

School-Based Health Services Medicaid Policy Manual

Administrative Services and Telehealth MODULE 1



BACKGROUND

- School-Based Health Services are regulated by the Centers of Medicaid and Medicare (CMS) and administered by the West Virginia Department of Health and Human Resources (WVDHHR) through the Bureau for Medical Services (BMS).
- Local Education Agencies (LEAs) are enrolled with Medicaid as a provider. In doing so, LEAs must conform to state and federal rules, regulations, and confidentiality requirements.
- LEAs must cooperate fully with the Bureau for Children and Families (BCF) and court systems.

Administrative Requirements (continued)

- All Medicaid members (students with Medicaid cards) and/or their parents or guardians have the right to freedom of choice when choosing a provider for treatment.
- All Medicaid providers should coordinate care if a member has other Medicaid services delivered by private providers.
- Appropriate releases of information should be signed and in compliance with the Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA).

MEMBER ELIGIBILITY

- Member eligibility School-Based Health Services include medically necessary covered health care services pursuant to an active Individual Education Plan (IEP) provided by or through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA).
- A Service Plan must be developed for each related service listed on a member's IEP.
- Consent for services cannot be obtained over the phone.
- No retroactive billing is allowed.

SERVICES AND SUPPLIES THAT ARE:

- Appropriate and necessary for the symptoms, diagnosis or treatment of an illness.
- Provided for the diagnosis or direct care of an illness.
- Within the standards of good practice.
- Not primarily for the convenience of the plan member or provider.
- The most appropriate level of care that can be safely provided.

Medical Necessity (continued)

Must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

PROVIDER ENROLLMENT

- All LEAs must abide by the following chapters of the West Virginia Medicaid Manual:
 - Chapter 100-General Information
 - Chapter 200-Definitions
 - Chapter 300-Provider Participation Requirements
 - Chapter 400-Member Eligibility
 - Chapter 538-School Based Health Services
 - Chapter 800-Program Integrity
 - Chapter 801-Quality Improvement

- In order to participate in the WV Medicaid program and receive payment from the Bureau for Medical Services (BMS), providers must meet all enrollment criteria as described in Chapter 300, Provider Participation Requirements.

Administrative Requirements

The School-Based Health Policy (SBHS) Chapter 538 of the BMS Policy Manual, was developed based on the approved SBHS State Plan; which was approved by the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2014.

The West Virginia Department of Education and the Bureau for Medical Services acted as partners in the development of the policy.

Enrollment-Staff Qualifications

<u>Discipline</u>	<u>License</u>	<u>Documentation of being deemed by State Dept. of Education</u>	<u>NPI (NEW)</u>	<u>W-9 issued for the county</u>	<u>Enrollment Application</u>	<u>Copy of Degree and/or License to be kept at County Board Office</u>	<u>Copy of card or screenshot</u>	<u>Facility</u>
Registered Nurse	X		X	X	X		X	
Speech Pathologist	X		X	X	X		X	
School Speech Pathologist Language Assistant- (Will not be enrolled in the Claims System)		X				X -MA,MS, BA,BS, AA OR AS		
Audiologist	X		X	X	X		X	
Lisc. Psychologist	X		X	X	X		X	
School Psychologist		X	X	X	X	X-MA OR MS		
Occupational Therapist	X		X	X	X		X	
Certified Occupational Therapist (COTA)	X-					X		
Physical Therapist	X		X	X	X			
Physical Therapy Assistant	X					X		
Targeted Case Manager								X
Personal Care Aide								X
Transportation								X

Fingerprint-Based Background Checks

- All provider staff having direct contact with members must, at a minimum, have results from a state level, fingerprint-based background check. This check must be conducted initially and again every three years.
- If the current or prospective employee has lived or worked out of state within the last five years, or currently lives or works out of state, an additional federal background check through the WV State Police is needed upon hire and every three years.
- Providers may do an on-line preliminary check and use these results for a period of three (3) months while waiting for state and/or federal fingerprint results.
- An individual who is convicted of one or more of the following crimes listed on the next slide may not bill and/or provide services to a Medicaid member or have access to a Medicaid member's information at any time.

Fingerprint-Based Background Checks (continued)

- Abduction
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery
- Child/adult abuse or neglect
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult
- Any type of felony battery
- Felony arson
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- Felony drug-related offenses within the last 10 years
- Felony driving under the influence (DUI) within the last 10 years
- Hate crimes

Fingerprint-Based Background Checks (continued)

- Kidnapping
- Murder/homicide
- Neglect or abuse by a caregiver
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct; distribution and exhibition of material depicting minors in sexually explicit conduct; or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct
- Purchase or sale of a child
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
- Healthcare fraud
- Felony forgery

- Subject to review by BMS and/or its contracted agents.
- The contracted agent may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These guidelines function as policy.
- Additional information governing the surveillance and utilization control program may be found in Chapter 100, General Information of the BMS Provider Manual.

- Provider reviews monitor the quality of services and are conducted by the BMS contracted agent.
- On-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards.
- Provider reviews and/or desk reviews may be conducted in follow up to receipt of incident management reports, complaint data, plan of corrections (POC), etc.

Training and Technical Assistance

- The contracted agent develops and conducts training for providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance.
- Training is available through both face-to-face and web-based venues.

Provider Reviews-Plan of Corrections

- Upon completion of each review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the Local Education Agency to attend.
- A draft exit report and a plan of correction (POC) will be completed by the provider.
- If potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent.
- After the 30-day comment period has ended, BMS will review the draft exit report and comments and issue a final report.

