Pennsylvania Department of Human Services
School-Based ACCESS Program Handbook
September 2022

CONTENTS

SECTION 1 – GENERAL INFORMATION

1.1 Introduction

The PA School-Based ACCESS Program (SBAP) Handbook is intended to be used by Local Education Agencies (LEA) who are enrolled in Pennsylvania's Medical Assistance (MA) Program as school-based service providers through the Pennsylvania Department of Human Services (DHS).

The handbook provides MA regulatory requirements, instructions, and other information to assist providers in appropriately claiming for reimbursement of school-based services.

All MA regulatory and billing requirements must be met in order to bill. However, the MA regulatory and billing requirements presented in this handbook do not supersede the requirements of the Individuals with Disabilities Education Act (IDEA).

MA-enrolled providers are held responsible for the accuracy of the claims submitted. All enrolled MA providers are responsible to follow the requirements found in 55 Pa. Code Chapter 1101 and Chapter 1150. See the links below for a full version of the regulations:

General Provisions
MA Program Payment Policies

Additionally, MA providers receive MA bulletins that address billing requirements for MA Program services. MA providers can use the Bulletin Search function on DHS' website.

For the most current version of the handbook refer to the SBAP page on DHS' website under "Providers."

1.2 School-Based ACCESS Program

Federal History

Created in 1965 through Title XIX of the Social Security Act, Medicaid is the state and federal government program that provides health care coverage for eligible individuals, including low-income individuals and individuals with disabilities.

The Medicare Catastrophic Coverage Act amended Title XIX by providing that payment through the Medicaid program is not prohibited because such "services are included in the child's

individualized education program established pursuant to Part B of the Individuals with Disabilities Act." (Social Security Act § 1903c [42 U.S.C. 1396b(c)])

State History

The SBAP has operated in PA since 1991. The SBAP allows LEAs to receive reimbursement for health-related services provided to MA-enrolled children who are under 21 years of age when those services are documented in the child's IEP.

In 2012, DHS established a new payment methodology based on cost for both direct services and administrative claiming.

Key components of the SBAP payment methodology include:

- Direct Services and Special Transportation Claiming;
- Medicaid Administrative Claiming (MAC);
- Random Moment Time Study (RMTS); and
- Annual Cost Reconciliation and Settlement.

Health-related services provided or purchased by LEAs defined in a student's IEP may be compensable provided:

- The student is MA-eligible on the dates of service;
- The services are defined in Pennsylvania's Medicaid State Plan and are medically necessary;
- The services are ordered or prescribed by a licensed Medical Doctor (M.D.), licensed Doctor of Osteopathic Medicine (D.O.), licensed Certified Registered Nurse Practitioner (CRNP), or other licensed practitioner within his or her scope of practice;
- The services are provided as part of a face-to-face encounter with the student;
- The services defined in the IEP include frequency and duration;
- The one-time parental consent and annual parental notification to access public benefits is obtained; and
- Federal and state regulations are followed, including those which govern provider qualifications and documentation.

1.3 Participation Requirements

1.3.a. New SBAP Providers

New SBAP Providers are to complete each of the steps below:

- Enroll with PA Medical Assistance (see Section 2);

- Complete an LEA Agreement (see Appendix A);
- Certify a calendar for participation in the RMTS (see Section 8.3.d);
- Certify both direct and administrative cost pool lists for participation in the RMTS (see Section 8.4);
- Provide information to the Lot 2 vendor required for rate setting (see Section 7.3); and
- Complete training on the Lot 1 vendor's system (for services logs, claiming, and RMTS. See Section 8.2).

For additional information, see the sections referenced above and the LEA Participation Flowchart, found in Appendix E. The steps above, in particular certifying a calendar and staff pool lists, require that LEAs begin their participation in SBAP at the start of a quarter. LEAs are encouraged to begin participation at the start of the school year (the July to September quarter) in order to take advantage of all of the benefits of the SBAP.

By signing an LEA Agreement, the LEA is acknowledging the requirement to participate in each of the program components. Failure to participate in each of the program components may result in a lower or no reimbursement.

1.3.b. Ongoing Responsibilities

LEAs that participate in the SBAP must do **all** of the following in each year of participation:

- Comply with all applicable state and federal statutes, regulations, and policies which pertain to participation in the Pennsylvania MA Program;
- Assign a representative of the LEA to participate in SBAP mandatory training;
- Participate fully in all aspects of the RMTS (see Section 8);
- Complete annual financial report (AFR) for PDE, ensure an indirect cost rate is requested and the necessary information provided for its calculation (see Section 9.4);
- Submit compensable direct service claims (see Section 7.2);
- Complete annual cost reconciliation/cost settlement of direct service claiming (see Section 7.6); and
- Participate in all mandatory Oversight and Monitoring reviews and Quality Assurance Reviews (see Section 7.7).

Failure to participate in each of the program components may result in a lower or no reimbursement.

LEAs are responsible to revalidate their enrollment with the MA Program every five years (see Section 2.2).

1.3.c. Discontinuing Participation in SBAP

LEAs may stop claiming at any time but should notify DHS in writing of their intent to stop participating in the SBAP. LEAs should also check the Lot 1 vendor website for outstanding or upcoming RMTS moments.

The SBAP conducts cost settlement annually on June 30 of the fiscal year. LEAs are responsible for Cost Settlement for the last fiscal year in which they participate in SBAP. While an LEA may stop participating at any time during the fiscal year, Cost Settlement is still required for the last fiscal year. If an LEA discontinues participation in SBAP and does NOT complete cost settlement for the fiscal year, all MAC and interim payments for that fiscal year will be recouped.

LEAs must maintain relevant documentation even if they discontinue participating in the SBAP in accordance with Section 5.

1.4 Covered Services

- Assistive Technology Devices
- Audiology Services
- Hearing-Impaired Services
- Nursing Services
- Nurse Practitioner Services
- Occupational Therapy Services
- Orientation, Mobility and Vision Services
- Personal Care Services
- Physical Therapy Services
- Physician Services
- Psychiatric Services
- Psychological Services
- Social Work and Counseling Services
- Special Transportation Services
- Speech and Language Services

Specific information regarding each covered service is found in Section 3.

1.5 Commonwealth Contractors

DHS utilizes contractors to help administer the SBAP statewide. The contractors' services are divided into two contracts or "lots."

Lot 1 services include conducting the RMTS, submitting quarterly claiming for Medicaid administrative activities to DHS, and operating and maintaining a third-party billing system to submit claims to DHS for direct services and special transportation.

Lot 2 services include performing annual cost reconciliation and settlement tasks and conducting quarterly RMTS coding reviews.

After an open and competitive Request for Proposals (RFP) process, DHS entered into contracts, beginning on July 1, 2016, with **Public Consulting Group** (PCG) for Lot 1 services, and with **Sivic Solutions Group** (SSG) for Lot 2 services. The terms of the contracts are three years, with two optional one-year extensions.

LEAs cannot submit claims for direct service or Medicaid administration directly to the Pennsylvania MA Program. LEAs may contract with third-party vendors to assist with preparation of program documentation, claims data and cost reports; however, all data must be electronically submitted by the LEAs to DHS' contractors for submission to the Pennsylvania MA Program. LEAs are responsible for the actions of their third-party vendors.

<u>Lot 1 Contractors' Responsibilities</u>

- Assist LEAs with MA provider enrollment process with DHS
- Assist LEAs to identify MA-enrolled students
- Provide Help Desk and Customer Service
- Provide onsite and webinar trainings for ACCESS coordinators, administrators, business managers, special education directors, and service providers
- Conduct statewide annual training sessions
- Submit and reconcile MA claims on behalf of LEAs
- Provide secure website for data transmissions
- Provide web-based service provider application to document services
- Provide an online RMTS system
- Provide claim analysis reports
- Provide fiscal reports
- Provide custom reports upon request
- Provide LEAs with provider log templates and other claims-related documents

- Programmatically monitor the validity of claims
- Assist LEAs with self-audits
- Provide quality assurance reviews
- Create online user manuals for contractors' systems

Lot 2 Contractors' Responsibilities

- Provide Help Desk and Customer Service
- Provide onsite and webinar trainings for ACCESS coordinators, administrators, business managers, special education directors, and service providers
- Conduct statewide annual training sessions
- Provide an online cost report system
- Assist LEAs with self-audits
- Develop annual LEA rates
- Calculate annual cost settlement
- Create online user manuals for contractors' systems

Contractor Contact Information

PCG Help Desk: 1-866-912-2976 or SBAPSupport@pcgus.com

SSG Help Desk: 1-877-916-3222 or PAsupport@sivicsolutionsgroup.com

SECTION 2 – MEDICAL ASSISTANCE PROVIDER ENROLLMENT

2.1 Enrollment of Local Education Agency (LEA) Providers

In order for LEAs to participate in the SBAP, they must first be enrolled as a provider in the MA Program through DHS. *Provider Type (PT) 35 - Public School* is the MA enrollment applicable for participating in the SBAP.

Enrollment must be completed on a paper application for LEAs wishing to participate in the SBAP as PT 35.

DHS' Lot 1 contractor will assist LEAs to facilitate the enrollment process with DHS. The following LEAs are eligible to enroll as an MA provider:

- School Districts
- Charter Schools
- Intermediate Units
- Vocational-Technical Schools
- Preschool Early Intervention Programs

As a condition of enrollment in the MA Program, LEAs are required to sign a provider agreement in which they are agreeing to comply with all applicable state and federal laws, regulations, and policies which pertain to participation in the Pennsylvania MA Program. The MA provider agreement is included in the PT 35 MA application.

2.2 Provider Revalidation

As required by the Code of Federal Regulations (42 CFR 455.414), the State Medicaid Agency (DHS) must revalidate the enrollment of all providers, regardless of provider type, at least every five years. This includes LEAs enrolled as PT 35 participating in the SBAP, and any prescribing practitioner who signs Medical Practitioner Authorization Forms in the SBAP.

Revalidation must be completed on a paper application for LEAs participating in the SBAP and enrolled as PT 35.

Refer to Medical Assistance Bulletin 99-16-10, titled "Revalidation of Medical Assistance (MA) Providers", for more information.

Helpful resources:

- MA Enrollment Information
- PT 35 MA Application and Required Forms
- Sample Application

- DHS Provider Enrollment Hotline **1-800-537-8862**

2.3 Enrollment of Ordering, Referring and Prescribing Providers

The federal Patient Protection and Affordable Care Act (ACA) and implementing regulations require that all states comply with the provider screening and enrollment regulations found in the Code of Federal Regulations, including 42 CFR 455.410. This provision requires physicians and other practitioners who order or refer items or services for beneficiaries to enroll as MA providers.

This federal requirement means that all physicians and other prescribing practitioners, who order/prescribe SBAP services, must be enrolled as MA providers.

Refer to MA Bulletin 99-16-07 titled "Enrollment of Ordering, Referring and Prescribing Providers."

SECTION 3 – COVERED DIRECT SERVICES

Licensure and Certification: All individuals providing services to MA-enrolled students in the SBAP must maintain current Pennsylvania licensure or certification demonstrating their eligibility to provide such services. Failure of the individual to hold the appropriate licensure, or certification, or of the LEA to maintain documentation of licensure or certification, may result in the recoupment of any MA payments made for services by that provider.

Documentation of credentials and licensing required for each provider type is included within this section.

Delivery Method: While DHS has historically expressed its intent for MA services to be rendered to MA beneficiaries in person, **some services may be delivered using telemedicine**.

Refer to Medical Assistance Bulletin 99-22-02 titled "Updates to Guidelines for the Delivery of Physical Health Services via Telemedicine," and any subsequent guidance issued by DHS on the use of telemedicine. Note that originating site facility fees discussed in Bulletin 99-22-02 are not applicable within SBAP. All providers using telemedicine are advised to remain informed on all federal and state statutes, regulations and guidance regarding telemedicine.

3.1 Assistive Technology Devices (42 CFR 440.70(b)(3))

Definition	An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve the functional capabilities of a child with a disability and prescribed by a physician. An assistive technology device (ATD) ***does not*** include a medical device surgically implanted or replaced. The ATD must be medically necessary and set forth in the IEP. Devices reimbursed through the SBAP become the property of the student and are used only by the student.
Prescription	ATDs must be prescribed/ordered by a licensed MD or licensed DO enrolled in the MA Program.
Provider Qualifications	ATDs are obtained by the LEA from a licensed medical supplier.

Examples of Claimable Devices	• Augmentative or alternative communication devices • Vision devices • Assistive listening amplification devices See Assistive Device List (found on Lot 1 vendor website within the document, Claiming for Assistive Devices) for devices that qualify for reimbursement.
Examples of Non-Claimable Devices	• Wheelchairs, walkers, and other durable medical equipment • Hearing aids, hearing aid batteries • Cochlear implants, batteries for cochlear implants • Eyeglasses
Requirements and Process to Claim for ATDs	• The IEP team determines the need for the device. • The IEP team describes the student's need(s) related to the device in the IEP. • The LEA obtains parental consent to claim for the device. • The LEA obtains prescription or order for device. • The device is determined to be compatible with the student's needs. • The LEA orders the device. • The LEA verifies the student's MA enrollment. • The LEA sends a *Transfer of Ownership* notice to the parent/guardian. • The LEA sends an assistive device billing slip to the contractor indicating the appropriate billing codes (Y-codes) along with a copy of the invoice and Transfer of Ownership Letter.
Procedure Codes	T1999 U3 TM – Assistive Device
Units of Service	Per Device, Max. 1 per Day
Forms	Assistive Device Parental Consent Form Assistive Device Medical Practitioner Authorization Form Assistive Device Transfer of Ownership Notice Assistive Device Billing Form ATD Forms (found on Lot 1 vendor website within the document, Claiming for Assistive Devices).

