust or Void that means this claim has already been adjusted or voided. You can check by doing a claim search

ADJUSTMENT VS. VOID

Adjustment

Only a paid claim can be adjusted

Make an adjustment if you need to make minor corrections to the claim

Providers have 12 months from the payment date to make an adjustment

Payment is made based on the adjustment

Void

Voiding a claim “kills” the claim, it is a full return.

The money will be recouped

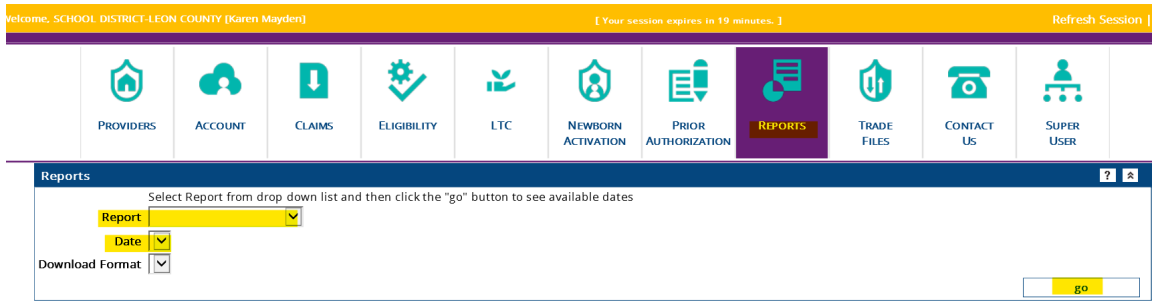
Replacement for a void must be submitted by Exceptional Claim within 6 months from the date of void **IF** the void is over 12 months from the date of service

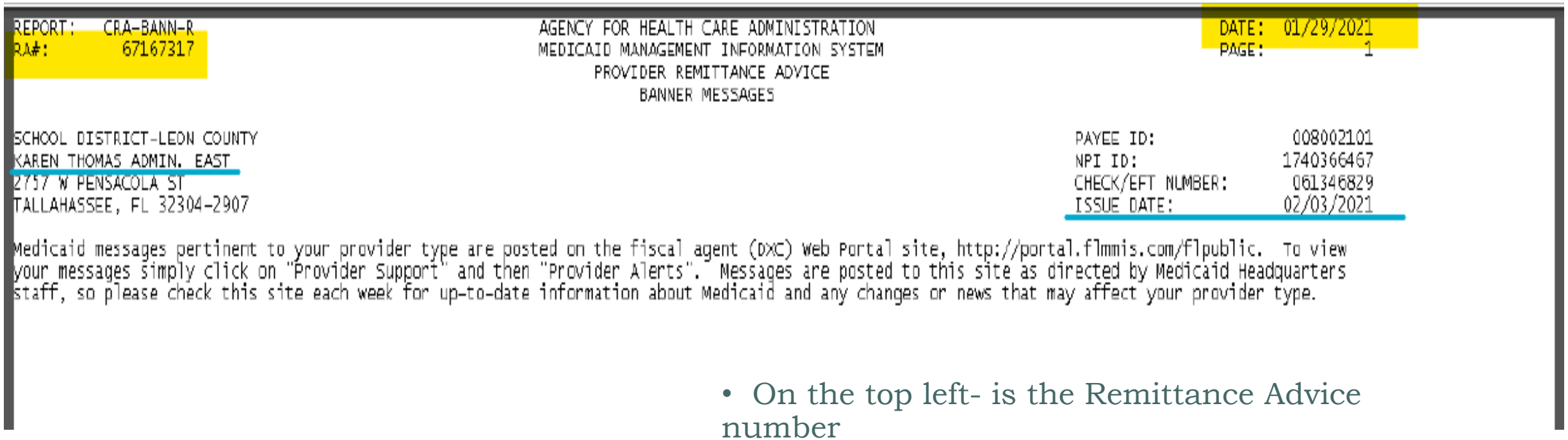
REMITTANCE ADVICE (RA)

Reports, **Go**, (choose date needed) **Date**, **View**

The RA will pull up in a PDF format. I recommend saving it to your desktop or on a flash drive.

