Medicaid to Schools

Provider Manual
Volume II

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New
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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1.0 NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and the Provider Specific Billing Manuals – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices Section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual – Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2.0 Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Additional responsibilities of school providers are outlined below.

2.1 Student Information and Parental Consent

A signed parental consent form to bill NH Medicaid must be on file. Please see the informational bulletin on parental consent published on March 1, 2022.

- It is acceptable to have a parental consent form that spans school districts within a SAU if all the associated school districts are included on the parental consent form. Please note that a new parental consent form must be obtained when a student moves out of the current SAU.
- All student records must remain with the SAU according to record retention requirements where the billing occurred, even if the student moves to a new district.
- See the "Record Keeping" section of the General Billing Manual – Volume I for documentation requirements.
- In accordance with 34 CFR 300.154 (d)(2)(iv), Ed 1120.08, and 42 CFR 300.154(d)(2)(v), informed parental consent shall be obtained prior to the enrolled school provider billing the student's Medicaid.

3.0 Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website). Services are covered based on what is outlined in the IEP, 504, or healthcare plan.

Medicaid covered services in the school setting are outlined below. For additional details on covered services, please refer to He-W 589.04, Covered Services and Provider Qualifications.

3.1 Services

3.1.1 SUPPLIES AND EQUIPMENT

3.1.2 OCCUPATIONAL THERAPY SERVICES

3.1.3 PHYSICAL THERAPY SERVICES

3.1.3 SPEECH LANGUAGE THERAPY SERVICES

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3.1.9 REHABILITATIVE ASSISTANT SERVICES

3.1.10 PSYCHOTHERAPY/MENTAL HEALTH SERVICES

3.1.11 PSYCHOLOGICAL TESTING SERVICES

3.1.12 EVALUATIONS AND ASSESSMENTS

3.1.13 SPECIALIZED TRANSPORTATION

- Specialized transportation is a Medicaid covered service when the student is physically present in the vehicle and both scenario 1 and 2 below are true:
    1. It is listed in the student's care plan (IEP, Section 504 or Health Care Plan) as a required

service and:

- The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus, OR
- The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the care plan.

2. The student receives a Medicaid coverable service during the school day OR receives a Medicaid coverable service in the community during the school day. The covered service must be listed in the student's IEP, 504, or healthcare plan.
    - When the student receives the service at school, Medicaid will cover transportation to and from the school.
    - When the student receives the service in the community during the school day, Medicaid will cover transportation to and from the service, leaving and returning from the school.
        - Medicaid will not cover transportation to the school that day (unless the student also receives a service at the school the day).

When the services of a nurse, a rehabilitation assistant (RA) or other such professional on the vehicle are medically necessary and ordered in the student's IEP, Section 504 Plan, or Health Care Plan, the school can be reimbursed for the nurse, RA, or other professional, and the transportation. The school must use the ordering NPI of the ordering provider for the professional on the bus for the transportation claim. The child does not need to receive a Medicaid coverable service on the day of the transportation in this instance.

Transportation provided by a parent is Medicaid reimbursable if the above criteria are met. A written agreement between the parent and the School District must be executed. Mileage reimbursement should be the federal reimbursement rate.

3.2 Service Limits

No more than 4 evaluation codes each for OT, PT, ST (12 total) can be billed in one State fiscal year (7/1 to 6/30). After the 4 evaluation limit has been reached, subsequent evaluation sessions should be billed as a reevaluation.

3.3 Billing Requirements for Covered Services

- Medical services are billable to Medicaid:
    - If they are listed in the active IEP, 504 Plan or Health Care Plan for the school year.
    - If they are ordered by an appropriate ordering provider.
        - Ordering providers must be enrolled with NH Medicaid and must be licensed to order the specific service in question. Ordering providers out of state must be enrolled with NH Medicaid.

- All services must be ordered by an NH Medicaid enrolled ordering provider, regardless of who is performing the service (the ordering provider themselves or another non-ordering provider qualified to provide the service).
- Appropriate ordering providers in the school setting include:
  - Physicians (MD)
  - Physician Assistant
  - Advanced Practice Registered Nurse (APRN)
  - Osteopath
  - Podiatrist/Chiropodist
  - Master's Level Psychologist
  - Master Licensed Alcohol and Drug Counselor (MLADC)
  - Physical Therapist*
  - Speech Therapist*

  *Speech therapists and physical therapists have the authority under their license to "order" their own services. If this is the case and the therapist ordered their own services, then the rendering provider would be the ordering provider on the claim.