3.2 Audiology Services (42 CFR 440.110(c))

Definition	Audiology services are services provided by or under the direction of a licensed audiologist related to the evaluation, diagnosis, and treatment of a student with conditions of the human auditory system whose communication disorders center in whole or in part in the hearing function. Services also include necessary supplies and equipment as well as direct assistance with selection, acquisition, training or use of an ATD.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Licensed audiologist or audiologist assistant under the direction of a licensed audiologist (See "Supervision of Assistants")
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Supervision of Assistants	Services rendered by Assistants, as defined by 49 Pa. Code § 45.301 and 49 Pa. Code § 45.304, must be supervised in accordance with 49 Pa. Code § 45.306. All services provided under the direction of a licensed audiologist must have a supervisory signature on SBAP documentation.
Individual or Group	Individual or group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Evaluation/Assessments • Determining the range, nature, and degree of hearing loss, including referrals for medical or other professional attention to improve the student's hearing • Providing qualified activities, such as language skills, auditory training, speech, lip-reading, hearing evaluation, and speech conversation • Counseling a student regarding his/her hearing loss • Determining the student's need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of the amplification • Identifying hearing loss as early as possible in a student's life by implementing a formal plan for identification

Procedure Codes	92507 U4 TM/UA – Audiology Service 92523 U3 TM – Initial Evaluation S9152 U4 TM – Re-Evaluation POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 32 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Audiology Services Log Service Provider Evaluation Log

3.3 Hearing-Impaired Services (42 CFR 440.110(c))

Definition	Hearing services related to the evaluation, diagnosis, and treatment of a student whose cognitive and educational development has been adversely affected by a hearing deficit. Services also include necessary supplies and equipment as well as direct assistance with selection, acquisition, training, or use of an ATD.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	A teacher of the hearing-impaired must meet one of the following: • Has a professional certificate issued by the Council on Education of the Deaf (CED); or • Has a Master's degree, from an accredited college or university, with a major in teaching of the hearing-impaired or in a related field with comparable course work and training.
Documentation of Credentials Maintained Onsite	Verification of professional certification issued by CED or verification of specified academic degree.
Individual or Group	Individual or a group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Articulation for Hearing Support • Assessment • Assistive Technology • Auditory Comprehension

	• Auditory Discrimination • Auditory Memory • Auditory Training • Auditory Training and Language Skills • Augment Oral Communication • Augment Written Communication • Aural Rehabilitation • Expressive Language • Figure-Ground Discrimination • FM Training Auditory Memory • Hearing Aid Maintenance • Hearing/FM Aid Instruction to Student • Language Enhancement • Receptive and Expressive Communication Feedback through Listening Technology in the Hearing-Impaired Services • Receptive Language • Speech Reading
Procedure Codes	92507 U3 TM – Individual Service 92507 U9 TM/HQ – Group Service 92523 U5 TM – Initial Evaluation 92523 U6 TM – Re-Evaluation POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 48 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Teacher of the Hearing Impaired Services Log Service Provider Evaluation Log

3.4 Nursing Services (42 CFR 440.60(a))

Definition	Services to address the medical needs of the beneficiary provided through direct interventions that are within the scope of the professional practice of a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) during a face-to-face encounter and on a one-to-one basis.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.

Provider Qualifications	The following may qualify to render nursing services: • Licensed Certified Registered Nurse Practitioner (CRNP) • Licensed Registered Nurse (RN) • Licensed Practical Nurse (LPN)
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Individual or Group	Individual only
Delivery Method	All services must be in person with the beneficiary. Services delivered through telemedicine are NOT compensable.
Examples of Services	• Diagnostic testing such as blood glucose testing, vital signs, etc. • Insertion and sterile irrigation of catheters • Dressings and wound care • Chest wall manipulation-inhalation therapy, suctioning, postural drainage, etc. • Positioning and range of motion exercises • Oral medication dispensing and/or complex medication administration such as injection, nasal, rectal, intravenous, etc. • Tracheotomy care, oxygen administration, ventilator care • Administering enteral and intravenous total parenteral nutrition • Face-to-face assessments and evaluations to determine medical status, identify actual and potential medical needs, planning for nursing and PCA activities, or referral to other SBAP service providers or the IEP team • Observation for adverse reactions to medication • Educating the student about medications and adherence to medication regimen • Medical education provided to students related to health status and treatment. For example, teaching a student self-catheterization or self-blood glucose testing, how to determine the amount of insulin needed, and giving self-injections • Monitoring the incidence and prevalence of designated health problems or medical conditions, e.g., seizure precautions or extreme lethargy

	• Hands-on assistance, cueing, or supervision of medical services, including catheterizations, suctioning, oxygen administration, and tube feedings.
Procedure Codes	T1003 U3 TM – LPN Service T1002 U3 TM – RN Service T1502 U3 TM – Medication Administration
Units of Service	Service: 15-minute Unit, Max. 32 units per Day Medication Administration: Per Encounter, Max. 15 per Day
Forms	Nursing Services Log Service Provider Evaluation Log

3.5 Nurse Practitioner Services (42 CFR 440.166 and 42 CFR 440.60(a))

Definition	Services to diagnosis and treat a student on a one-to-one basis with medical needs within the CRNP's scope of practice.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Licensed CRNP CRNPs must have a collaborative agreement with a licensed physician in Pennsylvania to order, refer or prescribe services (CRNP Practice 49 Pa. Code § 21.282a) and to enroll in the MA Program.
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Individual or Group	Individual only
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Diagnostic testing such as blood glucose testing, vital signs, etc. • Insertion and sterile irrigation of catheters • Dressings and wound care • Chest wall manipulation-inhalation therapy, suctioning, postural drainage, etc. • Positioning and range of motion exercises • Oral medication dispensing and/or complex medication administration such as injection, nasal, rectal, intravenous, etc.

	• Tracheotomy care, oxygen administration, ventilator care • Administering enteral and intravenous total parenteral nutrition • Face-to-face assessments and evaluations to determine medical status, identify actual and potential medical needs, planning for nursing and PCA activities, or referral to other SBAP service providers or the IEP team • Observation for adverse reactions to medication • Educating the student about medications and adherence to medication regimen • Medical education provided to students related to health status and treatment. For example, teaching a student self-catheterization or self-blood glucose testing, how to determine the amount of insulin needed, and giving self-injections • Monitoring the incidence and prevalence of designated health problems or medical conditions, e.g. seizure precautions or extreme lethargy • Hands-on assistance, cueing, or supervision of medical services, including catheterizations, suctioning, oxygen administration, and tube feedings. • Face-to-face encounter with student in connection with the completion of Medical Practitioner Authorization Forms; prescriptions; referral reports and documentation; relative to the SBAP.
Procedure Codes	T1002 U3 TM – RN Service T1502 U3 TM – Medication Administration T1023 U3 TM – Physician Service POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Nursing Service: 15-minute Unit, Max. 32 units per Day Medication Administration: Per Encounter, Max. 15 per Day CRNP Service: Per Encounter, Max. 1 per Day
Forms	Nursing Services Log Physician Services Log (Use when the CRNP is prescribing/ordering SBAP services, only in conjunction with a face-to-face encounter with the student) Service Provider Evaluation Log Medical Practitioner Authorization Form for SBAP Services and Medical Practitioner Authorization Form for Evaluation Services

3.6 Occupational Therapy Services (42 CFR 440.110(b))

Definition	Occupational Therapy (OT) services provided to a student by or under the direction of a licensed occupational therapist include necessary supplies and equipment as well as direct assistance with selection, acquisition, training or use of an ATD. OT services also include evaluation, diagnosis, and treatment of congenital delays and other impairments that impact functional daily living activities and skills.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Licensed Occupational Therapist or licensed OT assistant under the direction of a licensed OT (See "Supervision of Licensed OT Assistant")
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Supervision of Licensed OT Assistant	A licensed OT assistant may render occupational therapy services to students under the supervision of a licensed OT within his or her scope of practice and the supervision requirements under his or her license. (49 Pa. Code § 42.22) Supervision is conducted and documented by the licensed OT. All services provided under the direction of a licensed OT must have a supervisory signature on SBAP documentation.
Individual or Group	Individual or group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Assistive Technology; Access to Device • Assistive Technology; Student Training • Domestic Maintenance; Adaptive Activities • Equipment; Splint/Orthotic/Prosthetic Check • Equipment; Splint/Orthotic/Prosthetic Training • Equipment; Student Training • Equipment; Student Training; Headstick, Dowel Pointer, Mouthstick, Switch

	• Fine Motor/Upper Extremity; Functional Range of Motion • Fine Motor; Bilateral Hand Coordination • Fine Motor; Desktop Manipulatives • Fine Motor; Finger Isolation • Fine Motor; Grasp/Release • Fine Motor; In-Hand Manipulation • Fine Motor; One-Handed Strategies • Fine Motor; Strengthening/Endurance • Functional Academics; Adaptive Handwriting/Writing Accommodations • Functional Academics; Adaptive Handwriting/Writing Implement • Functional Academics; Adaptive Handwriting/Writing Surface • Functional Academics; Handwriting Control/Coordination • Mobility; Grasp of Ambulation Device • Mobility; Transfer Training • Mobility; Transition Training • Mobility; Wheelchair Mobility • Mobility; Fine • Mobility; Gross • Neuromuscular Development; Head Control • Neuromuscular Development; Lower Extremity • Neuromuscular Development; Trunk Control • Neuromuscular Development; Upper Extremity • Personal Maintenance; Adaptive Dressing Skills • Personal Maintenance; Adaptive Grooming/Hygiene • Personal Maintenance; Therapeutic Feeding • Personal Maintenance; Toileting • Positioning; Adaptive Seating • Positioning; Adaptive Standing • Positioning; Alternative Device • Recreation/Leisure; Adaptive Activities • Relaxation/Facilitation Techniques • Sensory Processing; Classroom Focusing/Attending Skills • Sensory Processing; Management of Classroom Tools/Materials • Sensory Processing; Self-Regulation Skills • Sensory Processing; Transition Behaviors • Therapeutic Exercise; Coordination Activities

	• Therapeutic Exercise; Endurance Training • Therapeutic Exercise; Functional Range of Motion • Therapeutic Exercise; Muscle Strengthening • Therapeutic Exercise; Organization/Motor Planning/ • Spatial Concepts • Therapeutic Exercise; Stretching • Vocational; Adaptive Activities • Visual; Motor Skills • Visual; Perception Skills • Psycho-Social Skills • Environmental Adaptations
Procedure Codes	97166 U3 TM – Initial Evaluation 97168 U3 TM – Re-Evaluation 97530 U3 TM – Individual Service 97530 U8 TM/HQ – Group Service POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 32 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Occupational Therapy Services Log Service Provider Evaluation Log

3.7 Orientation, Mobility and Vision Services (42 CFR 440.130(d))

Definition	Services related to the evaluation, diagnosis, and treatment of a student who is blind or visually impaired to attain systematic and safe orientation and movement within his or her environment.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Orientation and Mobility Specialist certified by the Academy for the Certification of Vision Rehabilitation and Education Professionals (ACVREP) or the National Blindness Professional Certification Board (NBPCB).
Documentation of Credentials	Copy of ACVREP certificate or NBPCB certificate showing full name and dates of certification reflecting the period services were provided.

Maintained Onsite	
Individual or Group	Individual only.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Basic Visual Motor Skills • Basic Visual Perception • Moving through Environment • ID of Safety and Information Signs • Location of Commercial Services • ID of Landmarks • Spatial Orientation • Telling Time • Methods of Crossing Streets • School Environment Familiarization • Map Making • Practical Living Awareness • Age-Appropriate Social Skills • Exercises related to social skills and dealing with the sighted world • Teaching methods to promote safety in moving about • Therapy related to visual perception, movement, spatial orientation • Training to locate and use community resources, such as taking a bus to school or summoning help in an emergency situation
Procedure Codes	97533 U3 TM – O&M Service 99172 U3 TM – Initial Evaluation 99172 U4 TM – Re-Evaluation POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 64 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Orientation, Mobility and Vision Services Log Service Provider Evaluation Log

3.8 Personal Care Services (42 CFR 440.167)

Definition	Personal care is a one-to-one service provided to beneficiaries with physical or mental impairments or conditions in accordance with a plan of treatment and prescribed by a physician.
Prescription	Services must be prescribed/ordered by a licensed MD or licensed DO enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	An individual must meet all of the following criteria to be a qualified provider: • 18 year of age or older; and • Not a legally responsible relative; and • High school diploma or general equivalency diploma (GED); and • Current certification in first aid; and • Current certification in cardiopulmonary resuscitation (CPR).
Documentation of Credentials Maintained Onsite	Proof of high school diploma or GED and copies of First Aid and CPR certification cards showing full name and dates of eligibility reflecting the period services were provided.
Individual or Group	Individual only
Delivery Method	All services must be in person with the beneficiary. Services delivered through telemedicine are NOT compensable.
Examples of Services	For personal care services to be compensable, they must be: 1. In-person with the student. 2. A medically necessary service. 3. NOT educational in nature. • Assist the student to use equipment that is necessary due to student's disability. • Assist the student to use and maintain augmentative communication devices. • Assist a student to ambulate, position, and transfer. • Assist with or carry out range of motion and other exercises. • Assist with Activities of Daily Living (ADL), such as feeding, grooming, bathing, toileting, etc. • Cue, redirect or monitor to ensure the individual performs ADL tasks because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may

	not be able to dress without instruction on how to do so or may need reminders of what to do and when. • Monitor the incidence and prevalence of designated health problems or medical conditions, e.g., seizure activity or extreme lethargy. • Accompany student on school bus or other vehicle per the IEP. • Assist student to get on or off school bus or other vehicle upon arrival or departure from school, per the IEP. • Cuing the student to pay attention, participate in activities, and complete tasks. Personal Care Services are not to be used to help students with educational activities.
Procedure Codes	T1019 U3 TM – PCA Service
Units of Service	Service: 15-minute Unit, Max. 64 units per Day
Forms	Personal Care Services Log A Personal Care Services Log must be signed by a teacher or supervisor.

3.9 Physical Therapy Services (42 CFR 440.110(a))

Definition	Physical Therapy (PT) services provided to a student by or under the direction of a licensed PT include necessary supplies and equipment, as well as, direct assistance with selection, acquisition, training or use of an ATD. PT services also include evaluation, diagnosis, and treatment through the use of therapeutic exercises and rehabilitative procedures for beneficiaries with mechanical, physiological and developmental impairments, functional limitations and disabilities, other health-related or movement-related conditions.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Licensed PT or certified PT assistant under the direction of a licensed PT (See "Supervision of Certified PT Assistant")
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.