RAs are posted in your portal for 90 days, if you must order an RA, they cost $.55/page, are not double-sided nor are face sheets removed, and can take up to 6 weeks to get.





REPORT: CRA-BANN-R
RA#: 67167317

AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
BANNER MESSAGES

DATE: 01/29/2021
PAGE: 1

SCHOOL DISTRICT-LEON COUNTY
KAREN THOMAS ADMIN. EAST
2757 W PENSACOLA ST
TALLAHASSEE, FL 32304-2907

PAYEE ID: 008002101
NPI ID: 1740366467
CHECK/EFT NUMBER: 061346829
ISSUE DATE: 02/03/2021

Medicaid messages pertinent to your provider type are posted on the fiscal agent (DXC) Web Portal site, http://portal.flmmis.com/flpublic. To view your messages simply click on "Provider Support" and then "Provider Alerts". Messages are posted to this site as directed by Medicaid Headquarters staff, so please check this site each week for up-to-date information about Medicaid and any changes or news that may affect your provider type.

Remittance Advice-page 1

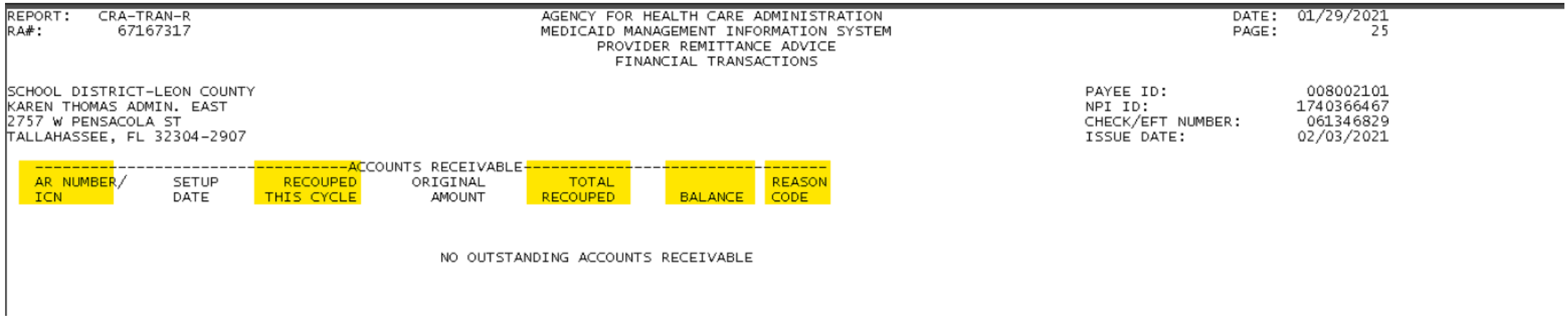
- On the top left- is the Remittance Advice number
- As you can see underlined in blue on the left side is the school address and that this is addressed to Karen Thomas.
- On the right underlined in blue is the date the money is actually paid into the account. These dates usually differ by a few days

ICN PATIENT NUMBER	SERVICE DATES FROM THRU		BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
MEDICAID ID: [redacted]	BENEFICIARY NAME: [redacted]						
[redacted]7759	011221 011321		13.88	9.46	0.00	0.00	9.46
206074							

PL	SERV	PROC CD	MODIFIERS	EAPG CODE	EAPG WEIG	DISC PERC	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PAID AMOUNT	DETAIL EOBS
	03	92508					2.00	011221	011221	MCD 008002101	6.94	4.73	0.00	4.73	9918
	03	92508					2.00	011321	011321	MCD 008002101	6.94	4.73	0.00	4.73	9918

- This segment of an RA provides all the information that is billed.