- All orders must:
  - Include the date of service and have a date span of no more than one year. If there is no date span, or the date span extends beyond one year, the orders are effective for one year from the date of the signature. The date span or date of signature must be on the order itself.
  - Be in place before services are billed.
  - Include a description of the medical condition to verify medical necessity. Include ICD-10 code, if known.
  - Describe the actual service needed i.e. occupational therapy, skilled nursing, etc.
  - Be signed and dated by a physician, advanced practice registered nurse, physician assistant, or other licensed practitioner. Please consult the guidance issued by the Office of Professional Licensure and Certification for specific information regarding scope of practice and authority to order services.
  - The ordering provider must be enrolled in New Hampshire Medicaid on the date of service. Provider enrollment can be verified utilizing the "Ordering Provider Lookup Tool" on the MMIS.

- Any Medicaid claim submitted by a school must include:
  - The ordering provider and the billing provider (school)
    - If the billing or ordering provider is not included on the claim, the claim will deny.
    - Rendering providers are not required on a claim.
    - If a provider (ordering, billing, or rendering) who is not enrolled in NH Medicaid on the date of service is included on a Medicaid claim, the claim will deny.

- Contractors: Schools are responsible for verifying licensure, certification, and OIG exclusions for all providers, whether those providers are contractors or work directly for the school. Contractors shall not bill directly for medical services provided in the school setting.

- Telehealth: Medical services delivered via telehealth including those services in a school setting are reimbursable pursuant to RSA 167:4-D. Claims should be submitted with the appropriate procedure code and TM modifier along with modifier GT and place of service 02 for telehealth.

- Group Services: Group services are covered under Medicaid. Group services are defined as services delivered to two (2) or more students. The maximum group size should be limited by

the clinician such that the clinician is able to provide appropriate care to meet the medical needs of each member of the group. Billing for group versus individual services should always match what is indicated in the student's IEP, Section 504, or Healthcare plan.

- In the group setting, the actual cost to provide one unit of a covered service must be allocated across all students in the group by dividing the actual cost by the total number of students in the group. There is no requirement that all members of the group be eligible for Medicaid, and the actual cost of delivering the group service must be allocated across all group members regardless of Medicaid status.
- Even if only one member of the group is present on the date of service (for example, if the other member of the group is sick), the service is still billed as a group service, as indicated in the IEP.

- Licensure: Providers of medical services in a school setting must be appropriately licensed/certified in NH. Schools may not bill Medicaid for services provided by an unlicensed individual or for an individual whose licensure is pending, except in the case where a candidate for licensure is appropriately supervised by a Board approved supervisor (refer to below).

- Supervised practice: Certain provider types (Rehab Assistants, Therapy Assistants, etc.) as well as appropriate candidates for licensure, as verified by OPLC, are able to render services under the supervision of a verified, licensed supervisor. This licensed supervisor must sign off on all of the services rendered by the supervisee on all medical documentation related to those services and assumes responsibility for those services, although no rendering provider is required on the claim submitted by the school. Please see 6.0 Documentation for more details on 30-day review requirements for supervised practice.

4.0 Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, prior to delivery of the service, that it is non-covered by NH Medicaid, and that should the member still choose to receive the service, then the member will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

Non-covered services include:

- Services not listed in a student's care plan;
- Consultations, visits, trainings, meetings, or discussions between healthcare providers or individuals in which the student was not physically present for at least 51% of the time;
- Services which are non-covered pursuant to rules in He-W 500 and are not covered under EPSDT;
- Supported employment such as vocational goals and job tasks;
- Services which are solely educational, remedial education, or vocational instruction or tutoring;
- Services performed by educators or individuals who are not healthcare clinicians such as teachers of the visually impaired or deaf unless:
    - The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;
    - The individual is a rehabilitative assistant providing rehabilitative assistance services pursuant to He-W 589.04(af)-(aj); or
    - The individual currently holds a certification as a BCBA;
- Leisure and social activities that are non-medical;
- General supervision of a student as required for any student based on the student's development and for non-medical reasons;
- Services that are solely personal care services delivered by a legally responsible family member pursuant to 42 CFR 440.167;
- Performance of tasks for the sole purpose of assistance with completion of educational assignments;
- Day care;
- Teaching parenting skills;
- Review of records, documentation development, or report writing;
- Attending meetings, including individualize education program meetings and IEP team meetings;
- Parent consultations, contacts, or trainings;
- School guidance counselor services unless:
    - The individual has a valid healthcare license issued by the appropriate licensing board, commission, or council and is acting within the scope of his or her license;
    - The individual is a rehabilitative assistant providing rehabilitative assistance

