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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

INTRODUCTION

School based services described in this chapter are covered by the Virginia Medicaid program. Providers of school based services must meet the qualifications described in Chapter II, “Provider Participation Requirements.” Services must be provided in accordance with the service criteria defined in this chapter and in conjunction with the current assessment of the recipient’s support needs as documented in the Individualized Education Program (IEP) and other Department of Medical Assistance Services (DMAS)/Department of Education (DOE) approved documents developed for the recipient.

Under the Individuals with Disabilities Education Act (IDEA), public schools are required to provide children with disabilities a free appropriate public education, including special education and related services according to each child’s IEP.

While school divisions are financially responsible for educational services, in the case of a Medicaid-eligible child, state Medicaid agencies are responsible for the “related services” identified in the child's IEP if they are covered under the state’s Medicaid plan. Related services are those services that enable a child to benefit from special education.

The forms that are referenced in this chapter can be found via the DOE website: www.doe.virginia.gov under Medicaid and Special Education Services.

MEDICAID SERVICES PROVIDED BY SCHOOLS

The Virginia Medicaid State Plan coverage for school services moved in 2007 from the rehabilitation regulations section to the Early Periodic Screening Diagnosis and Treatment (EPSDT) regulations section. These school services include EPSDT well-child screening services and EPSDT special education health services. EPSDT well-child screening services are billable to DMAS for the Fee-for-service Medicaid/Family Access to Medical Insurance (FAMIS) school population. EPSDT special education health services, which are billable to DMAS by school divisions, include the following:

- Physical therapy, occupational therapy, and speech-language pathology services;
- Audiology Services;
- Skilled Nursing Services;
- Psychiatric and Psychological Services;
- Personal Care Services;
- Medical Evaluation Services;

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- Transportation; and
- Medical Assessments.

The following special education health services are not billable to DMAS for FAMIS enrolled children:

- Audiology Services;
- Psychiatric and Psychological Services performed by the following;
 - A licensed clinical social worker (LCSW);
 - A licensed professional counselor (LPC);
 - A licensed psychiatric clinical nurse specialist (CNS); or
 - A licensed marriage and family therapist.
- Personal Care Services;
- Medical Evaluation Services; and
- Transportation.

ELIGIBILITY REQUIREMENTS

To be eligible for services provided by a school division, the recipient must be a currently enrolled Medicaid or FAMIS Plus/Medallion recipient under the age of 23 years or a FAMIS enrollee under the age of 19. Students under the age of 21 are eligible to receive EPSDT services provided by schools as medically necessary. For guidelines for providing outpatient services to eligible individuals 21 years of age and older, school providers may refer to the Rehabilitation Manual, Psychiatric Services Manual, and Physicians Manual available on the DMAS website at www.dmas.virginia.gov.

Students enrolled in a Medicaid managed care organization (MCO) must have EPSDT well-child screenings coordinated through the MCO. School divisions will not be reimbursed for EPSDT well-child screenings for MCO enrolled children.

With the exception of EPSDT well-child screenings, students who receive these services must have special education needs as documented on an IEP developed for the student. The need for services must be documented in the recipient's IEP prior to the start of service. Assessments, reassessments and medical evaluations do not necessarily have to be in the IEP prior to the start of services, as they are performed to determine the appropriateness of the health services in the IEP. If these services are done in order to determine if an IEP is needed or needs updated, the school will need to include these services in the IEP to be reimbursed by DMAS, either initially or through an amendment to the IEP.

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All practitioners and providers of services shall be required to meet state and federal licensing and certification requirements. Services not specifically documented in the recipient's record as having been rendered shall be deemed not to have been rendered, and no payment shall be provided.

CERTIFICATION AND RECERTIFICATION

The IEP is the certification that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice. For DMAS reimbursement, the IEP team must consist of qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The IEP cannot be used to authorize skilled nursing services or personal care services supervised by a registered nurse. Skilled nursing services and personal care services supervised by a registered nurse must be based on a written order from a physician, physician assistant or nurse practitioner and be recertified by one of these professionals on an annual basis. (Please note the physician, physician assistant or nurse practitioner does not have to be a part of the IEP team to order skilled nursing services.)