- The recipient's Medicaid ID, Name, ICN (underlined in blue), Claim Billed Amount, Claim Allowed Amount, Claim Paid Amount, Detail Procedure code, Modifier(s), Units billed, Service Dates, Billed Amount, Paid Amount per line item, EOB (Explanation of Benefit) Codes



REPORT: CRA-TRAN-R
RA#: 67167317

AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: 01/29/2021
PAGE: 25

SCHOOL DISTRICT-LEON COUNTY
KAREN THOMAS ADMIN. EAST
2757 W PENSACOLA ST
TALLAHASSEE, FL 32304-2907

PAYEE ID: 008002101
NPI ID: 1740366467
CHECK/EFT NUMBER: 061346829
ISSUE DATE: 02/03/2021

ACCOUNTS RECEIVABLE

AR NUMBER/ ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL RECOUPED	BALANCE	REASON CODE

NO OUTSTANDING ACCOUNTS RECEIVABLE

- Near the end of the RA there is a page that will show if there are recoupments set up.
- It will display the impacted ICN, amount recouped, the total recouped, and the balance left; as well as the reason code

REPORT: CRA-SUMM-R
RA#: 67167317

AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
REMITTANCE ADVICE SUMMARY

DATE: 01/29/2021
PAGE: 26

SCHOOL DISTRICT-LEON COUNTY
KAREN THOMAS ADMIN. EAST
2757 W PENSACOLA ST
TALLAHASSEE, FL 32304-2907

PAYEE ID: 008002101
NPI ID: 1740366467
CHECK/EFT NUMBER: 061346829
ISSUE DATE: 02/03/2021

----------CLAIMS DATA----------

	CURRENT NUMBER	CURRENT AMOUNT
CLAIMS PAID	134	1,835.98
CLAIM ADJUSTMENTS	0	0.00
TOTAL CLAIMS PAYMENTS	134	1,835.98
CLAIMS DENIED	2	
CLAIMS IN PROCESS	0	

----------EARNINGS DATA----------

PAYMENTS:	
CLAIMS PAYMENTS	1,835.98
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00
ACCOUNTS RECEIVABLE (OFFSETS):	
CLAIM SPECIFIC:	
CURRENT CYCLE	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)
NON-CLAIM SPECIFIC OFFSETS	(-0.00)
NET PAYMENT	1,835.98
REFUNDS:	
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)
OTHER FINANCIAL:	
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00
VOIDS	(0.00)
NET EARNINGS	1,835.98

ICN		SERVICE DATES		BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PAID AMOUNT
PATIENT NUMBER		FROM	THRU					
MEDICAID ID: [redacted]		BENEFICIARY NAME: [redacted]						
[redacted]7759		011221	011321	13.88	9.46	0.00	0.00	9.46
206074								

PL	SERV	PROC CD	MODIFIERS	EAPG CODE	EAPG WEIG	DISC PERC	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PAID AMOUNT	DETAIL EOBS
	03	92508					2.00	011221	011221	MCD 008002101	6.94	4.73	0.00	4.73	9918
	03	92508					2.00	011321	011321	MCD 008002101	6.94	4.73	0.00	4.73	9918

REPORT: CRA-EOBM-R
RA#: 67167317

AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 01/29/2021
PAGE: 27

SCHOOL DISTRICT-LEON COUNTY
KAREN THOMAS ADMIN. EAST
2757 W PENSACOLA ST
TALLAHASSEE, FL 32304-2907

PAYEE ID: 008002101
NPI ID: 1740366467
CHECK/EFT NUMBER: 061346829
ISSUE DATE: 02/03/2021

REASON CODE/ EOB CODE	REASON CODE DESCRIPTION/ EOB CODE DESCRIPTION
4257	INVALID PROCEDURE CODE MODIFIER
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED

- The last page of an RA displays the EOB Codes. I highlighted the code that matched the below segment. EOB code 9918, shows the Max Fee Schedule Paid

- This EOB code matches what was shown previously in the claim

RESOURCES

Public Web Portal

www.mymedicaid-florida.com

Call Center contact

- (800)289-7799
  - Option 4-Provider Enrollment
  - Option 7-Provider Field Services Contact Call Center and Field Services Representative

AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

(877)254-1055

www.ahca.myflorida.com

USEFUL INFORMATION

Even though you are a school administrator you are also a Medicaid Provider, this is another of the many hats you wear

When signing into the web portal, your username is service-specific. You will need to sign in (switch to) the portal for the service you want to bill, check the claim, review a Remittance Advice

If you do not find what you are looking for change your account, you may be in the wrong provider account

Contact your Field Service Representative, we are all here to help.