services pursuant to He-W 589.04(af)-(aj); or
    - The individual currently holds a certification as a BCBA;
- Services by individuals not having a current license for the practice specialty area for the service area being provided; and
- Services requiring the technical or professional skill that a state statute or regulation mandates shall be performed by a health care clinician licensed or certified by the State.

5.0 Service Authorizations

Service Authorizations are not required for services billed by the school provider.

Detailed Service Authorization guidelines are found in the General Billing Manual – Volume I.

6.0 Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I for more detailed documentation requirements.

6.1 Documentation Requirements for Services Provided in a School

1. Clinical documentation required by NH administrative rule He-W 520, including:
    - A copy of the care plan and, if an IEP, evidence of implementation of the IEP as required by Ed 1109.04(b);
    - The name of the student, the medical assistance ID number, and documentation demonstrating receipt of each unit of the covered service;
    - The names, qualifications, and credentials of all performing providers for each service delivered for which the school sought FFP;
    - The documentation of the qualifications, names, and signatures of persons directing or supervising the individuals providing the covered services if direction or supervision is required under this part or applicable law, and the date of supervisory approval.
    - Date(s) of each service delivered and the location where the services were performed;
    - The type of covered service provided and a description of each service provided;
    - The duration of the provision of the each covered service, number of units performed, and the number of minutes for each delivered service;
    - The start and stop times of the delivered services, and whether there was a break in services or time away by the performing provider;
    - Indication whether the services were delivered in a group setting or individually;
    - Indication of whether the student was actually present for the service and indication whether the student was present for at least 51% of the time;
    - In the case of group services, documentation of the number of participants in the group who received the covered service regardless of the participants' Medicaid eligibility;
    - A copy of a physician's or other licensed clinician's order if required; and
    - Documentation of the qualifications and the handwritten signature of the individual(s) attesting to the medical non-academic nature of the covered rehabilitative assistance services.
2. 30 day review documentation:
    - Every 30 days, the licensed clinician designated by the enrolled school provider's care plan team should evaluate and document the rehabilitation assistant's (RA's) level of competency for performing the medical/behavioral tasks outlined in the plan of care. The licensed clinician shall review activities performed by the RA and the effectiveness of such activities as observed by the RA. The 30-day review

must be signed by the licensed clinician. 30-day review documentation must meet all requirements under He-W 589.06 (d). Documentation must include:

- Date of the sessions
- Attestation that the services were provided

Best practice documentation would also include:

- If services were not provided, reason for the cancellation
- Type of contact (i.e. face to face, observation, telephone call)
- Areas covered (duties, expectations, skills development, etc.)
- List of RA training (i.e. supervisor training or online learning course) completed within the past 30 days, as applicable
- Issues identified for the inability to follow the care plan, effectiveness of the service, and any action to be taken
- Date of next session

3. Transportation providers shall maintain a daily transportation log to include:
   - Student's name;
   - Date of service;
   - Clear indication that the student is being transported either one-way or round-trip;
   - The total number of students on the bus, both in the morning and the afternoon;
   - The total miles the bus traveled, both in the morning and in the afternoon;
   - Driver's name; and
   - Driver's signature.
4. As applicable, the creation, storage, retention, disclosure, and destruction of documentation required by this part shall comply with all federal and state privacy and security laws and rules including the substance use disorder patient records regulations pursuant to 42 CFR Part 2, Family Educational Rights and Privacy Act, and the Health Insurance Portability and Accountability Act of 1996.

7.0 Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider manuals, fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services, or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume I.