Supervision of Certified PT Assistant	A certified PT assistant may render physical therapy services to students under the supervision of a licensed PT within his or her scope of practice and the supervision requirements under his or her license (49 Pa. Code § 40.173). Supervision is conducted and documented by the licensed PT. All services provided under the direction of a licensed PT must have a supervisory signature on SBAP documentation.
Individual or Group	Individual or group of 2 or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Assistive Technology; Access to Device • Assistive Technology; Student Training • Balance Training • Equipment; Splint/Orthotic/Prosthetic Check • Equipment; Splint/Orthotic/Prosthetic Training • Equipment; Student Training • Functional Mobility; Community • Functional Mobility; Indoor – Level Surfaces • Functional Mobility; Indoor – Uneven Surfaces • Functional Mobility; Outdoor – Varying Terrain • Functional Mobility; Outdoor – Level Surfaces • Functional Mobility; Transfer Training • Functional Mobility; Transition Training • Functional Mobility; Transportation • Functional Mobility; Wheelchair • Functional Mobility; Stairs • Gait/Ambulation Training • Neuromuscular Development; Head Control • Neuromuscular Development; Lower Extremity • Neuromuscular Development; Trunk Control • Neuromuscular Development; Upper Extremity • Positioning; Adaptive Seating • Positioning; Adaptive Standing • Positioning; Alternative Device • Positioning; Postural Alignment • Posture and Body Mechanics

	• Pulmonary Support • Relaxation/Facilitation Techniques • Therapeutic Exercise; Coordination Activities • Therapeutic Exercise; Endurance Training • Therapeutic Exercise; Functional Range of Motion • Therapeutic Exercise; Muscle Strengthening • Therapeutic Exercise; Stretching
Procedure Codes	97162 U3 TM – Initial Evaluation 97164 U3 TM – Re-Evaluation 97110 U3 TM – Individual Service 97110 U8 TM/HQ – Group Service POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 32 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Physical Therapy Services Log Service Provider Evaluation Log

3.10 Physician Services (42 CFR 440.50(a))

Definition	Services to diagnose and treat a student on a one-to-one basis with medical needs.
Prescription	Services must be prescribed/ordered by a licensed MD or licensed DO enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	• Licensed MD • Licensed DO
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Individual or Group	Individual only
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Face-to-face encounter with student in conjunction with completion of Medical Practitioner Authorization Forms; prescriptions; referral reports and documentation; relative to the SBAP.

Procedure Codes	T1023 U3 TM – Physician Service POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: Per Encounter, Max. 1 per Day
Forms	Physician Services Log Medical Practitioner Authorization Form for SBAP Services and Medical Practitioner Authorization Form for Evaluation Services

3.11 Psychiatric Services (42 CFR 440.50(a))

Definition	Services related to the evaluation, diagnosis, and treatment that address a student's mental, emotional, or behavioral disorders.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Licensed physician with specialty in psychiatry
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Individual or Group	Individual or group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Communicating with the student relating to student's history, mental status or behavior • Conducting individual psychotherapy • Crisis Assistance
Procedure Codes	90791 U3 TM – Initial Evaluation 90791 U4 TM – Re-Evaluation 90832 U3 TM – Individual Service 90853 U3 TM – Group Service POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Individual Service: 30-minute Unit, Max. 4 units per Day Group Service: 15-minute Unit, Max. 32 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days

Forms	Psychiatric Services Log Service Provider Evaluation Log

3.12 Psychological Services (42 CFR 440.130(d))

Definition	Services related to the assessment and evaluation, treatment planning and individual and group therapy that address a student's mental, emotional, or behavioral disorders.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP, licensed Physician Assistant or licensed psychologist enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	• Licensed Psychologist • PDE-Certified School Psychologist (CSPG No. 81)
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided, or a PDE certificate for a PDE-Certified School Psychologist.
Individual or Group	Individual or a group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Individual therapy or counseling • Group therapy or counseling • Crisis assistance • Skills training designed to improve the basic functioning of the student in activities of daily and community living and improve social interaction with others
Procedure Codes	H2027 U3 TM – Individual Service H2027 TM/HQ – Group Service 96156 U4 TM – Initial Evaluation 96156 U3 TM – Re-Evaluation POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Individual Service: 15-minute Unit, Max. 80 units per Day Group Service: 15-minute Unit, Max. 48 units per Day

	Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Psychological Services Log Psychological Evaluation Log

3.13 Social Work and Counseling Services (42 CFR 440.130(d))

Definition	Services related to the evaluation, diagnosis, and treatment that address a student's mental, emotional, or behavioral disorder
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP, licensed Physician Assistant, licensed social worker, or licensed professional counselor enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	• Licensed Social Worker • Licensed Professional Counselor • Licensed Marriage and Family Therapist
Documentation of Credentials Maintained Onsite	Copy of Department of State license showing full name and dates of licensure reflecting the period services were provided.
Individual or Group	Individual or a group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Social Work counseling • Addressing problems in a student's living arrangements that affect adjustment to and performance in school • Family counseling to address a student's needs • Crisis Assistance • Social Skills Training • Community-based Training
Procedure Codes	H0031 U3 TM – Initial Evaluation H0031 U4 TM – Re-Evaluation H0046 U3 TM – Individual Service H0046 U7 TM/HQ – Group Service

	POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Individual Service: 15-minute Unit, Max. 48 units per Day Group Service: 15-minute Unit, Max. 48 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Social Work and Counseling Services Log Service Provider Evaluation Log

3.14 Special Transportation Services (42 CFR 440.170(a))

Definition	Special transportation services include: 1. Travel to and from school and between schools or school buildings on a day when an MA service is on the IEP to be rendered on school premises and special transportation is included on the IEP as a separate service. 2. Travel to and from off-site premises on a day when an MA service is on the IEP to be rendered off-site and special transportation is included in the IEP as a separate service. 3. Use of a specialty adapted vehicle (such as a specially adapted bus, van or other vehicle such as a wheelchair lift, special harness, safety vest or special car seat).
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	Special transportation services are provided by a school or other entity under contract with the LEA to provide the services. Special transportation services must be provided in accordance with the Public School Code of 1949 (24 P.S. §§ 1-101 – 27-2702), the Vehicle Code (75 Pa.C.S. §§ 101 – 9701), regulations at 22 Pa. Code Chapter 23 (relating to pupil transportation) and 67 Pa. Code Chapters 71 and 171 (relating to school bus drivers, and school buses and school vehicles).
Limitations	• Special transportation services must be provided on the same date of service that an MA-covered service, required by the student's IEP, is received, resulting in a paid direct service claim. • Special transportation services must be provided on a specially adapted school vehicle or other vehicle to or from the location where the MA service is received.

	• Special transportation services must represent a one-way trip. • Special transportation services provided must be documented in a transportation log. • Transportation services must be billed as an individual service.
Procedure Codes	A0434 U3 TM – Special Transportation
Units of Service	Per Trip, Max. 2 per Day
Forms	Special Transportation Services Log

3.15 Speech and Language Services (42 CFR 440.110(c))

Definition	Speech and language services are diagnostic, screening, preventive or corrective services of a student with communicative disorders involving the function of speech, voice, language, or swallowing. Services also include necessary supplies and equipment as well as direct assistance with selection, acquisition, training or use of an ATD.
Prescription	Services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP or licensed Physician Assistant enrolled in the MA Program within the scope of his or her practice under state law.
Provider Qualifications	A qualified Speech-Language Pathologist (SLP) must meet at least one of the following: • Has a Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA); or • Has completed the equivalent educational requirements and work experience necessary for the CCC; or • Has completed the academic program and is acquiring supervised work experience to qualify for the CCC (See "Supervision of Clinical Fellows"); or • Is licensed as an SLP.
Documentation of Credentials Maintained Onsite	Copy of Department of State license OR copy of ASHA CCC showing full name and dates of licensure reflecting the period services were provided.
Supervision of Assistants	Services rendered by Assistants, as defined by 49 Pa. Code § 45.301 and 49 Pa. Code § 45.304, must be supervised in accordance with 49 Pa. Code § 45.306. All services provided under the direction of a licensed SLP must have a supervisory signature on SBAP documentation.

Supervision of Clinical Fellows	Services rendered by Clinical Fellows, as recognized by ASHA, should follow the ASHA requirements for qualifications of mentoring SLPs: ASHA Information for Clinical Fellowship (CF) Mentoring SLPs ASHA: Responsibilities of Individuals who Mentor Clinical Fellows in Speech-Language Pathology All services provided under the direction of either a licensed SLP or an SLP with an ASHA CCC must have a supervisory signature on SBAP documentation.
Supervision of PDE-certified Speech-Language Pathologists	Services rendered by PDE-certified SLP (CSPG No. 063) must be provided "under the direction of" either a licensed SLP or an SLP with an ASHA CCC. All services provided must include a supervisory signature on SBAP documentation. The term "under the direction of" means that the licensed SLP or an SLP with an ASHA CCC is personally involved with the student under his or her direction and accepts responsibility for the actions of the personnel that he or she agrees to direct. The licensed SLP or ASHA CCC SLP must see each student at least once, have input into the type of care provided, and review the student's treatment on an ongoing basis.
Individual or Group	Individual or a group of two or more students.
Delivery Method	Services may be delivered in person or through telemedicine.
Examples of Services	• Administer Evaluations/Assessments • Articulation; Discrimination • Articulation; Oral Motor • Articulation; Sound Production • Articulation; Transfer Assessment • Augmentative Communication; Expressive Symbols • Augmentative Communication; Programming Device • Augmentative Communication; Symbol Discrimination • Augmentative Communication; Symbol Identification • Augmentative Communication; Transfer • Aural Rehabilitation; Auditory Discrimination • Aural Rehabilitation; Compensation Techniques • Aural Rehabilitation; Speech Reading • Aural Rehabilitation; Survival Communication Repair Strategies • Expressive Language; Grammatical Forms

	• Expressive Language; Increase Length and Complexity of Utterances • Expressive Language; Semantics • Expressive Language; Social Interaction/Conversational Skills • Feeding/Swallowing; Advancement of Diet • Feeding/Swallowing; Compensatory Techniques • Feeding/Swallowing; Diet Modification • Feeding/Swallowing; Oral Motor • Fluency; Establish Fluency at Different Levels • Fluency; Strategies/Techniques • Fluency; Transfer • Phonological Awareness • Receptive Language; Narrative and Text • Receptive Language; Understanding Basic Concepts • Receptive Language; Understanding Directions and Sentences • Receptive Language; Vocabulary/Strategies • Voice; Duration • Voice; Loudness • Voice; Pitch • Voice; Quality • Voice; Resonance • Receptive and Expressive Communication feedback through Listening Technology in the Hearing-Impaired Services
Procedure Codes	92507 UB TM/GN – Individual Service 92508 U3 TM – Group Service 92523 U4 TM/GN – Initial Evaluation S9152 U3 TM – Re-Evaluation POS 02 is to be used when services are rendered via telemedicine.
Units of Service	Service: 15-minute Unit, Max. 48 units per Day Initial Evaluations: Per Evaluation, Max. 1 per 180 Days Re-Evaluations: Per Evaluation, Max. 1 per 30 Days
Forms	Speech/Language/Hearing Services Log Service Provider Evaluation Log

3.16 Co-Treatment Services

Co-treatment services may occur as long as the services are documented in the IEP. The documentation must clearly identify the medical necessity of each service, why it is appropriate that the services occur simultaneously, and that the co-treatment is consistent with standards of care and quality.

Co-treatment cannot occur for the therapists' convenience but must be what is medically necessary for the student.

Documentation must be maintained by each practitioner for the services provided.

SECTION 4 – BILLING INFORMATION & REQUIREMENTS

4.1 Third-Party Resources

Pursuant to 42 CFR 433.137 through 433.139, MA must be the payer of last resort. This means that all identifiable financial resources must be utilized prior to the expenditure of MA funds.

Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by federal statute).

If another insurer or program has the responsibility to pay for medical costs incurred by a MA-enrolled individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as "third-party liability" or TPL. The commonwealth reaches out to private insurance companies to determine if they cover the health-related services in IEPs provided by the LEAs and requests annual blanket denials from the private insurance companies that do not cover such services.

Some insurance companies do not provide blanket denials, but rather indicate that they cover some services provided in the schools. In cases where an LEA has submitted claims that are later determined as not included in the insurer's denial, the affected claims will be voided. LEAs will see such voids in their monthly management reports. The LEA does not have to submit documentation during this activity; this is an automatic process.

4.2 Medical Necessity/Medical Authorization

As a condition of MA payment, health-related services identified in a student's IEP must be authorized or prescribed by a licensed practitioner, acting within their scope of practice and enrolled in the MA Program. These practitioners include:

- Medical Doctor (MD) – all services
- Doctor of Osteopathy (DO) – all services
- Certified Registered Nurse Practitioner (CRNP) – all services, except for assistive technology devices, personal care services, and physician services.
    - CRNPs must have a collaborative agreement with a licensed physician in Pennsylvania to order, refer or prescribe services (CRNP Practice 49 Pa. Code § 21.282a) and to enroll in the MA Program.

    - LEAs must be able to produce a copy of the collaborative agreement when requested.
- Physician Assistants – all services, except for assistive technology devices, personal care services, nurse practitioner services, and physician services.
    - Physician Assistants must have a written agreement with a supervising licensed physician in Pennsylvania who has delegated authority to order, refer or prescribe services (Written Agreements 49 Pa. Code § 18.142) for a patient under the physician's care. The written agreement must be in place in order for the Physician Assistant to enroll in the MA Program.
    - LEAs must be able to produce a copy of the written agreement when requested.
- Licensed Psychiatrist – all services
- Licensed Psychologist – psychological services only
- Licensed Social Worker or Licensed Professional Counselor – only for their own social work and counseling services

Medically necessary services must be ordered or prescribed through a practitioner's prescription or a Medical Practitioner Authorization Form (MPAF): Medical Practitioner Authorization Form for SBAP Services and Medical Practitioner Authorization Form for Evaluation Services

In order for a service to be compensable, the signature date of the prescription or MPAF must be obtained prior to the date of the MA health-related service for which the LEA is billing. Services that occur prior to the date of the practitioner's authorization are not compensable and will not be billed to the MA Program.