MY INFORMATION

Karen Mayden-Samanamud

- Area 4-St. Johns, Flagler, Volusia, and Clay counties
- kmayden@gainwelltechnologies.com
- Feel free to contact me for any of your questions; I am available to help in all regions
- I schedule trainings Tuesday-Thursdays

WHAT QUESTIONS DO YOU HAVE?

Medicaid Parental Consent and Annual Notification Checklist

District:

Paragraph 6A-6.03028(3), Florida Administrative Code (F.A.C.), IEP Requirements.

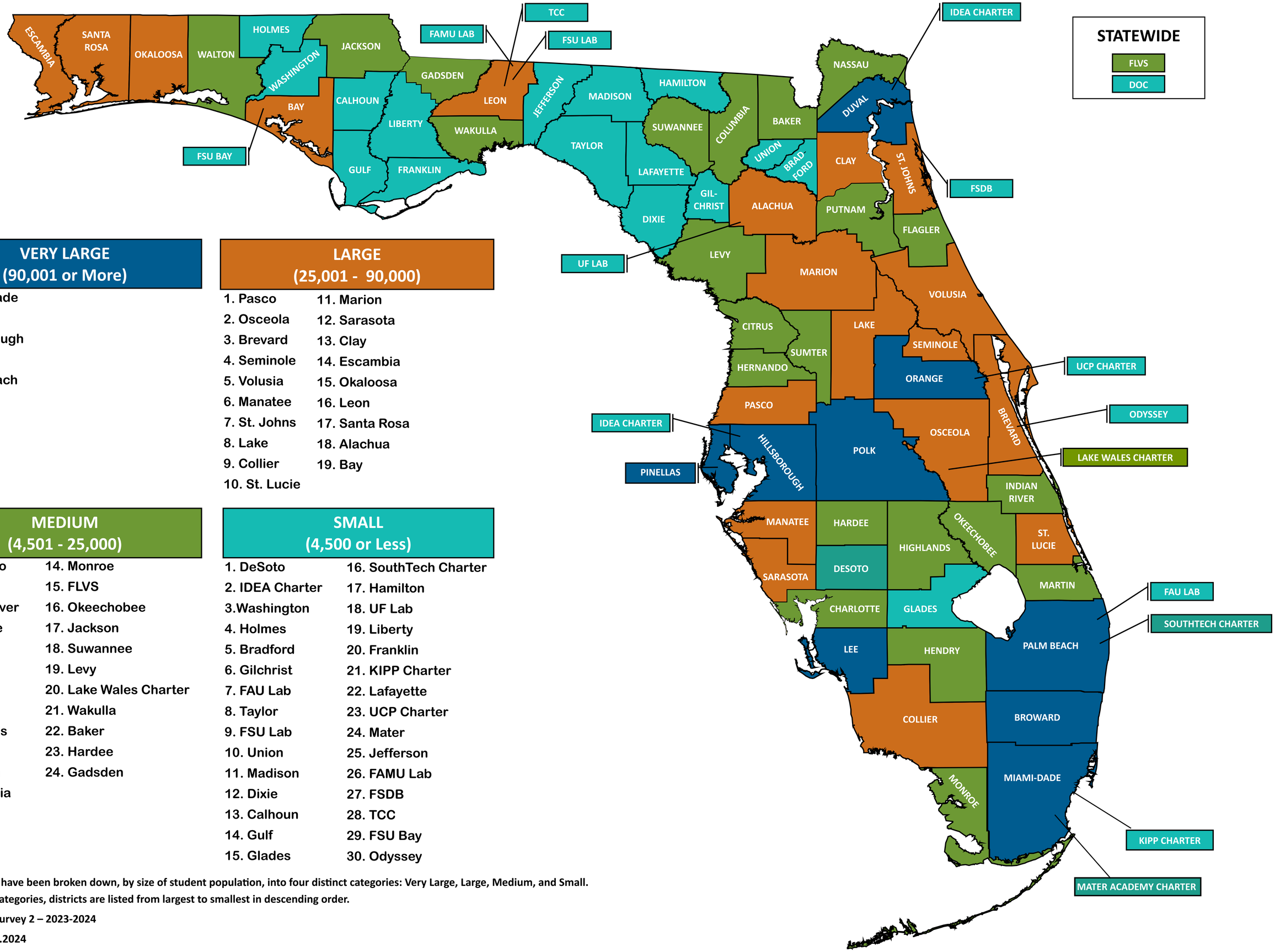
(q) Procedures for students with disabilities who are covered by public benefits or insurance. A school district may use the Medicaid or other public benefits or insurance programs in which a student participates to provide or pay for services required under Rules 6A-6.03011-.0361, F.A.C., as permitted under the public benefits or insurance program, except as provided herein.