PARENT/GUARDIAN CONSENT AND COORDINATION WITH SERVICES PROVIDED OUTSIDE THE SCHOOL

Family Education Rights and Privacy Act (34CFR §99.31) and IDEA (34CFR §300.154)(d)2(iv)A requires parent/guardian consent for schools to bill DMAS for health-related services written in an IEP. Parent/Guardian consent is entirely voluntary. If the parent/guardian does not give consent, it will not affect the services to which the child is entitled. The school division is still required to provide a free and appropriate public education, including any services provided as part of an IEP.

Medicaid reimbursement for school services does not affect the child's Medicaid or FAMIS eligibility or the ability for the child to receive services outside the school setting. DMAS, however, does consider it a duplication of services if the school provider and the non-school provider have treatment plans for the student that are identical. In order to avoid duplication of services, coordination of the services between the two providers is critical. When similar providers are not coordinating services, the treatment plans may be in conflict with the desired recipient outcome. There is further explanation of this requirement located later in this Chapter.

OVERVIEW OF THE EPSDT PROGRAM

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR §441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. The goal of EPSDT is to identify and treat health

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problems as early as possible. EPSDT provides examination and treatment services at no cost to the enrollee.

CRITERIA FOR EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SCREENINGS

EPSDT is Medicaid's comprehensive and preventive children's health program geared to the early assessment of children's health care needs through periodic examinations. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly.

Included in the benefits commonly provided in school based health clinic settings are EPSDT screenings. EPSDT services include: screening/well child check-ups (EPSDT/Periodic screenings), sick visits (Inter-periodic Screenings), and treatment services to correct a medical condition, make it better, or prevent the child's health status from worsening. Screening services must be performed by a physician, physician assistant or nurse practitioner. DMAS reimburses school divisions for EPSDT screenings on fee-for-service enrolled children, when performed by an approved EPSDT provider. Consistent with federal regulations, clinics (including school based health clinics) must be under the direction of a physician. All providers must be qualified to render services as required under Virginia law.

EPSDT Screenings and Managed Care Organization Enrolled Children

Medicaid managed care organization (MCO) plans receive a fixed payment under which EPSDT screenings are included. Federal guidance states that any reimbursements made by DMAS to school divisions for school-based health screenings and related tests for children with Medicaid managed care (MEDALLION II) coverage constitutes duplicative payment. Therefore, DMAS does not reimburse school divisions directly for EPSDT screening services and related tests for children enrolled in a Medicaid MCO plan.

A provider may verify the type of coverage or MCO enrollment through MediCall (1-800-772-9996) or by subscribing to the Automated Response System (ARS) at <http://virginia.fhsc.com>. Recipients may have frequent changes to their type of coverage, so eligibility should be verified at each point of service.

For recipients enrolled in a MCO, the school should refer the child to his or her Primary Care Provider (PCP) and make a referral to the MCO to assume completion of the EPSDT screening process.

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Age Requirements for an EPSDT Screening for School Age Children

EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE
2 years 3 years 4 years	5 years 6 years 8 years 10 years	12 years 14 years 16 years 18 years 20 years

Required EPSDT Screening Components:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. A comprehensive unclothed physical exam;
3. Vision screening by a standardized testing method according to the DMAS periodicity schedule;
4. Hearing screening by a standardized testing method according to the DMAS periodicity schedule;
5. Developmental screening with a standard screening tool according to the American Academy of Pediatrics (AAP) guidelines;
6. Age appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines;
7. Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors); and
8. Health Education/Anticipatory Guidance/problem-focused guidance and counseling.

EPSDT screenings are Medicaid's well child visits and should occur according to the DMAS periodicity schedule (available at www.dmas.virginia.gov). Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family's history of mental health conditions.