Prescriptions or MPAFs must be concurrent with the IEP and obtained at least annually, or whenever there is a change to the health-related services in the IEP (i.e. service added or changes in frequency of service). A stamped signature is not acceptable on the authorization; however, electronic signatures that are made in accordance with the Electronic Transaction Act (73 P. S. § 2260.101 – 2260.5101) are acceptable.

Prior to signing and dating the prescription or MPAF, the practitioner must review the student's IEP to determine if the health-related service(s) recommended by the IEP team is/are medically necessary. A service, item, procedure, or level of care is medically necessary if it is necessary for the proper treatment or management of an illness, condition, injury or disability to prevent the onset of an illness, condition, injury or disability, to reduce or ameliorate physical, mental or developmental effects of an illness, condition, injury or disability or to assist in achieving or maintaining maximum functional capacity of daily activities. 55 Pa. Code § 1101.21 - 1101.21(a).

4.3 Documenting Individual and Group Therapy

Individual and/or group must be clearly identified on both the MPAF and the IEP with the frequency and duration specified for each type of session.

A combination of individual and/or group may be listed on the MPAF and the IEP, so long as it is medically necessary and the MPAF and IEP clearly indicates the frequency and duration for each type of session. For example, an IEP may specify "individual speech therapy for 30 minutes 2x per week" and "group speech therapy for 30 minutes 2x per month." An IEP with "individual or group therapy for 30 minutes 10x per month" does not properly identify the service to be provided; therefore, those services billed are non-compensable.

4.4 Provider Logs

A provider log template for each service type is made available to LEAs on the Lot 1 Vendor website at https://paaccess.pcgus.com/documents.html. LEAs may opt to develop their own template; however, the logs must reflect the required information contained in the DHS templates.

The provider services log must indicate whether the service type is Direct: Telemedicine or Direct: In Person when documenting the service and how it was provided. The "Description of Service" section of the provider service paper log should be used to record details about the service which was provided, including whether any service disruptions or connectivity issues occurred during the service delivery and whether the service was delivered using telephone-only.

Provider logs are daily progress notes and should only be completed by qualified providers. The daily logs provide evidence of the delivery of a covered service, progress toward the goals and objectives, analysis of treatment strategy and needed adjustments, and the continued need for services supporting medical necessity.

Provider logs are required to contain exact "Start Time" and "End Time." Rounding up service minutes is prohibited. Most SBAP services are based upon a 15-minute billing unit; exceptions to the 15-minute billing unit include evaluations and medication administration. Non-consecutive service minutes may accumulate on a date of service for the same service type provided to the same student. Overlapping service minutes is prohibited. For example, if a nursing service includes a tube feeding lasting 45 minutes, additional activities such as checking vitals that are performed during that 45-minute tube feed may not be billed as a separate service.

Electronic signatures may be used in lieu of physical signatures provided that the electronic signature is made in accordance with the requirements set out in Section 5.3.

4.5 Medical Assistance Eligibility Verification

As MA providers, LEAs can access the PROMISe™ site to check a student's MA eligibility.

- For MA eligibility questions, LEAs can call the DHS Provider Helpline at 1-800-766-5387. The DHS Provider Helpline can assist LEAs with questions relating to the "Eligibility Verification System" and can provide verification of MA eligibility and plan information.

- The following categories are non-MA categories:
  - ACX is managed by the Office of Long-Term Living (OLTL).
  - EIX is managed by the Office of Child Development and Early Learning (OCDEL).
  - MHX is managed by the Office of Mental Health and Substance Abuse Services (OMHSAS).
  - MRX is managed by the Office of Developmental Programs (ODP).

Individuals enrolled in these categories do not have MA benefits (MA Eligibility Handbook, 305.1 Category, General Policy).

Additionally, LEAs can assist parents/students' families with applying for and/or renewing MA benefits. There are several ways to complete the MA application process, which are described on the DHS website under "Apply for Benefits". Additional Resources:

- County Assistance Office (CAO) Directory
- MA Eligibility Handbook
- Medical Assistance Transportation Program (MATP) Eligibility Quick Reference Guide

4.6 Student Eligibility

LEAs may only claim MA reimbursement for services provided to students who meet the following criteria:

- Are under 21 years of age; and
- Meet one or more of the following IDEA disability categories (34 CFR 300.8 Child with a Disability):
  - Autism
  - Deaf-Blindness
  - Deafness
  - Developmental Delay (ages 3-5 in Early Intervention) (22 Pa. Code § 14.101)

    - Emotional Disturbance
    - Hearing Impairment
    - Intellectual Disability
    - Multiple Disabilities
    - Orthopedic Impairment
    - Other Health Impairment
    - Specific Learning Disability
    - Speech or Language Impairment
    - Traumatic Brain Injury
    - Visual Impairment; and
- Have an IEP that includes medically necessary health-related service(s); and
- Are MA-eligible on the date of service.

4.7 Parental Consent

The Individuals with Disabilities Education Act (IDEA) Part B final regulations at 34 CFR 300.154 (d) require parental consent to access public benefits of insurance (e.g., Medicaid).

Specifically, the regulations require that LEAs obtain a one-time written consent from the parent before accessing the child's or the parent's public benefits or insurance for the first time and provide written notification to the child's parents annually thereafter. Further information can be found in the March 5, 2013 Penn*Link and Parental Consent FAQ.

It is best practice to obtain the one-time parental consent at the initial IEP meeting; however, each LEA should establish a protocol for obtaining the consent. If the LEA chooses to allow electronic signatures on parental consent forms, the guidelines in Section 5.3 must be followed. Refer to the Pennsylvania Department of Education for more information related to electronic signatures.

Consent is voluntary, and a parent may revoke consent at any time. LEAs may retain any reimbursement received prior to the revocation date.

Services delivered per the IEP prior to the date of the one-time parental consent are not compensable.

Parental Consent/Notification Forms:
One-Time Parental Consent Form
Annual Parental Notification Form

Granting consent will not impact MA services the parent(s) or their child receives outside of school. A December 28, 2009 memo from DHS clarifies that health-related IEP service which are submitted to the MA Program are separate from the MA services a student receives outside of school. The memo further explains that the MA Program does not impose benefit caps or limits on covered services for MA-enrolled students.

4.8 Evaluations

Medicaid can provide reimbursement for an evaluation when a health-related service is identified and documented in the IEP. However, evaluations that identify the need for special education services, but not for health-related services, are not billable to Medicaid.

4.8.a Authorization for an Evaluation

All initial evaluations and re-evaluations must be authorized or prescribed by a licensed MD, licensed DO, licensed CRNP, or licensed practitioner within his or her scope of practice and enrolled in the MA Program. Licensed practitioners including licensed psychologists, licensed social workers, and licensed professional counselors enrolled in the MA Program can sign medical authorizations for services and/or evaluations within their scope of practice.

The medical authorization or prescription is required to be in place prior to or on the date of service for all initial evaluations and re-evaluations. If a re-evaluation is included in the existing MPAF, the re-evaluation may be conducted any time during the annual authorization period.

NOTE: a psychological initial evaluation or re-evaluation that is conducted by a non-licensed, PDE-certified school psychologist is compensable only when first ordered or prescribed by a licensed physician, licensed CRNP, or licensed psychologist within his or her scope of practice and enrolled in the MA Program.

4.8.b Initial Evaluations

An initial evaluation occurs any time that a student is evaluated or assessed in a service type under which they have not been previously evaluated.

When parental consent and medical authorization are in the child's record at the time of the evaluation, and an ongoing health-related service in the service type being evaluated is identified and documented in the student's IEP**,** the initial evaluation may be billed.

An initial evaluation may be billed in both the Early Intervention and the School Age programs.

An initial psychological evaluation conducted solely to determine a student's eligibility for special education services **may not be billed**. However, if the psychological evaluation

identifies an MA health-related covered service(s) to be documented in the IEP, the evaluation may be billed.

4.8.c Re-evaluations

A re-evaluation occurs any time that a student is evaluated or assessed in a service type under which they are currently receiving or have previously received services.

A re-evaluation is only compensable when parental consent, medical authorization, and a current IEP are all in the child's record at the time of the re-evaluation, and the re-evaluation results in an ongoing MA health-related covered service from the evaluation conducted.

NOTE: A psychological re-evaluation conducted solely to determine a student's ongoing eligibility for special education services **may not be billed**. However, if the psychological re-evaluation identifies the continued need for counseling/therapy services and this is documented in the IEP, the re-evaluation may be billed. As set forth in Section 3.13, counseling and social work services must be prescribed/ordered by a licensed MD, licensed DO, licensed CRNP, or licensed psychologist, but can be delivered by the practitioners identified in Section 3.13.

4.8.d Billing Information

All initial evaluations and re-evaluations are billed based upon a "Per Evaluation" unit of service.

Parental Consent is required to be completed prior to or on the date of service of the evaluation in order to bill for the evaluation.

For Early Intervention initial evaluations, the Date of Service is the IEP Meeting Date or the child's 3rd birthday, whichever is later.

For School Age initial evaluations, the Date of Service is the IEP Meeting Date.

The Date of Service to be used for billing an initial service type evaluation when an IEP exists (i.e. when a new service is being added to an existing IEP) would be the last date the evaluation activities with the student were performed.

The Date of Service to be used for billing a re-evaluation when an IEP exists (i.e. when a service type will remain in the IEP) would be the last date the evaluation activities with the student were performed.

4.9 ICD-10 Diagnosis Codes

Each student for whom the LEA provides special education and health-related services under IDEA has been identified as having one of 14 qualifying disabilities (IDEA; P.L. 108-446). For health-related services to be billed to MA, the student's IDEA disability category must be mapped to an appropriate ICD-10 coding category based on diagnosis.

LEAs identify the student's primary, secondary, and tertiary disability from a dropdown menu within the Lot 1 Vendor's system.

The following table outlines IDEA qualifying disabilities which have been cross-walked to an appropriate ICD-10 coding category.

IDEA Disability	Corresponding Coding Category (ICD-10)
Autism	Autism Spectrum Disorder
Deaf-Blindness	Deaf-Blind
Deafness	Deafness
Emotional Disturbance	Emotional Disability
Hearing Impairment	Hearing Impaired
Intellectual Disability	Cognitive Disability
Multiple Disabilities	Multiple Disabilities
Orthopedic Impairment	Orthopedic Impairment
Other Health Impairment	Other Health Impairment
Specific Learning Disability	Specific Learning Disability
Speech or Language Impairment	Language Impairment
Speech or Language Impairment	Speech Impairment
Traumatic Brain Injury	Traumatic Brain Injury
Visual Impairment	Blind/visually impaired
Visual Impairment	Low vision/visually impaired
Developmental Delay (ages 3-5 in Early Intervention) (22 Pa. Code § 14.101)	Developmental Delay

SECTION 5 – DOCUMENTATION

5.1 Record Keeping

Records must comply with State Medicaid Regulations 55 Pa. Code § 1101.51 *Ongoing responsibilities of providers*.

As an MA provider, an LEA is responsible for the accuracy of its documentation of health-related MA-covered services that were reimbursed by Medicaid.

All records must be legible and must be made available upon request to federal and/or state reviewers and their authorized agents or representatives.

Original documents must be maintained for "On Behalf Of" entries, which allow an LEA user to enter service documentation on behalf of their service providers through a Permission Agreement.

At a minimum, the LEA must maintain the following records:

- A copy of the student's IEP and any addenda, such as a treatment plan, behavioral plan, or nutritional plan. To be eligible for MA reimbursement, the service must be part of and be described in the IEP.
- Parental Consent Form signed and dated by the parent or guardian for the student, as well as annual Parental Notifications.
- Prescription or Medical Practitioner Authorization Form for SBAP Services signed by an appropriate licensed practitioner as defined in Section 4.2. Any practitioner's orders that are referenced on the prescription or MPAF must be maintained as part of the prescription or MPAF.
- Copies of each of its employed and contracted providers' licenses, certifications and other documentation that verifies the service providers meet MA provider qualifications for the services that were reimbursed by Medicaid. Providers' license information can be found on the Pennsylvania Department of State's website.
- Medical or other records, such as daily progress notes or daily provider logs, that fully disclose and document the extent of services provided.
- Evaluations, assessments, and testing that were performed to evaluate IEP needs and/or that led to the creation of an IEP.
- Verification of student and service provider attendance.
- Transportation logs (if applicable).

- Financial data used for the Direct Service and Administrative staff pools for each quarter.
- Financial data used to complete the annual Cost Reports.
- Documentation supporting the annual IEP ratio.
- Documentation supporting tuition costs (if applicable).
- Documentation supporting costs of medical supplies and equipment (if applicable).

At a minimum, records must include all of the following:

- The first and last name of the student who received the service (must be listed on every page).
- Student's date of birth.
- Name and title of the service provider who rendered the service.
- The student's diagnosis or a description of the medical condition.
- The date on which the service was rendered.
- A treatment code or narrative description that corresponds to the direct service rendered.
- The signature(s) of the service provider and the supervisor (if applicable).
- Alterations or additions to a log must be signed and dated.
- Progress indicators or narrative that describes the effectiveness and outcome of the treatment. If using a progress indicator, a detailed narrative is required that describes the student's response and progress toward the service goals.

5.2 Records Retention Requirement

Pennsylvania MA Regulations (55 Pa. Code § 1101.51 (e)) require medical and fiscal records that fully disclose the nature and extent of the services rendered to MA beneficiaries be retained for at least four years, or longer if required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 and implementing regulations at 45 CFR Parts 160, 162, and 164. It is the responsibility of the LEA to maintain documentation, regardless of whether the student leaves the LEA for any reason, including graduation.

Failure to appropriately document services and maintain records may result in recoupment of MA reimbursement and/or termination of the written provider agreement.

5.3 Electronic Records

For daily progress notes or daily provider logs that are maintained electronically:

1. The electronic records database must be secured by both physical and electronic means;

2. Logs must be date- and time-stamped; and
3. Log revisions must be maintained via an audit trail.

A control method should restrict access to authorized personnel only. Each authorized service provider should have a unique, confidential authentication method (such as a username/password combination, or a biometric device).