1. With regard to services required to provide FAPE to an eligible student under the IDEA, the school district:

☐	a. May not require parents to sign up for or enroll in public insurance programs in order for their student to receive FAPE under Part B of the IDEA;
☐	b. May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to the IDEA, but pursuant to subparagraph (3)(q)3. of this rule, may pay the cost that the parent otherwise would be required to pay;
☐	c. May not use a student's benefits under a public insurance program if that use would:
☐	(I) Decrease available lifetime coverage or any other insured benefit;
☐	(II) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the student outside of the time the student is in school;
☐	(III) Increase premiums or lead to the discontinuation of benefits or insurance; or
☐	(IV) Risk loss of eligibility for home and community-based waivers, based on aggregate health related expenditures; and,
☐	d. Prior to accessing the student's or parent's public benefits or insurance for the first time, and after providing notification to the student's parent as described in sub-subparagraph e. of paragraph (3)(q), the school district must obtain written, parental consent that specifies:
☐	(I) The personally identifiable information that may be disclosed such as records or information about the services that may be provided to the student;
☐	(II) The purpose of disclosure, such as for purpose of billing for services;
☐	(III) The agency to which the disclosure may be made; and,
☐	(IV) That the parent understands and agrees that the school district may access the parent's or student's public benefits or insurance to pay for services required under Rules 6A-6.03011-.0361, F.A.C.
☐	e. Prior to accessing a student's or parent's public benefits or insurance for the first time, and annually thereafter, the school district must provide written notification consistent with the requirements found in paragraphs 6A-6.03311(1)(a) and (b), F.A.C., to the student's parents that includes:
☐	(I) A statement of the parental consent provision in sub-subparagraph d. of this paragraph;
☐	(II) A statement of the no cost provisions of subparagraph (3)(q)1.;
☐	(III) A statement that the parents have the right to withdraw their consent to disclose their child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance at any time; and,
☐	(IV) A statement that the withdrawal of consent or refusal to provide consent to disclose personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program does not relieve the school district of its responsibility to ensure that all required services are provided at no cost to the parents.