8.0 Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" Section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9.0 Medicare/Third Party Coverage

Third party liability does not apply to services billed by the school provider.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10.0 Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

10.1 Payment Policies for Services Provided in a School

- School reimbursement is calculated at 50% of actual costs or 50% of the established Medicaid fee schedule, whichever is less.
- Enrolled school providers shall submit claims for physical, occupational, and speech-language therapy services in accordance with the following:
    - Therapists should only bill for the amount of time spent providing direct treatment to the student
    - If two therapists are (e.g. PT and OT) are treating a student "simultaneously" (in the same session), each should bill only for the portion of the session during which they were working directly with the student. The total time billed between the two therapists cannot exceed the amount of time spent with the student, as each therapist is providing a distinct service only for a portion of that time.
    - If a rehabilitation assistant is assisting a student during a therapy session, the time billed by the therapist is based on the time that therapist spends providing direct rehab assistant services to the student. The rehab assistant may be providing service throughout the whole session (e.g. cuing the student) or may only be providing services for a portion of the session (e.g. toileting assistance) and should bill for the amount of time spent providing those distinct rehab assistant services, which may be the full duration of the session. If more than one rehab assistant is needed during a session, the amount of time billed for the date of service should reflect the total time spent with the student between the two rehab assistants.
        - The total amount of time for each service provided to a student on one date of service must be billed on one claim.
- In calculating the cost for transportation, the enrolled school providers may include the following actual costs related to the trip: (1) Fuel; (2) Insurance; (3) Driver's salary and benefits; (4) Salary and benefits of other persons working on the bus; (5) Depreciation, and (6) Maintenance.

- The total cost calculated above shall then be divided by the total number of miles for the trip both ways, and then divided by the total number of students on the bus, regardless of the students' Medicaid eligibility, to determine the cost per mile per student.

11.0 Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor state staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.2 Claim Completion Requirements

School providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the

fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

For additional guidance on how to complete a CMS1500 claim form please refer to the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual.

11.3 Claim Completion Requirements for Schools

1. Billing and ordering NPI's are required on all claims.
   - Rehabilitative assistants do not obtain NPI numbers. The NPI number of the supervising provider is used for billing purposes.
2. All School services claims should include the TM modifier to indicate that the service was provided through the school.
3. Place of service: School services will align with one of the following place of service codes that should be included on all claims:
   - 03: school
   - 02: telehealth
4. Dates of Service:
   - One claim line should correspond to one date of service.
     - Date span billing should not be used. Date span billing means multiple dates of service on a single claim line. Claims with date spans will deny.
5. NH Medicaid follows Medicare claims processing guidelines. When billing for a timed procedure code, in order to meet the requirements for the time increment specified by that code, at least half of that time must be spent with the patient (ex. For a 15 minute procedure code, at least 8 minutes must be spent with the student).
   - For a service for which the minimum timed code is 15 minutes, schools may not bill for less than 8 minutes spent with the patient. (i.e., schools cannot bill for T1002 if less than 8 minutes is spent with the student).
   - For a service for which the minimum timed code is 30 minutes, schools may not bill for less than 16 minutes spent with the patient (i.e., schools cannot bill for 90832 if less than 16 minutes is spent with the student).

- In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for CPT codes 90832 and 90833, 38-52 minutes for CPT codes 90834 and 90836, and 53 or more minutes for CPT codes 90837 and 90838).

6. Maximum billable units for a service can be found on the Medicaid Fee Schedule. Failure to comply with the maximum units allowed will result in recoupment of payments in excess of the established limits.

11.3.1 Specialized Transportation

1. Mileage begins when the first student is picked up and ends when the last student exits the bus for that route.
   - For example, if the bus travels 30 miles and picks up 3 students, the calculation is 30 miles divided by 3 students. If only 1 of the 3 students is on Medicaid, 10 miles can be billed for that student so long as the student receives a Medicaid covered service that day.
2. Cost per mile should be calculated for each trip daily. The cost is to be calculated for each bus separately and is not the average cost of all buses transporting special education students.
3. When a School contracts their transportation, the Contractor's cost to the District is the rate that should be billed.
4. Mileage reimbursement should be the federal mileage reimbursement rate.

12.0 Terminology

Activities of daily living (ADL) means basic self-care tasks such as personal hygiene, grooming, eating, dressing, transferring, mobility, and toileting.

Applied behavior analysis (ABA) means a treatment modality that employs the process of systematically applying interventions based on the principles of learning theory to improve socially significant behaviors, and is covered through the EPSDT benefit pursuant to He-W 546 and in accordance with He-W 589.04(at).

Augmentative and alternative communication (AAC) aids means electronic or non-electronic aids, devices, or systems ordered by a licensed speech-language pathologist that assist a student to overcome or ameliorate the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities, such as communication boards or books, speech amplifiers, and electronic devices that produce speech and/or written output.