For example, when a service provider enters an electronic record, a unique user identifier and timestamp is recorded with the record. This creates an electronic fingerprint that is unique to the service provider and verifies when and by whom the data was entered or modified.

The database should also provide an audit trail. Each time a service is entered into the database, a permanent record should be created. This original data should be retrievable without edits or alterations and allow for a side-by-side comparison between the original record and the modification. An electronic identifier with a date and time stamp must be associated with the original record and any modified records. The author of any changes should be linked and easily identifiable to the original record.

On documents requiring signature, electronic signatures may be used in lieu of physical signatures provided that the electronic signature is made in accordance with the Electronic Transaction Act (73 P. S. § 2260.101 – 2260.5101) and:

- Identifies the individual signing the document by his or her name and title;
- Ensures that the document cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides an audit trail that validates the signer's identity.

LEAs must be able to provide a hard copy of the log showing verification of the provider's PIN/password or an actual signature; a handwritten original is not required.

LEAs that use electronic signatures must have written policies and procedures in place regarding their use. Electronically transmitted signatures must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person. In addition to complying with security policies and procedures, providers who use computer keys or electronic signatures should sign a statement assuring that they alone will have access to and use the key or computer password. The policies, procedures, and statements of exclusive use must be maintained and available at the LEA's location.

Resources:

- Electronic Signature Verification Statement
- MA Bulletin 99-10-03 Policy Clarification Regarding Written Prescriptions, Orders and Requests

5.4 Preclusion/Exclusion Checks

As MA providers, LEAs are required to screen employees and contractors for exclusion from participation in federal health care programs. MA Bulletin 99-11-05 outlines the specific requirements:

- Providers who participate in the MA Program are required to screen their employees and contractors, both individuals and entities, ***prior to hire and monthly thereafter,*** to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care program.
- Providers face consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals or entities. Medicaid providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries when those individuals or entities are excluded from participation in any Medicare, Medicaid, or other Federal health care programs **are subject to termination of their enrollment in, and exclusion from, participation in the MA Program and all federal health care programs, recoupment of overpayments, and imposition of civil monetary penalties.**

In the SBAP, the preclusion/exclusion checks would apply to any individual listed on the LEA's Direct Service and Administrative Staff Pool Lists, and to any individual or entity employed or contracted by the LEA which directly or indirectly supports any service or item payable by Medicaid. Examples would include, but not be limited to the following:

- SBAP direct service staff, supervisory staff, billing staff, and transportation staff;
- Individuals listed on the Direct Service and Administrative Staff Pool Lists; and
- Vendors, such as DME suppliers, that are used to purchase assistive devices for SBAP students.

To ensure compliance, LEAs should:

1. Develop policies and procedures to screen all employees and contractors (both individuals and entities), **at time of hire or contracting; and on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs.**
2. Use the following three databases to determine exclusion status:

- **Pennsylvania Medicheck List***:* Database maintained by DHS that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program.

- **List of Excluded Individuals/Entities (LEIE)**: Database maintained by the U.S. Health & Human Services Office of Inspector General that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although DHS makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program.

- **System for Award Management (SAM)**: World-wide database maintained by the General Services Administration that provides information about parties that are excluded from receiving federal contracts, certain subcontracts, and certain federal financial and nonfinancial assistance and benefits.

3. Develop auditable documentation of when these procedures are performed.
4. Periodically conduct self-audits to determine compliance with this requirement.
5. Immediately self-report any discovered exclusion of an employee or contractor, either an individual or entity, to DHS' Bureau of Program Integrity. The Bureau of Program Integrity (BPI) SBAP Coordinator can be reached at (717) 772-4631.

SECTION 6 – QUALITY ASSURANCE AND AUDIT REQUIREMENTS

6.1 Bureau of Program Integrity Reviews

BPI is the Bureau within DHS that is mandated to:

- Prevent, identify, and combat fraud, waste, and abuse within the MA Program;
- Monitor providers' compliance with MA regulations and requirements;
- Conduct analyses of providers' claim patterns (such as by data mining) and provider records;
- Conduct preliminary investigations of suspected MA fraud, waste, and abuse;
- Refer suspected fraud to the Medicaid Fraud Control Section (MFCS) in the Pennsylvania Office of Attorney General for investigation;
- Suspend payments to providers that are referred to MFCS;
- Refer to other civil/criminal, state/federal agencies as appropriate;
- Recover overpayments that are not the result of fraud;
- Conduct reviews to determine if services were medically necessary and provided consistent with accepted medical treatment standards; and
- Impose administrative sanctions on providers.

BPI reviews may include, but are not limited to:

- Review of denied and/or paid claims;
- Record reviews by medical professionals;
- On-site visits to observe, interview staff, and/or to obtain records for review;
- Beneficiary interviews to evaluate services rendered.

BPI may take the following administrative actions:

- Recover overpayments and improperly paid funds;
- Request a self-audit;
- Request a corrective action plan (CAP);
- Refer suspected fraud to the MFCS;
- Suspend payments to a provider in whole or in part, when a credible allegation of fraud is identified that causes a referral to the MFCS;
- Refer to other criminal investigatory agencies, and to licensing oversight agencies; and/or
- Terminate a provider's provider agreement and preclude participation in the MA Program.

6.2 Reporting Suspected Medicaid Fraud

- MEDICAID FRAUD CONTROL SECTION (MFCS) IN THE PENNSYLVANIA OFFICE OF ATTORNEY GENERAL
- DHS MA PROVIDER COMPLIANCE FORM

6.3 Other Agencies

- MEDICAID INTEGRITY CONTRACTORS
- PAYMENT ERROR RATE MEASUREMENT (PERM) PROGRAM
- U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

6.4 Provider Self-Audits

Self-audits are a component of a Compliance Program and include:

- Periodic self-auditing of service delivery and billing;
- Comparison of what was billed with MA beneficiary (student) records; and
- Review of regulations and other requirements to ensure that services were rendered and billed correctly.

PA SBAP Self-Audit Record Review Document

Benefits of Self-Auditing

Everyone who participates in an LEA's SBAP, not just a compliance officer or committee, is responsible for compliance. As a result of ongoing compliance activities, LEAs can identify instances when billing for services would be inappropriate and hold the billing until their review is completed. If the review reveals that billing the services would be inappropriate, an LEA has prevented non-compliance.

Benefits of provider self-audit activities include:

- Identification of services that were billed inappropriately;
- Identification of overpayments and underpayments;
- Identification of individuals that might not be implementing services appropriately;
- Identification of individuals that might be submitting time inappropriately;
- The provider, not DHS, conducts the review; and
- DHS will **not seek double damages for self-reported** inappropriate payments.

6.5 Compliance Programs

Compliance Programs, to ensure systemic checks are in place to prevent inaccurate or inappropriate billing and compliance with the law, are required for MA Providers receiving annual Medicaid payments of at least $5 million. Resources include:

- MA Bulletin 99-07-01 titled "False Act Claims Provisions of Deficit Reduction Act of 2005 - Employee Education about False Claims Recovery"
- MA Bulletin 99-07-13 titled "Updated Regarding False Act Claims Provisions of Deficit Reduction Act of 2005 - Employee Education about False Claims Recovery"
- Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act

6.6 Voluntary Disclosures

DHS considers that providers have an ethical and legal duty to return inappropriate payments. DHS' Self-Audit Protocol (Protocol) is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation, or policy governing the MA Program, or matters exclusively involving overpayments or errors that do not suggest violations of law. DHS may, upon review of information submitted, or upon further investigation, determine that the matter implicates state criminal or federal law. In such instances, DHS will refer the matter to the appropriate federal or state agency.

The Protocol provides a mechanism for providers to ***voluntarily*** disclose overpayments or improper MA payments discovered through a self-audit; or through other means. The Protocol provides guidance on the preferred methodology, encourages all MA providers to implement Compliance Programs, and encourages all MA providers to conduct periodic self-audits.

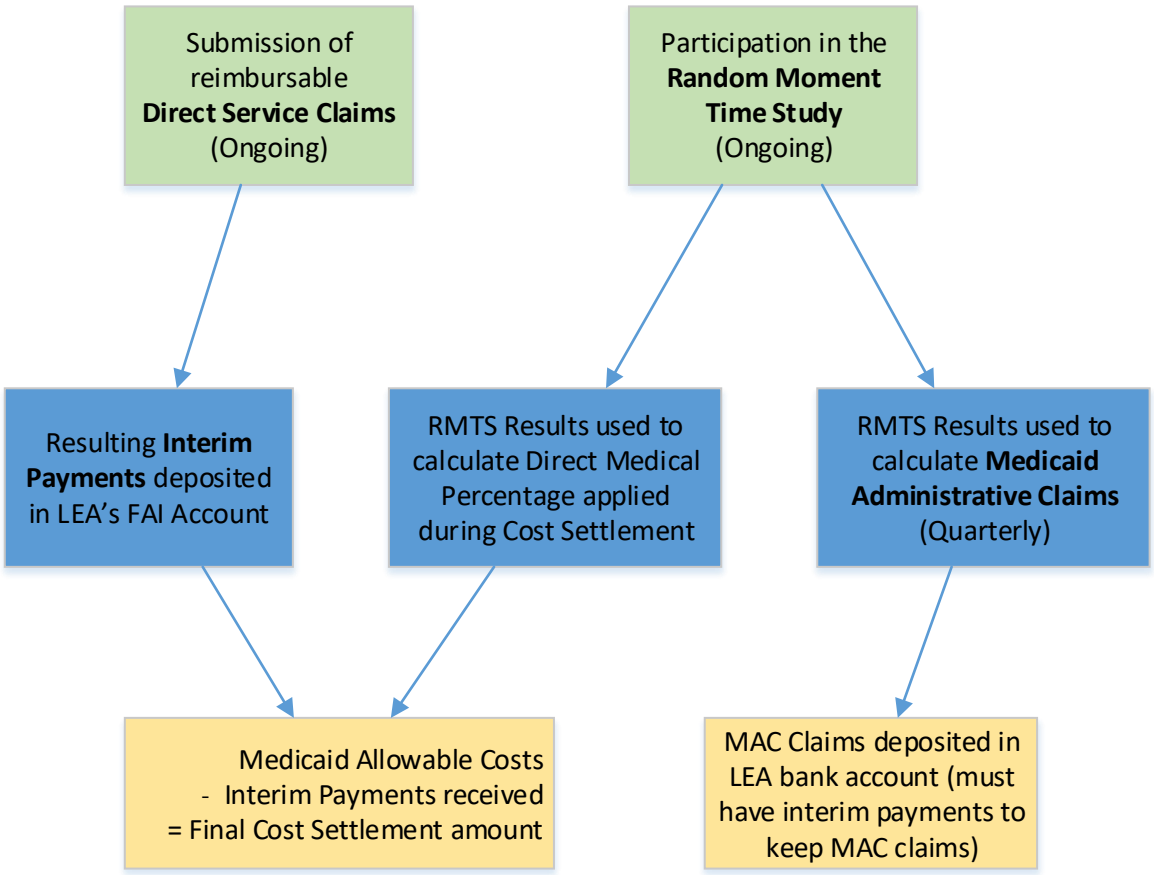
Self-Disclose to BPI at:

- By Phone: BPI SBAP Coordinator @ 717-772-4631
- By Mail: Bureau of Program Integrity
  Department of Human Services
  Attention SBAP Coordinator
  P.O. Box 2675
  Harrisburg, PA 17105-2675

SECTION 7 – SCHOOL-BASED SERVICES REIMBURSEMENT

7.1 Cost-Based Payment Methodology

School-based services, including special transportation, provided by LEAs will be paid on a cost-related basis. Each of the required program components are linked to arrive at the total cost-based reimbursement each LEA receives for the fiscal year as seen in the diagram below.



7.2 Direct Service Claiming and Timely Filing Requirement

Participating LEAs must regularly submit claims, through DHS' Lot 1 contractor, for direct services rendered.

Direct service and special transportation claims must be submitted to DHS within 180 days from the day the service was rendered.

Since the LEAs must first submit service logs to DHS' Lot 1 contractor prior to DHS' Lot 1 contractor's claim submission to the DHS' PROMISe™ system, LEAs should be timely entering

service logs into DHS' Lot 1 contractor's system. It is considered best practice for the LEA to enter the prior month's logs by the 15th of each month.

DHS' Lot 1 contractor will first review LEAs' service logs for the student's MA eligibility. If the student is not enrolled in MA on the date of service, the claim will not be submitted to DHS.

DHS' Lot 1 contractor will review LEAs' service logs for MA-enrolled students for the following compliance information:

- MA Provider Number for the Prescribing Practitioner
- NPI for the Prescribing Practitioner
- Medical Practitioner Authorization (Date)
- IEP (Date)
- Primary Disability
- PA Secure ID
- Parental Consent (Date)
- Provider Certification/Licensure (Date)

If any of the eight compliance items are missing from the LEAs' service logs, DHS' Lot 1 contractor will identify the missing information in a monthly report made available to the LEAs. This allows the LEA an opportunity to provide or complete the missing information which is needed for successful claim submission. Claims with incomplete compliance information are NOT submitted to DHS' PROMISe™ system for processing. If missing information is not provided or completed within 180 days of the date of service, the claim cannot be submitted, and the LEA loses the opportunity for reimbursement.

If all compliance items are included in the LEAs' service logs, DHS' Lot 1 contractor submits compliant claims to DHS' PROMISe™ system for processing.

Claims that are denied by DHS can be resubmitted. Resubmitted claims and claims adjustments must be fully adjudicated within 365 days from the date of service.

LEAs may use the following resources to submit service logs to DHS' Lot 1 contractor's system:
Data Exchange Imports – How To Guide
Data Exchange Formats – EasyTrac Import

7.3 Interim Payment Process

LEAs will initially receive payment for services rendered based on an interim payment process. DHS will determine provider-specific interim rates for school-based direct health-related services per unit of service. The provider-specific interim rate is the provisional rate established for a specific service for a time period pending completion of the cost reconciliation process for that period. Provider-specific interim rates are adjusted annually for each LEA and for each service type, based on the prior year's cost settlement by DHS' Lot 2 contractor.