Date Reviewed:

Florida Size-Alike Map



VERY LARGE (90,001 or More)

1. Miami-Dade
2. Broward
3. Hillsborough
4. Orange
5. Palm Beach
6. Duval
7. Polk
8. Lee
9. Pinellas

LARGE (25,001 - 90,000)

1. Pasco
2. Osceola
3. Brevard
4. Seminole
5. Volusia
6. Manatee
7. St. Johns
8. Lake
9. Collier
10. St. Lucie
11. Marion
12. Sarasota
13. Clay
14. Escambia
15. Okaloosa
16. Leon
17. Santa Rosa
18. Alachua
19. Bay

MEDIUM (4,501 - 25,000)

1. Hernando
2. Martin
3. Indian River
4. Charlotte
5. Citrus
6. Flagler
7. Hendry
8. Nassau
9. Highlands
10. Walton
11. Putnam
12. Columbia
13. Sumter
14. Monroe
15. FLVS
16. Okeechobee
17. Jackson
18. Suwannee
19. Levy
20. Lake Wales Charter
21. Wakulla
22. Baker
23. Hardee
24. Gadsden

SMALL (4,500 or Less)

1. DeSoto
2. IDEA Charter
3. Washington
4. Holmes
5. Bradford
6. Gilchrist
7. FAU Lab
8. Taylor
9. FSU Lab
10. Union
11. Madison
12. Dixie
13. Calhoun
14. Gulf
15. Glades
16. SouthTech Charter
17. Hamilton
18. UF Lab
19. Liberty
20. Franklin
21. KIPP Charter
22. Lafayette
23. UCP Charter
24. Mater
25. Jefferson
26. FAMU Lab
27. FSDB
28. TCC
29. FSU Bay
30. Odyssey

Note: Districts have been broken down, by size of student population, into four distinct categories: Very Large, Large, Medium, and Small. Within these categories, districts are listed from largest to smallest in descending order.

Source: Final Survey 2 – 2023-2024

Updated: 3.26.2024

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Objective	Task	Success Criteria	Resources	Workplan
Increase Medicaid reimbursement	Hire Medicaid fiscal staff	Show compliance with rule, statute, policy and increase Medicaid reimbursement	■ Medicaid Consultant with FDOE ■ School district Medicaid contacts	
Reduce school district costs	No cost/No contract Schedule demo of Electronic Medicaid Administrative Claiming System (EMACS) with FDOE	Potential future reduction in expenditures	■ Medicaid Consultant with FDOE ■ School district Medicaid contacts	
Increase Medicaid administrative claiming reimbursement	Review approved state- and district-specific job codes to ensure all approved staff (district and contract) are included in district quarterly sample pool	Show an increase in the claim	■ Pages 3-1 through 3-5 of the Medicaid School District Administrative Claiming Guide ■ Medicaid Consultant with FDOE ■ AHCA point of contact	
Increase Medicaid administrative claiming reimbursement	Complete certification form for job codes not currently approved by AHCA who provide Medicaid administrative claiming reimbursable activities and add approved staff to the district quarterly sample pool and claim (annually)	Show an increase in the claim	■ Pages 3-1 through 3-8 of the Medicaid School District Administrative Claiming Guide ■ Job Title Certification Form ■ Job Title Certification Checklist ■ Medicaid Consultant with FDOE ■ AHCA point of contact	

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Objective	Task	Success Criteria	Resources	
Increase Medicaid administrative claiming reimbursement	Review costs attributed to the non-sampled supervisory (one level up) and clerical staff (one level down) who provide direct support to those who perform SDAC activities, certify the position and add those costs to the quarterly claim	Show an increase in the claim	■ Pages 6-2 through 6-3 of the Medicaid School District Administrative Claiming Guide ■ Medicaid Consultant with FDOE	
Increase Medicaid administrative claiming reimbursement	Review cost center start and end times to verify accuracy (times should include staff hours not bell schedule times) and capture all staff administrative claiming activities	Compliance with time sample requirements and potential increase in the claim	■ Page 4-1 of the Medicaid School District Administrative Claiming Guide ■ Medicaid consultant with FDOE	
Increase Medicaid administrative claiming reimbursement	Train sample pool staff on the importance of the administrative claiming program along with training on completing their moments within 7 working days (electronic) or 30 working days (paper)	Receive 100% valid sample moments, which may potentially increase the claim	■ Training guides for participants	