Care plan means a written health care plan, including, but not limited to, an individualized education program or a 504 plan, which is maintained in the student's file and documents and supports the medical necessity of all claims to NH Medicaid for FFP.

Carry-over tasks means tasks, therapies, or activities that a rehabilitative assistant performs as instructed by the licensed clinician in support of the care plan's goals or the clinician's treatment plan.

Durable medical equipment (DME) means a type of item pursuant to He-W 571 that is:

- Non-disposable and able to withstand repeated use;
- Primarily used to serve a medical purpose for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury; and
- Not useful to an individual in the absence of an acute or chronic medically diagnosed health condition, illness, or injury.

Early and periodic, screening, diagnosis and treatment (EPSDT) services means a benefit pursuant to 42 CFR 440.40 and He-W 546, designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Medicaid enrolled individuals under age 21.

Enrolled school provider means a NH local education agency (LEA) or school administrative unit (SAU) that has agreed to participate in NH Medicaid pursuant to these rules and enrolled with NH Medicaid.

Group means 2 or more persons.

Individualized education plan (IEP) means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with 34 CFR 300.320 through 300.324, and the applicable NH board of education administrative rules.

Instrumental activities of daily living (IADL) means personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

Local education agency (LEA) means a local school district.

Medical assistance means the federally financed medical assistance program established pursuant to Title XIX of the Social Security Act also known as the Medicaid program.

Medically necessary means reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of, conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the student requesting the medically necessary service.

Order means a written authorization for the provision of services issued by an advance practice registered nurse (APRN), physician assistant, physician, or other licensed clinician with ordering privileges.

Other licensed clinician means any person licensed under state law and practicing within the scope of his or her licensure as authorized by the appropriate board, commission, or council responsible for licensing and regulating health care professions under the NH office of professional licensure and certification.

Performing-only provider means a health care provider that the Medicaid program does not allow to independently enroll with Medicaid and is affiliated with an enrolled school provider. The term includes healthcare providers such as rehabilitative assistants pursuant to this part, personal care service workers for individuals under the age of 21, and Board Certified Behavior Analysts.

Personal care services means medically necessary services related to assistance with ADL or IADL due to a student's illness, injury, or disability which are furnished to a student who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with developmental disabilities, or institution for mental illness, and are covered through the EPSDT benefit pursuant to He-W 546 and in accordance with He-W 589.04(at).

Physician means a person licensed to practice medicine in NH or the state in which he or she practices.

Private duty nursing means the provision of skilled nursing services for students who require more individual and continual skilled nursing observation, judgment, assessment, or interventions than are available from a visiting nurse, in contrast to part-time or intermittent care, such as wound care.

Psychologist means a person licensed to practice psychotherapy in NH pursuant to RSA 329-B or an equivalent licensing board in the state in which she or he practices.

Psychotherapist means a licensed clinical social worker, pastoral psychotherapist, clinical mental health counselor, or marriage and family therapist licensed under RSA 330-A who provides mental health services. This term includes psychiatrists licensed as physicians under RSA 329, advanced practice registered nurse (APRN) licensed under RSA 326-B:18 as psychiatric nurse practitioners, and psychologists, school psychologists, or associate school psychologists licensed by the board of psychology under RSA 329-B. This term also includes "mental health practitioner".

Psychotherapy means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.

Rehabilitative assistance services means non-skilled interventions covered through the EPSDT benefit and ordered by a physician, physicians' assistant, APRN, or other licensed clinician, as listed in the student's care plan.

School administrative unit (SAU) means a legally organized administrative body responsible for one or more school districts pursuant to RSA 194-C:1.

Section 504 plan (504 plan) means a plan for services for a student in accordance with Section 504 of the Rehabilitation Action of 1973 as amended.

Signature means:

- A person's name handwritten by that person, excluding any photocopy, stamp, or other facsimile of such name; or
- An electronic signature that complies with RSA 294-E.

Student means a person who is eligible for and receiving medical assistance under Medicaid pursuant to He-W 589.03.

Under the direction means that, except as prohibited by state law, the licensed health care clinician, whether or not he or she is physically present at the time that services are provided:

- Assumes professional responsibility for the services provided;
- Assures that the services are medically appropriate and performed safely; and
- Assures compliance with the clinical oversight requirements as required by law or rule adopted by the appropriate board, commission, or council responsible for licensing and regulating health care professions under the NH office of professional licensure and certification.