Interim payments representing the federal share of the amount of the claims paid by DHS, less the amount of associated processing fees, are deposited into each LEA's Financial Accounting Information (FAI) account, managed by PDE. For information on withdrawing funds from your LEA's FAI account, refer to Appendix C.

7.4 Transportation Reimbursement

LEAs bill for special transportation services (Section 3.14) throughout the school year; however, costs for special transportation are submitted annually on the cost reports during the cost reconciliation process.

Allowable transportation costs include only those personnel and non-personnel costs associated with Special Education reduced by any federal payments for those costs. The costs may include:

- Bus Drivers
- Mechanics
- Substitute Drivers
- Fuel & Oil
- Repairs & Maintenance
- Lease/Rentals
- Contract Use Cost
- Depreciation
- Insurance

LEAs reporting special transportation costs must complete both transportation ratios.

7.4.a Special Transportation Ratio

The Special Transportation Ratio is used when special transportation costs cannot be discreetly broken out from general transportation costs. This ratio is only applied to costs reported as "Not Only Specialized." LEAs must report both the numerator (total number of special

education students with special transportation services in their IEP) and the denominator (total number of all students receiving transportation services, special or non-special/general).

7.4.b One-Way Trip Ratio

The One-Way Trip Ratio allocates a portion of special transportation costs to the MA Program. DHS' Lot 2 contractor will input the numerator (total number of paid MA one-way trips for students with specialized transportation in their IEP), on behalf of the LEAs, based on the paid claims data from DHS. LEAs report only the denominator (total number of all one-way trips for special education students with specialized transportation in their IEP).

A One-Way Trip is defined as a trip to or from school for a special education student with specialized transportation in their IEP on the same day as a paid SBAP direct health-related service. Transportation to AND from school would be considered two one-way trips.

Compliance reminder: Special transportation services provided must be documented in a transportation log.

7.5 Health-Related Purchased Services

Health-related purchased services include costs incurred by an LEA to ensure a special education student with a qualifying IDEA disability receives the necessary health-related services. These costs may be tuition to an out-of-district entity or payment to an entity that the LEA contracts with to provide services within its district.

When a specific individual is identified and made available for participation in the RMTS by inclusion on the LEA's direct service cost pool, then the costs associated to that individual are reported as staff costs and are not considered purchased services.

7.5.a Tuition

LEAs that have agreements with licensed private academic schools, including Approved Private Schools (APS) and Chartered Schools for the Deaf and Blind (CSDB), to provide medically necessary school-based health services documented in the IEP to Medicaid eligible students, may report the tuition cost on their annual cost reports. Tuition paid to entities that are eligible to participate in SBAP is **NOT** an eligible cost and cannot be reported for SBAP.

LEAs can only include tuition costs for students who are receiving a direct health-related service as listed in their IEPs and when the supporting documentation is maintained. Costs are to be reported and documented using the accrual-based accounting process as utilized in cost

settlement. In other words, when completing the cost report for FY2022-2023, the LEA should enter the actual tuition costs associated to students attending outside institutions that year.

LEAs may claim 100% full tuition costs for eligible students enrolled in an APS or CSDB, including those with partial PDE funding. When providing documentation for those costs, the LEA may provide information from the Directory of Approved Private Schools (published by PDE) and any enrollment or invoicing documents received from the private school that provides the tuition costs. When those amounts are deducted from the LEAs funding and appear on the 4010 report, that report should be added to the documentation supporting those costs.

Tuition costs are subject to an individual health-related tuition percentage to determine the Medicaid allowable health-related portion of the total tuition costs.

When an LEA reports tuition for a student who is receiving a direct health-related service as listed in his/her IEP, no direct service or special transportation claims are to be submitted for that student. If the LEA is billed separately for health-related services that are not included in the tuition, those costs are to be reported under contracted costs.

To receive reimbursement for allowable health-related tuition costs, LEAs must still participate in all program components as indicated in the LEA Agreement (Appendix A) and Section 1.3.b of this Handbook, including submitting compensable direct service claims. An LEA that reports only tuition costs is NOT eligible to receive or retain MAC payments.

7.5.b Contracted Costs

Health-related purchased services include those costs paid to an entity the LEA contracts with to provide health-related services. Such contracts may not list a specific individual that the LEA is able to include on its direct staff pool list for the RMTS, but rather indicates that services will be provided by any one of a number of qualified individuals as identified in Section 3. As a result, the costs for an occupational therapist, for example, cannot be included in the salary/benefits portion of the cost report.

LEAs should request and maintain documentation supporting that all individuals providing SBAP services through a contract with the LEA are qualified as described in Section 3, along with copies of the contract and invoices for services provided. When reported at cost settlement, contracted costs are subject to the statewide RMTS direct medical service percentage to determine the MA allowable health-related costs.

LEAs may report costs for health-related purchased services that are not included in the tuition rates as contracted costs.

LEAs may submit claims for eligible health-related services (that are not included in tuition) to MA for interim payments only when the individual providing services agrees to participate in RMTS and submits logs to the LEA for submission to DHS' Lot 1 contractor.

7.6 Cost Reconciliation Process

On an annual basis, a provider-specific cost reconciliation process compares each LEA's interim payments for direct service claiming to each LEA's total Medicaid allowable costs to determine all overpayments and underpayments for that period. The cost reconciliation process is completed within 12 months after the close of the fiscal year.

7.6.a Cost Reports

In order to determine each LEA's annual, total Medicaid allowable costs, LEAs are required to complete and certify an annual cost report for all school-based direct health-related services delivered during the previous state fiscal year (July 1 – June 30). The annual cost reporting process begins October 1 and must be completed by December 31 of each year and must include the financial data outlined throughout Section 11 – Financial Reporting Compliance Requirements.

Total costs of providing or purchasing school-based direct health-related services, less any federal payments for these costs, will be captured annually in the cost reports by the LEAs.

LEAs annually report and certify allowable costs as described below:

- Direct health-related service provider salaries;
- Direct health-related service provider benefits, including: staff training and professional development and travel expenses;
- Direct health-related service contracted provider cost;
- Tuition paid to an APS, CSDB, or licensed private academic school;
- Contracted health-related purchased services;
- Health-related supplies and materials from the approved list (reported under direct medical other); and
- Transportation costs, including: salaried/contract bus drivers, fuel, repairs and maintenance.

Note: Costs can only be claimed for an individual employee or contractor included on the staff pool lists, and for only the quarter(s) for which the individual is listed. Individuals must be available for potential RMTS sampling for their costs to be allowable. See section 8.4 related to RMTS Participants.

LEAs must maintain documentation that supports the costs reported in the event of any future review or audit of the cost settlement results. See Section 5 for more information regarding record keeping requirements.

7.6.b Desk Reviews

The annual cost reports are subject to a Desk Review by DHS' Lot 2 contractor. Data entered by the LEA is evaluated by the contractor to identify entries that may indicate an error, such as significant increases or decreases in the amount reported or entries that are outliers. Upon receipt of the Desk Review, an LEA must confirm any information flagged during the review is either 1) accurate or 2) request to make adjustments/corrections. If an LEA identifies they have entered or omitted information in error, the Desk Review process provides the opportunity to make corrections before the cost settlement calculation is completed and the CPE forms are released for signature.

7.6.c Issuance of Cost Settlements

Following the Desk Review process, cost settlements are calculated by comparing the total Medicaid allowable costs to the LEA's interim payments for school-based health-related services provided during the applicable fiscal year being reported. DHS will issue a notice of cost settlement to the LEA that denotes the amount due to or from the LEA.

An LEA receiving a cost settlement notice is required to complete a Certified Public Expenditure (CPE) to certify the expenditures reported are allocable and allowable with the SBAP for the applicable fiscal year being reported. Failure to return the CPE is failure to complete the cost settlement process which will result in recoupment of all reimbursement for the fiscal year. The cost reconciliation process is completed within 12 months after the close of the fiscal year.

7.7 Program Monitoring and Compliance

DHS and its contractors conduct multiple reviews each year on randomly selected LEAs to ensure program compliance. These reviews include oversight and monitoring reviews, which involve reviews of LEA cost report information of past cost reconciliation; and quality assurance reviews, which involve reviews of LEA compliance in the current fiscal year.

7.7.a Oversight and Monitoring Reviews

As part of the Department's ongoing monitoring of program compliance, a number of randomly selected LEAs will be required to participate in Oversight and Monitoring Reviews each year. These reviews are conducted by DHS' Lot 2 contractor after completion of the cost reconciliation process.

LEAs will be notified of their selection for a review by letter, and will be given 60 days to provide source documentation to support the information reported on their cost report. Documentation will be required for all sections of the cost report completed by the LEA as described below:

- Salaried Staff (payroll reports, benefit calculations);
- Contracted Staff and Services (contracts, invoices, ledger entries showing payments);
- Direct Medical Service Staff – Credentials & Licensing;
- Direct Medical Services Materials and Other Costs (invoices, ledger entries showing payments);
- IEP Ratio (spreadsheet/database records of students with IEP & students with IEP & health-related service);
- Tuition Payments (contracts/letters of agreement; invoices; ledger entries showing payments; 4010 reports for year of attendance);
- One-Way Trip Ratio and Specialized Transportation Ratio (bus logs, spreadsheet/database); and
- Transportation Payroll and Other Costs (payroll reports; invoices; ledger entries showing payments).

Upon conclusion of the reviews, LEAs will receive a report of findings by category. A preliminary report will be issued to allow 30 days for the LEA to provide additional information to address any findings in the report. DHS will issue a final report advising the LEA of its findings and any recoupment of funds resulting from findings of non-compliance.

7.7.b Quality Assurance Reviews (QARs)

Quality Assurance Reviews (QARs) are conducted by DHS' Lot 1 contractor on an annual basis and focus on the current year's activities to determine LEA compliance with SBAP requirements. QARs are conducted for a minimum of 25% of participating LEAs each fiscal year. QARs are conducted on site with the LEA whenever possible, or as designated and approved by DHS. QARs shall cover, at a minimum:

- Staff pool lists;

- Credentials;
- Documentation related to costs and services;
- Parental consent forms; and
- Medical practitioner authorization forms.

7.8 Medicaid Administrative Claiming (MAC)

MAC allows expenditures for administrative activities in support of school-based services or that directly support the MA program, including outreach and care coordination.

Quarterly, LEAs report and certify allowable costs of staff included on their Direct Service Providers and Administrative Providers Staff Pool Lists through DHS' Lot 1 contractor.

The RMTS, fully described in Section 8, is the primary mechanism for identifying and categorizing MA administrative activities performed by LEA employees and contractors, and also serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under MA.

The MAC claim is calculated by taking the total certified costs and separately multiplying the costs related to each cost pool by both the quarterly statewide RMTS percentages and the LEA's Medicaid Eligibility Rate (MER).

The LEA **must** receive direct service claiming reimbursement in order to receive MAC reimbursement. If no interim payments are received for the fiscal year, then all MAC payments for that fiscal year will be recouped. The Department may notify LEAs when it determines the LEA has received no direct service claiming reimbursement as of the date of the notice. This notification affords the LEA an opportunity to identify and address any direct service claiming issues prior to the end of the fiscal year. If no interim payments are received for the fiscal year, then **all** MAC payments will be recouped.

LEAs are required to complete a CPE form for quarterly allowable administrative costs within a 10-business day deadline, before receiving MAC reimbursements. An LEA that fails to submit a signed copy of the CPE before the deadline will not have their claim included in the same quarter's payment submission. Quarterly MAC CPEs for a fiscal year may be received up through the annual deadline of September 30. For example, quarterly MAC CPEs for the fiscal year of July 1, 2022-June 30, 2023 must be received by September 30, 2023 in order to receive reimbursement.

MAC reimbursements are issued via direct deposit into bank accounts identified by LEAs. MAC reimbursements are not deposited into LEA FAI accounts and are not subject to the cost reconciliation process. To add or update bank account information to receive MAC reimbursements, please complete the following forms as appropriate:

- Add a New Bank Account
- Change Existing Bank Account Details

SECTION 8 – RANDOM MOMENT TIME STUDY (RMTS)

LEAs are required to participate in the statewide RMTS, which is designed to support proper MA reimbursement for delivered services, consistent with the requirements set forth by the state's approved Time Study Implementation Guide for Direct Services and Administrative Claiming.

8.1 RMTS Methodology

RMTS, sometimes referred to as Random Moment Sampling, is a federally-accepted method for tracking employee time and activities. According to 2 CFR § 200.430 (i)(5), "Substitute processes or systems for allocating salaries and wages to Federal awards may be used in place of or in addition to the records described in paragraph (1) if approved by the cognizant agency for indirect cost. Such systems may include, but are not limited to, random moment sampling...".

Random moment sampling or RMTS is particularly useful, because:

- It uses a verifiable, statistically valid random sampling technique that produces accurate labor distribution results, and
- It greatly reduces the amount of staff time needed to record an individual time study participant's activities.

The RMTS method polls participants on an individual basis at random time intervals over a quarterly (three-month) time period and totals the results. The RMTS method provides a statistically valid means of determining what portion of the selected group of participants' workloads is spent performing activities that are reimbursable by MA.

8.1.a Sampling Requirements

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary LEA administrative burden, DHS implements a consistent sampling methodology for all activity codes and groups to be used. The statewide RMTS sampling methodology has been constructed to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities.

Statistical calculations show that a minimum statewide sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. An over sample of a minimum of 15% (for a total of 3,000 moments per cost pool) is used to account for invalid moments. Invalid moments are observations that cannot be used for analysis, i.e., moments selected for staff who are no

longer at the school district, or who changed jobs and are no longer in an allowable position and the former position has not been filled.

8.2 SBAP Coordinators

Each LEA must designate an employee as the SBAP Coordinator to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The SBAP Coordinator acts as a liaison between DHS/DHS' Lot 1 contractor and the LEA providers.

The SBAP Coordinator responsibilities include but are not limited to:

- Certifying quarterly calendars and/or staff shifts;
- Identifying qualified staff for participation in the time study;
- Maintaining the LEA RMTS staff pool lists (Direct Service Providers and Administrative Providers);
- Providing participant information for the RMTS staff pool lists to DHS' Lot 1 contractor;
- Monitoring staff participation in the time study;
- Understanding the SBAP rules and distribution of information; and
- Acting as a liaison between DHS, DHS' Lot 1 contractor and the staff participant.