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Increase Medicaid administrative claiming reimbursement	Provide appropriate training for district contact on coding random moment samples for the Medicaid school district administrative claiming program	Decrease findings on the SDAC monitoring summary tool, which may increase the district claimable percentage and increase the claim	■ Florida School District Medicaid Administrative Claiming Guide ■ SDAC Monitoring Tool and RMS Monitor Review Process ■ Medicaid Consultant with FDOE ■ AHCA point of contact	
Increase Medicaid administrative claiming reimbursement	Review the claiming workbook to increase knowledge of the claiming process	Show an increase in the claim	■ Medicaid School District Administrative Claiming Guide	
Increase Medicaid administrative claiming reimbursement	Calculate district specific Medicaid eligibility rate	Show an increase in the claim	■ Medicaid Consultant with FDOE ■ AHCA point of contact	

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Objective	Task	Success Criteria	Resources	
Reduce school district fee for service costs	No cost/No contract Schedule demo of Medicaid Tracking System with FDOE	Potential future reduction in expenditures	■ Medicaid Consultant with FDOE ■ School district Medicaid contact	
Increase fee for service reimbursement	Capture Medicaid parental consent for IEP and non-IEP students (IDEA and FERPA Requirement)	Show an increase in Medicaid reimbursement	■ Medicaid Parental Consent and Annual Notification Requirements ■ Medicaid Parental Consent and Annual Notification Checklist ■ Medicaid Parental Consent Examples ■ Medicaid Annual Notification Example ■ School district Medicaid contact ■ Medicaid Consultant with FDOE	
Increase fee for service reimbursement	Review billing system(s) to ensure alignment with Medicaid billing requirements, including transportation	Decrease instances where claims need to be voided thereby decreasing loss of Medicaid reimbursement	■ Medicaid Certified School Match Program Coverage and Limitations Handbook ■ Fee for Service Monitoring Checklist, Fee for Service Monitoring Instrument, Shared District Resources with examples of ICD-10 Codes ■ Fee schedule ■ Medicaid Consultant with FDOE ■ School district Medicaid contact	

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Increase fee for service reimbursement	Review provider documentation to ensure all billable providers are documenting and all billable services are being documented to increase Medicaid reimbursable services	Show an increase in Medicaid reimbursement	▪ Reports from documentation system to share with administrative staff	
Increase fee for service reimbursement	Review and understand the remittance advice (RA) received from AHCA	Decrease denied claims	▪ Medicaid Consultant with FDOE ▪ School district Medicaid contact ▪ Fiscal agent representative	

IMPLEMENTATION AND PROGRAM READINESS ACTION PLAN

Objective	Task	Success Criteria	Resources	
Increase fee for service reimbursement	Follow up on denied claims	Decrease denied claims	■ Medicaid Consultant with FDOE	
Increase fee for service reimbursement	Run Medicaid eligibility checks monthly	Show an increase in Medicaid reimbursement	■ Medicaid Consultant with FDOE	
Increase fee for service reimbursement	Review billable provider's funding source and move 100% federally funded positions to locally funded positions	Show an increase in Medicaid reimbursement	■ Medicaid Consultant with FDOE ■ School district Medicaid contact	
Increase fee for service reimbursement	Complete a rate study to increase rates for each provider type including transportation	Show an increase in Medicaid reimbursement	■ Page B-1 through B-3 of the Medicaid Certified School Match Program Coverage and Limitations Handbook ■ AHCA Transportation Rate Calculation Guide and AHCA Transportation Calculation Sheet ■ Medicaid Consultant with FDOE ■ AHCA point of contact ■ School district Medicaid contact	

Increase fee for service reimbursement	Review s.409.9071, F.S., and draft rule AHCA provides and submit comments (when available), review documentation system to ensure compliance with draft rule (when available) and submit claims for services delivered to all Medicaid eligible students with a plan	Show an increase in Medicaid reimbursement	■ S. 409.9071, F.S. ■ Medicaid Consultant with FDOE ■ AHCA point of contact ■ School district Medicaid contact	