Provider Reviews-Plan of Corrections (continued)

The POC must include the following:

- How the deficient practice for the services cited in the report will be corrected;
- What system will be put into place to prevent recurrence of the deficient practice;
- How the provider will monitor to assure future compliance, and who will be responsible for the monitoring;
- The date the POC will be completed; and
- Any provider-specific training requests related to the deficiencies.

The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of services.

TO EFFECTUATE REPAYMENT

- Payment to BMS within 60 days after notification to the provider of the overpayment;
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to 12 months through monthly payments or the placement of a lien against future payments.

Administrative Requirements

- Assure implementation of BMS policies and procedures pertaining to service planning, documentation, and case record review.
- Records must contain completed member information.
- Records must be legible.
- Provide all requested records to the reviewers.
- If requested, provide copies of Medicaid member's records within one business day of the request.
- Facilitate the records access requested, equipment needed to be utilized to complete review process and person designated as a point of contact.

Administrative Requirements (continued)

- Documentation of services provided must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- BMS manual standards apply to all services available through telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Except for services billed under the T1017 code for Targeted Case Management, reimbursement is not available for telephone conversations, or electronic mail messages (e-mail).

- BMS encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid members. To utilize Telehealth, providers will need to document that the service was rendered under that modality.
- When filing a claim, the provider will bill the service code with a “GT” Modifier. Each service in the manual is identified as “Available” or “Not Available” for Telehealth. Some service codes give additional instruction and/or restriction for Telehealth, as appropriate.
- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used as long as the software is HIPAA compliant and abides by the federal code pertaining to Telehealth.

- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The provider at the distant site is responsible to maintain the standards of care within the identified scope of practice.

Telehealth (continued)

- The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The health care agency or entity as an enrolled WV Medicaid provider has the ultimate responsibility for the care of the patient. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within BMS Provider Manual Chapter 538.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.

Telehealth (continued)

- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in BMS Provider Manual, Chapter 538.

- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary. Member's consent to receive treatment via Telehealth shall be obtained and may be included in the member's initial general consent for treatment.
- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.

- The health care practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including:
 - The right to withdraw at any time.
 - A description of the risks, benefits and consequences of telemedicine.
 - Application of all existing confidentiality protections.
 - Right of the patient to documentation regarding all transmitted medical information.
 - Prohibition of dissemination of any patient images or information to other entities without further written consent.

Telehealth (continued)

- BMS Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for telephone conversations, electronic mail messages (e-mail), or facsimile transmissions (fax) between a provider and a member.

Service Exclusions and Limitations

Service limitations governing the provision of all WV Medicaid services will apply pursuant to [Chapter 100, General Information](#) of the BMS Provider Manual.

SERVICE EXCLUSIONS:

In addition to the exclusions listed in [Chapter 100, Information](#), BMS will not pay for the following services:

- Telephone consultations-excluding T1017.
- Meeting with the Medicaid member or Medicaid member's family for the sole purpose of reviewing evaluation and/or results. (This cannot be billed under any circumstance for any code.)
- Missed appointments, including but not limited to, canceled appointments and appointments not kept.
- Services not meeting the definition of medical necessity.
- Time spent in preparation of reports including IEPs.
- A copy of medical report when the agency paid for the original service.
- Experimental services or drugs.
- Methadone administration or management.
- Any activity provided for the purpose of leisure or recreation.
- Services rendered outside the scope of a provider's license.

Rounding Units of Service

- Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. Units of service based on an episode or event cannot be rounded.
- Many services are described as being “planned,” “structured,” or “scheduled.” If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.

The following services are eligible for rounding:

- Targeted Case Management
- Occupational Therapy/Physical Therapy
- Nursing
- Personal Care
- Speech, Language and Audiology Services

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. The billing period cannot overlap calendar months. Only whole units of service may be billed.

Rounding Units of Service (continued)

Jan. 1	Jan. 2	Jan. 3	Correct Billing
5 min. - TCM	5 min. -TCM	5 min. - TCM	Bill 15 minutes TCM for January 3.
Jan. 1	Correct Billing		
15 min. - TCM	Bill 15 minutes for TCM for January 1		
Jan. 29	Jan. 30	Feb. 1	Correct Billing
5 min. – TCM	5 min. – TCM	5 min. - TCM	Cannot bill due to a new calendar month beginning
Jan. 1	Jan. 2	Jan. 3	Correct Billing
5 min. - TCM	10 min. - TCM	10 min. - TCM	Bill 15 minutes for TCM on January 3 Cannot round up to 30 minutes for TCM
Jan.1	Jan. 2	Jan. 3	Correct Billing
5 min. - TCM	Absent from school or no Medicaid Services provided	10 min. - TCM	Bill 15 minutes for TCM on January 3

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to [Chapter 100, General Information](#) and [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual.

Providers of Services must comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name; address; birth date; Medicaid identification number; pertinent diagnostic information; a current service plan signed by the provider; signature and credentials of staff providing the service; designation of what service was provided; documentation of services provided; the dates the services were provided; and the actual time spent providing the service by listing the start-and-stop times as required by service.

Documentation and Record Retention (continued)

- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Providers of services must also comply with the specific documentation requirements for the program or service procedure, as described in BMS Provider Manual, Chapter 538.
- Original documentation must be maintained at the LEA Board of Education central office.

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

School-Based Health Services Contacts

MEDICAID PARTNERS:

West Virginia Department of Education

Office of Federal Programs:

▪ Contact: Terry Riley 304-558-1956

tjriley@k12.wv.us

Bureau of Medical Services (BMS):

<http://www.dhhr.wv.gov/bms/Programs/Pages/default.aspx>

Home and Community Based Services Unit

School Based Health Services:

▪ Contact: Cynthia Parsons 304-356-4936

Cynthia.A.Parsons@wv.gov