8.2.a SBAP RMTS Coordinator Training

The training for the SBAP Coordinators has been designed to assist them in appropriately identifying staff that are eligible to participate in the RMTS program. The training materials outline examples of activities that are reimbursable under the program, which will enable the SBAP Coordinator to match eligible staff and reimbursable activities.

SBAP Coordinators must attend an initial RMTS training and all additional mandatory RMTS trainings. DHS' contractor provides initial training for the SBAP Coordinators, which includes an overview of the RMTS software system and information on how to access and input information into said system. The SBAP Coordinator for each LEA is required to attend the time study training. It is essential for the SBAP Coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and the importance of their role to the success of the program.

The SBAP Coordinator is supplied with the "Medicaid School-Based Administrative Claiming Guide" and "Medicaid and School Health: A Technical Assistance Guide" which identify Medicaid allowable activities. All training materials are accessible to the SBAP Coordinators. In

addition, annual training is provided to the SBAP Coordinators to cover topics such as SBAP updates, process modifications and compliance issues.

Central coding is a function of DHS and its contractors.

8.3 RMTS Process

8.3.a Sampling Period

The sampling period is defined as a three-month quarterly period. The following are the quarters followed for the SBAP:

- October 1 – December 31 (active – moments issued)
- January 1 – March 31 (active – moments issued)
- April 1 – June 30 (active – moments issued)
- July 1 – September 30 (inactive – no moments issued)

8.3.b April-June Quarter

The sampling period is designed in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide:

> *"If the school year ends in the middle of a calendar quarter (for example, sometime in June, the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study." (page 42, Example 4)*

LEA staff members are paid to work during those dates that the LEA is in session; as an example, an LEA may end the school year sometime in May each year. All days, including and through the end of the school year, would be included in the potential days to be chosen for the time study. It is important to understand that although an LEA may end the school year prior to the close of the quarter, staff members are paid for services provided through the end of the quarter. An LEA typically spreads staff compensation over the entire calendar year even when staff members are not working. The LEA considers this compensation to be reimbursement for time when staff members actually work rather than compensation for the staff members' time off during the summer months.

8.3.c July-September Quarter

Because most LEAs are not operating or providing services in the summer months, a time study will not be conducted in the quarter from July to September. An average of the prior three quarters time study results will be used to calculate a claim for the summer months.

This is consistent with the May 2003 Medicaid School-Based Administrative Claiming Guide: *"...the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break." (page 42)*

8.3.d LEA Quarterly Calendars/Shifts and Staff Pool Lists

Dates that the LEA will be in session will be determined quarterly by the SBAP Coordinator. LEAs will review and certify their calendars each quarter to determine the dates the LEA pays for its staff to work and those dates will be included in the sample. LEAs that fail to certify their calendars before the quarterly deadlines will be required to use DHS' Lot 1 contractor's default calendar.

As a best practice, LEAs should identify the latest start time and earliest end time within the district when determining their calendars.

LEAs must use shifts to ensure that individuals on the staff pool lists can be selected to receive a moment at any time during their working hours. Additionally, LEAs can utilize shifts on their calendars for service providers, such as an itinerant OT, who work specific days/times (e.g., Monday and Wednesday from 9:00am to 11:30am). Shifts should represent actual working/paid hours for everyone on the staff pool list. In times when it is not possible to exactly identify when a participant works in a shift, the LEA should always choose the earliest possible start time and latest end time. An unlimited number of shifts can be entered and used on the LEA's calendar to address these varied work schedules.

For each active quarter, LEAs will be provided with a date on which they must submit and certify their calendars/shifts and staff rosters, which is approximately one month prior to the start of the time study quarter. No changes or additions are made after the sample is drawn and created, in order to maintain a verifiable, statistically valid sample.

8.3.e Moment Generation

Moments are generated for the entire three-month quarterly period prior to the start of the quarter. Each selected moment is defined as a specific one-minute unit and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the selected participant. The statewide sample comprises all LEAs that participate in the SBAP; each LEA may have its own work/non-work days (defined by the calendar of the LEA) and work hours.

Time study participants are notified via e-mail of their requirement to participate in the time study and of their sampled moment. Throughout this entire process, the LEA SBAP Coordinators have real-time access in the online system to view their sampled staff, the dates/times of their sampled staff's moments, and whether or not the moment has been completed.

8.3.f Valid Moments

Valid moments are completed moments that have been received by DHS' Lot 1 contractor and have been determined to be complete and accurate. All documentation of sampled moments must be returned within five working days, as identified by the LEA's certified calendar, after the sampled date. Documentation of moments not received within the required time frame cannot be used in the calculation.

Non-returned moments are moments not returned by the LEA. If the staff for whom the moment was intended is no longer employed by the LEA but the position that staff person was in has been filled, the moment is to be completed by the replacement staff person. If the position remains vacant, a notation of such is made on the moment and DHS' Lot 1 contractor marks the moment "invalid."

8.3.g Moment Follow-Up Questions

It is important for each selected participant to provide sufficient detail to describe the activity that occurred during the selected moment. In a situation where insufficient information is provided to determine the appropriate activity code, DHS' Lot 1 contractor may contact the selected participant and request submission of additional information. Once the information is received, the moment is coded and included in the final time study percentage calculation. If no additional information is received, the moment may be coded as non-MA.

8.4 RMTS Participants

The purpose of the statewide time study is to identify the proportion of direct service and administrative time allowable and reimbursable under MA. Staff performing MA-related activities in an LEA seeking reimbursement are required to participate in the statewide time study using the approved RMTS methodology. This information is used for direct service cost reporting to enable the state to conduct a cost settlement at the end of the fiscal year for the SBAP. The administrative time study results are applied to the allowable administrative costs of the participating LEAs to calculate the quarterly MAC.

All LEAs that participate in the SBAP are required to be in the time study and identify allowable costs within a given LEA. Staff members and contractors who perform direct service and administrative activities are required to participate in a quarterly time study.

Costs can only be claimed for an individual employee or contractor included on the staff pool lists, and for only the quarter(s) for which the individual is listed. Therefore, only positions included on the staff pool lists for potential RMTS sampling can have costs included in the cost pools for administrative and direct service claiming purposes.

Staff pool lists will be updated quarterly to reflect staff changes at the LEA level. If a staff person leaves the LEA and the position is then filled during the quarter, the LEA must update the contact information associated with that position in DHS' Lot 1 contractor's system. In the event that a new position is created, or a LEA did not include a position on the staff pool list created at the beginning of the quarter, it cannot add the staff person/position until the next quarter.

The two universes of time study participants and associated cost pools are mutually exclusive.

The following categories of staff have been identified as appropriate participants for the time study. Additions to the list may be made depending upon job duties. The decision and approval to include additional staff will be made on a case-by-case basis.

8.4.a Direct Service Cost Pool

The following services and rendering providers may be included in the Direct Service Cost Pool:

- Nursing Services that are provided by a licensed registered nurse, licensed practical nurse, or licensed certified registered nurse practitioner.
- Nurse Practitioner Services that are provided by a licensed certified registered nurse practitioner
- Occupational Therapy Services that are provided by or under the supervision of a licensed occupational therapist.

- Orientation, Mobility and Vision Services that are provided by an orientation and mobility specialist.
- Personal Care Services that are provided by a personal care assistant.
- Physical Therapy Services that are provided by or under the supervision of a licensed physical therapist.
- Physician Services that are provided by a currently licensed doctor of medicine or currently licensed doctor of osteopathy.
- Psychological, Social Work, and Counseling Services that are provided by a licensed psychologist, school psychologist, licensed psychiatrist, licensed social worker, licensed professional counselor, or licensed family and marriage therapist.
- Speech, Language and Hearing Services that are provided by a licensed speech pathologist, licensed audiologist, or a teacher of the hearing impaired.

Only qualified providers, as defined in Section 3, are permitted to be listed on the Direct Service Cost Pool.

8.4.b Administrative Service Providers Cost Pool

The Administrative Service Providers Cost Pool includes LEA staff that do not provide allowable direct service, but who perform activities that support direct services. The following staff may be included in the time study:

- School Administrators, including principals and assistant principals
- State Certified Counselor
- Non-certified Psychologist/Psychologist Interns
- Non-certified Social Worker
- Psychologist Intern
- Special Education Administrator
- School Bilingual Assistant
- Speech-Language Pathologist (Non-Masters Level and Non-Licensed)
- Program Specialist
- SBAP Coordinator
- Supervisors of persons providing direct service
- Transportation Coordinator
- Other groups/individuals that may be identified by the LEA

Providers included in the Administrative Service Provider Pool cannot be included in the Direct Service Cost Pool. **There is to be no duplication of staff or services in the two cost pools.** A claim for a direct service cannot be submitted for reimbursement when provided by an individual in the Administrative Service Provider Pool.

Staff listed under the Direct Service Cost Pool, or the Administrative Service Providers Cost Pool are not automatically included in the time study. The LEA must determine whether the job position is less than 100% Medicaid funded. Staff that are 100% federally funded will be excluded from the time study as none of their costs are reimbursable. Staff members that are partially federally funded may be included in the time study; however, any costs that are included in the cost pool must be net of all federal sources.

The administration of the time study is identical for each of the cost pools.

8.4.c Staff Pool Lists

Before the statewide sample is generated, each LEA must submit a staff pool list and certify that all staff included on the list are appropriate for inclusion in the time study. Staff deemed inappropriate during review of time study quarters will be removed from the time study and excluded from claims.

If a staff person leaves the LEA in the middle of the quarter and the position is filled during the quarter, the LEA must update the contact information associated with that position in DHS' Lot 1 contractor's system. In the event that a new position is created, or a LEA does not include an existing position on the staff pool list created at the beginning of the quarter and used to generate the statewide sample, the LEA must wait until the next quarter to add that staff person/position.

Allowable staff must be listed on an approved staff pool list prior to the time study quarter. If an allowable staff person is not listed on the staff pool list, costs cannot be claimed for the position.

The SBAP Coordinator will assign staff to a specific job category in one of the two cost pools and DHS' Lot 1 contractor will use the LEA's certified staff list for each cost pool to generate the statewide sample for each pool. DHS' Lot 1 contractor does not add staff, delete vacancies or create the cost pool list for any LEA. The cost pools and staff within those pools are completed directly by the LEA's SBAP Coordinator. DHS' Lot 1 contractor will summarize the individual LEA cost pool lists into a statewide cost pool that is used to generate the sample for the given sample period.

LEA personnel who participate in the time study must be assigned to job categories that describe their job function. If a category includes a limited mix of job functions and titles, the functional (or working) job title must be listed beside each person's name.

8.5 RMTS Compliance

The time study must have a statewide response rate of at least 85% to be compliant. If the statewide compliance rate is not met, all non-returned moments are coded as *non-MA time and included in the overall quarterly time study results.* If the statewide compliance rate is reached, no action will be taken with those non-returned moments, and they will be dropped from the overall quarterly time study results.

To assist in reaching the statewide compliance rate, LEAs are monitored to ensure they are properly returning sample moments. As much information as possible to explain why the non-returned moments were unanswered is gathered from the SBAP Coordinators and/or participants. LEAs should individually strive for a 100% response rate each quarter.

If the statewide response rate is less than 90%, DHS may send warning letters and impose sanctions on individual LEAs that fail to reach a satisfactory response rate. After receiving a warning letter, LEAs in default in subsequent quarters will not be allowed to claim and will not be able to participate in administrative claiming for the remainder of that fiscal year. If such a penalty is imposed, the LEA is required to return any payments received for that fiscal year under the SBAP.

8.6 RMTS Documentation and Recordkeeping Requirements

Documentation of sampled moments must be sufficient to provide answers to six questions needed for accurate coding:

1. Were you working during your sampled moment?
2. Who was with you?
3. What were you doing?
4. Why were you doing this activity?
5. Is this activity regarding a Special Education student?
6. Is the service you provided part of the child's IEP?

Each sampled participant must complete the six questions above for each moment in which they were selected. After answering the six questions, the sampled participant certifies the accuracy of their response prior to submission.

The LEA must certify that all RMTS participants hold the necessary provider qualifications to bill MA for their services and maintain documentation of licensures or credentials.

All participating LEAs are required to maintain documentation supporting the RMTS results, which are used in the MA claim. Each LEA is required to maintain the following documents:

- A Direct Service Cost Pool list of eligible individuals, including job categories and licensures/credentials;
- An Administrative Service Provider Only Cost Pool of eligible individuals, including job categories;
- Any financial data used to develop the administrative claim and/or cost report and a copy of the completed cost report.

LEAs are required to comply with all state and federal laws regarding record retention.

SECTION 9 – COST ALLOCATION FACTORS

9.1 Federal Medical Assistance Percentage (FMAP) Rate

The federal government pays states for a specified percentage of program expenditures called the Federal Medical Assistance Percentage (FMAP). The FMAP varies by state based on criteria such as per capita income. The FMAP is adjusted each federal fiscal year (Oct 1-Sept 30) and the minimum rate is 50%. The FMAP is published annually in the Federal Register and archived by the U.S. Department of Health and Human Services.

9.2 Individualized Education Program (IEP) Ratio

LEAs are required to provide an IEP Ratio on their annual cost reports. When applied, this LEA-specific IEP Ratio discounts the allowable costs associated with the Direct Service cost pool by the percentage of IEP Medicaid students.

Using the December 1 Count Report, LEAs are required to report the total number of **all special education students** with a health-related service(s) in their IEP. This number is the denominator of the IEP ratio. The numerator is the total number of **Medicaid eligible special education students** with a health-related service(s) in their IEP**.** Both the numerator and denominator are calculated as of December 1 of the fiscal year. For example, student data and eligibility from December 1, 2022 would be used to determine the IEP ratios for the FY 2022-2023 cost settlement. All participating LEAs are required to maintain documentation supporting both the numerator and the denominator of the reported IEP ratios, including the names and birthdates of students.

$$\frac{\text{Total number of } \textbf{Medicaid Eligible Special Education Students} \text{ With a Health-Related service in their IEP}}{\text{Total Number of } \textbf{All Special Education Students} \text{ With a Health-Related Service in their IEP}} = \text{IEP Ratio}$$

Note: Failure to maintain documentation supporting the reported IEP ratio, when determined during an audit or oversight and monitoring, will result in the recoupment of all SBAP payments received for that fiscal year, to include interim payments, payments resulting from cost settlement, and MAC payments.

9.3 Medicaid Eligibility Rate (MER)

Costs associated with several MA administrative activities performed by the LEAs are adjusted by the LEA Medicaid Eligibility Rate (MER). The MER reduces these costs to the amount for services specific to MA-eligible individuals. The numerator of the MER is the total number of MA-eligible students in the LEA and the denominator is the total number of students enrolled in the LEA. The MER for the MAC program is calculated on an annual basis by DHS' Lot 1 contractor.

9.4 Unrestricted Indirect Cost Rate (UICR)

Indirect costs are calculated consistent with 45 CFR Part 75.

UICRs are applied during the cost settlement process each year to determine the amount of allowable indirect costs for each LEA participating in the SBAP.

The UICRs are LEA-specific, developed and certified by the Pennsylvania Department of Education (PDE), and are **updated annually**. LEAs must follow PDE's instructions to complete the Indirect Cost section of the Annual Financial Report (AFR)and provide the required information **each year** in order to receive an approved UICR. Per PDE, the AFR is to be completed each year by October 31. PDE provides information about how to complete the Annual Financial Report on its website.

UICRs are *applied in* the fiscal year in which they are certified and posted by PDE, at which time the UICRs are *applied to* the cost settlement of the prior fiscal year that is underway at that time. Therefore, an AFR submitted by the 10/31/2022 deadline where an unrestricted rate has been requested by the LEA and certified by PDE, results in a UICR to be applied during the 2022-2023 fiscal year.

LEA-specific UICRs approved and certified by PDE must be received by DHS no later than February 15 of the next year, or else the LEA will not receive indirect costs in quarterly MAC claims or the Cost Settlement process.

The chart below shows the fiscal years impacted by the calculation and application of the UICR.

PDE AFR / UICR			SBAP Application of UICR	
Data Year	**Year AFR is Submitted Requesting Rate**	**Year Rate is Posted**	**Cost Settlement Year UICR is Applied to**	**Year Cost Settlement is Conducted**
20-21	21-22	22-23	21-22	22-23
21-22	22-23	23-24	22-23	23-24
22-23	23-24	24-25	23-24	24-25
23-24	24-25	25-26	24-25	25-26

SECTION 10 – COST CERTIFICATION/CERTIFIED PUBLIC EXPENDITURES (CPE)

LEAs will only be reimbursed the federal share of any administrative and direct service claiming. The Chief Financial Officer, Chief Executive Officer, Executive Director, Superintendent, Business Manager or other individual designated as the financial contact by the LEA will be required to certify the LEA's total actual incurred allowable costs and expenditures, including federal and non-federal share, and the availability of necessary public matching funds. The certification statement, or Certified Public Expenditures (CPE), will be included as part of the annual cost report and with each quarterly MAC claim (See Appendix D).

LEAs will be required to maintain documentation that substantiates the certified funds used for administrative and direct service claiming. Failure to appropriately document the certified funds will result in non-payment.

SECTION 11 – FINANCIAL REPORTING COMPLIANCE REQUIREMENTS

11.1 Financial Data

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditure reports generated by the LEA payroll and financial systems. This includes data related to any benefits paid by the LEA for the employee, such as health insurance, retirement contributions, and travel or training benefits. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules.

The expenditures accumulated must correlate to the claiming period. The quarterly financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter (cash-based accounting). The annual financial data to be included in the calculation of the annual cost report for the cost reconciliation process must be completed using accrual-based accounting. Due to the differences in accounting methodologies mentioned above, costs entered for the quarterly reports will not roll over into the annual cost report.

The only costs that will be included are those that meet reporting requirements and that are from eligible categories. 2 CFR 200.420-.476 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program, and provides principles to be applied in establishing the allocability or unallocability of certain items of cost. These principles apply whether a cost is treated as direct or indirect.

11.2 Unallowable Costs

Costs that may not be included for claiming are:

- Direct costs related to staff that are not identified as eligible time study participants (i.e., costs related to non-special education teachers, cafeteria, transportation, and all other non-school-based administrative areas)
- Costs that are paid with 100 percent federal funds
- Any costs that have already been fully paid by other revenue sources (state/federal, recoveries, etc.)

11.3 Revenue Offset

Expenditures included in the administrative claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by MA. These "recognized" revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the district and pass through from state or local agencies).
- State expenditures that have been matched with federal funds (including fee-for-service). Both the state and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries.

APPENDIX A – LEA AGREEMENT SAMPLE

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Pennsylvania School-Based Access Program (SBAP)
Local Education Agency Agreement to Participate
[FY 20xx – 20xx]

The School-Based ACCESS Program (SBAP) is administered by the Department of Human Services (DHS) and its contractors, [Commonwealth's Lot 1 Contractor] and [Commonwealth's Lot 2 Contractor].

The _____ (LEA name) agrees to participate in the SBAP by signature of its authorized representative below, and acknowledges that it will:

- ***Comply*** with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance (MA) Program; **and**
- ***Assign*** a representative of the LEA to participate in SBAP training designated as mandatory; **and**
- ***Participate*** in the Random Moment Time Study (RMTS); **and**
- ***Submit*** compensable direct service claims; **and**
- ***Complete*** annual cost reconciliation/cost settlement of direct service claiming.

Direct Service Claiming Process and Fees:
All claims paid under the SBAP will be deposited into a restricted receipt account managed by the Commonwealth's Comptroller Operations.

Monthly processing fees will be deducted from the LEA's restricted receipt account and remitted to [Commonwealth's Lot 1 Contractor].

Dates of Service [7/1/xx to 6/30/xx]	
Direct Service	[$0.xx/claim]
Transportation	[$0.xx/claim]

Funds can be withdrawn by submitting PDE Form 352 (School Age) or
352 M (for EI programs) to the Pennsylvania Department of Education, Bureau of Special Education along with a brief description of the intended use of the funds. Funds must be used to enhance and supplement the special education program within the LEA.

Medicaid Administrative Claim (MAC) Process and Fees:

The LEA must receive direct service claiming reimbursement in order to receive and retain MAC reimbursement.

The LEA will provide the information and data to [Commonwealth's Lot 1 Contractor] which is needed to conduct the three (3) quarterly time studies.

The LEA will receive 25% of documented and approved administrative costs less [Commonwealth's Lot 1 Contractor]'s processing fee associated with administrative claiming.

[Commonwealth's Lot 1 Contractor]'s processing fee for each billable administrative claim unit submitted under the program is 50% of the LEA share, up to a maximum of $540, per quarter. (For Example, if the LEA Share is $600.00, the processing fee will be $300.00)

DHS will receive 25% of the documented and approved administrative costs.

MAC payments are issued via direct deposit to the bank account identified by the LEA and not deposited in its restricted receipt account.

Signature of LEA Representative: _____

Printed Name: _____

Title: _____ Date: _____

RETURN COMPLETED FORM TO [Commonwealth's Lot 1 Contractor] VIA FAX [(xxx) xxx-xxxx] OR EMAIL [Commonwealth's Lot 1 Contractor]

APPENDIX B – MA PROVIDER AGREEMENT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

_____

(hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients.
3. The provider agrees upon request, to furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under paragraph (A) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. The provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
5. The provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

A. the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and

B. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5–year period ending on the date of the request.

6. The provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
7. The provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the provider, and will provide to the Department any information needed for the Department to conduct a background check of the provider and its owners.
8. The provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

9. The provider agrees that if there is any change in the ownership or control of the provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the provider.
10. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty days prior notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

PROVIDER ELIGIBILITY AGREEMENT

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance Program that the information submitted in or with this application is true, accurate and complete.
I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete.
I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities
I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance Program.

_____ _____

(Provider – Original Signature) **(Date)**
(Owner or Authorized Agent)

_____

(Name – Please Type or Print)

APPENDIX C – PDE 352 GUIDELINES AND FORM

PDE-352 Guidelines

School-Based ACCESS Program

Funds that are reimbursed from the federal Medicaid School-Based ACCESS Program (SBAP) for direct health-related services are kept in Local Education Agency (LEA) specific accounts at the Pennsylvania Department of Education (PDE). To receive these funds, each LEA must complete form PDE-352 and submit it to the Bureau of Special Education (BSE) along with a short narrative explaining what the funds will be used for and how they will expand or enhance special education programs. The chief administrative officer must sign this form. Funds may be used to support the education of any special education student, not only those who are Medicaid eligible. Once the funds have been approved for disbursement, PDE-352 is sent to the Comptroller's office for processing. Funds are transferred to the LEA's local bank account approximately two months after the request is received by BSE. Narratives are filed along with copies of the PDE-352. Digital copies of form PDE-352 should be submitted by email to RA-EDSBAPFUNDING@pa.gov.

Do not send copies of invoices or purchase orders. Provide a general description of the items or services purchased and their effect on the special education program. If possible, bundle several small requests and submit on one form. It is more cost effective to process two or three large requests per year per school district than ten or twelve small ones. **The Comptroller's office will not process requests that are under $1,000.00.**

There are several restrictions on the use of ACCESS funds. They must be used within the special education program. They may not be used to supplant professional positions that the LEA has been supporting. They may not be transferred to the district general fund and used outside the special education program. The following list of acceptable uses of ACCESS money is a sampling.

Allowable School-Based ACCESS Expenditures

(Digital Form PDE-352 should be submitted by email to RA-EDSBAPFUNDING@pa.gov)

Personnel

New professional special education positions (teachers, therapists)- salaries and benefits

Special Education classroom instructional aides-salaries and benefits

Personal Care aides-salaries and benefits

School Based ACCESS Program coordinators-salaries and benefits

Nurses-salaries/benefits for percentage of time spent with special education students

Clerical support staff for ACCESS record keeping-salaries and benefits

Clerical support staff for the special education program for the time spent in direct student support (typing, filing, mailing of IEPs, ERs, Invitations to IEP meetings) -salaries and benefits.

Substitutes for special education classes for teachers attending IEP meetings or trainings

ACCESS Program Costs

Copiers

Computers

Paper Supplies

Equipment Maintenance

FAX machine

Printers

File Cabinets

Internet access for purposes of accessing web-based systems; e.g. SBAP Billing program and IEP writer program

Training

CPR and First Aid Training

Conferences and Workshops for Special Educators and Administrators

Inclusion Conferences and Workshops for Regular Educators

Parent Training for Special Education

Manuals or other materials required for training programs

Property

Student computers

Staff computers when they are used for writing IEPs, ERs, lesson or treatment plans, or record keeping

Specialized furniture for students

Treatment room furniture

Furniture needed for computer use

Televisions and VCRs (with closed caption capability)

Portable stair climbers

Wheelchairs

Computer networking

Swimming pool lifts

Therapy equipment

Contracted Services

Psychological testing

Specialized transportation outside the regular school transportation system

Training for staff

Community based program costs

Maintenance contracts on computers, copiers, etc.

Transportation

Refitting specialized buses with car seats, seat belts, etc.

Specialized buses for special education transportation

Supplies

Personal care supplies for special education students

Health room supplies for special education students

Paper supplies needed for School Based ACCESS Program, IEPs, ERs, or other student specific documents

Student and Curriculum Specific

Field trips that are tied to the curriculum

Speakers and programs brought into the school

Programs above the ESY provided by the district such as swimming lessons, additional community-based programs

Tests

Books

Software

Workbooks

Adaptive feeding equipment

IEP writer programs and support/training needed for implementation

Instructional materials

Teacher manuals

Tuition which is the result of a settlement agreement.

PDE-352 Available Here (excel format)

For additional reimbursement information, please contact:

Pennsylvania Department of Education-Bureau of Special Education
333 Market Street l Harrisburg, PA 17126-0333
Phone: 717-783-6913 l Fax: 717-783-6139
RA-EDSBAPFUNDING@pa.gov l www.education.pa.gov

APPENDIX D – CPE FORM

Certification of Public Expenditures for State of Pennsylvania Annual SBAP Medicaid Cost Report

LEA Name: School Name
National Provider Identification (NPI): xxxxxxxxxx
Medicaid Provider Number: xxxxxxxxx-xxxx

The undersigned certifies that this statement of expenditures is allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instruction and guidance issued by the single state agency and in effect during the state fiscal year. **Complete Section II and sign and date below. The form must be submitted with your claim.**

HEREBY CERTIFY that for the reporting period: _____

Section I:

1. Total Expenditures _____
2. Total Medicaid Expenditures _____
3. Medicaid Interim Payments _____
4. Medicaid Cost Settlement _____

Section II:

LEA Financial Account Code

The expenditures identified above as the match for the Federal funds received from Medicaid are drawn from the following approved local account(s):

Fund		Function		Object
_____	-	_____	-	_____
_____	-	_____	-	_____
_____	-	_____	-	_____
_____	-	_____	-	_____

Please note that if you need additional space, you may include additional account information on a separate sheet attached to this document.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER
INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION

CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

1. All expenditures presented should be allowable in accordance with Federal and State Plan Amendment agreement requirements.
2. I have examined this statement, the accompanying supported exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and believe they are true and correct statements prepared from our books and records in accordance with applicable instructions.
3. The expenditures included in this statement are based on the actual cost recorded expenditures.
4. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable Federal requirements for the non-Federal share match of expenditures, including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs.
5. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the Pennsylvania Department of Human Services effective for the above indicated reporting period.
6. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
7. I understand that this information will be used as a basis for claims for Federal funds, and possibly state funds, and that a falsification and concealment of a material fact may be prosecuted under Federal or state civil or criminal law.

_____ _____

Signature of Signer
(CEO, CFO, or Superintendent)

Title of Signer

_____ _____

Printed/Typed Name of Signer

Date

_____

Address of Signer
(street or P.O. Box, city, state, 5-digit zip)

_____ _____

Contact Phone Number

Fax Number

_____

Email Address

APPENDIX E – LEA PARTICIPATION FLOWCHART