The comprehensive health screening/well child visit content should be in line with the most current recommendations of the **AAP Guidelines for Health Supervision**. Another

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resource for preventive health guidelines is the AAP compatible “**Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents**”.

Surveillance, Assessment and Screening

Developmental issues and milestones are subjectively observed during each well child visit just as hearing and vision ability is subjectively observed by the practitioner. This practice is referred to as “surveillance”. Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

Assessment and screening is a reimbursable service when a standardized screening tool is used. Assessment and screening differs from surveillance because the activity uses an objective measurement tool. The tools used may vary according to the type of screening or assessment that is provided.

Hearing and Vision Screening and Surveillance

The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children’s hearing is assessed according to the AAP policy for “Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening”. Children’s vision assessment should be provided according to the AAP policy for “Eye Examination in Infants, Children, and Young Adults by Pediatricians”. Hearing and Vision screenings follow the most current AAP periodicity schedule as stated in the AAP “Recommendations for Preventive Pediatric Health Care”.

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, Protocols for Medical Management, that defines best practices for caring for infants and young children who are in need of follow-up from universal newborn hearing screening programs and for children who are found to have hearing loss. The Early Hearing Detection and Intervention protocols can be accessed the Virginia EHDI Program Web site, <http://www.vahealth.org/hearing/>. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

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Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics Section on Ophthalmology.

The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Developmental Assessment and Screening

Developmental surveillance and/or assessment must be provided at each well child visit. When necessary, the EPSDT visit should incorporate the use of a standardized developmental screening tool for children under three years of age, as described in the 2006 policy statement of the AAP, “Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening.”

Immunization and Laboratory Tests

Age appropriate immunizations should be provided according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All “catch up” schedules for missed vaccines should follow ACIP guidelines.

Lead testing must occur at 12 months and at 24 months of age. When the child is a new enrollee, lead testing is mandated under the age of 6 if there is no medical record to indicate that a lead test was previously administered. Other lab tests such as urinalysis, hematocrit, or hemoglobin tests are required at the AAP recommended intervals. Documentation of such testing is necessary for admission into programs such as Head Start. Head Start programs follow the EPSDT screening guidelines as guidance for their admission policies.

Anticipatory Guidance

Health Education, also called “Anticipatory Guidance”, and problem focused guidance and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels. The Bright Futures program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at www.vahealth.org/brightfutures/index.asp. DMAS endorses Bright Futures and Bright Futures Virginia.

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CRITERIA FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY SERVICES

Admission Criteria

Eligibility for school outpatient rehabilitative/habilitative/maintenance services is based on the recipient's medical need for one or more of the following covered services: physical therapy, occupational therapy, or speech-language pathology services. Effective July 1, 2006, all Medicaid services provided in the school setting are covered under the EPSDT regulations which allows for medically justified services which are provided to treat or correct identified health problems. Thus, physical therapy, occupational therapy, or speech-language pathology services may include habilitative (services to assist an individual in obtaining a skill) and maintenance therapy (services to assist an individual from losing a skill), to correct or ameliorate a health condition for children under the age of 21.

A licensed practitioner of the healing arts, as described in 42 CFR §440.110, must initiate physical therapy, occupational therapy, or speech-language pathology services. Physical therapy, occupational therapy, and speech-language pathology services are medically necessary treatment for providing services to the child related to the child's IEP goals. Any one of these therapy services may be offered as the sole service and shall not be contingent upon the provision of another service.

Definition of a Visit

A visit is defined as a treatment session where a therapist works with a recipient to provide covered services. Visits are not defined in measurements or increments of time. The furnishing of any services by a therapist on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this constitutes two visits - one each of physical therapy and occupational therapy. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy sessions in the same day (e.g., a morning session and an afternoon session), this would constitute two visits. Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists are the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Medicaid will reimburse for group therapy for a minimum of two but no more than six recipients per treatment session.

Coordination of Rehabilitation/Habilitation/Maintenance Services

The purpose of coordination of services is to maximize therapy benefits for the recipient. Coordination of services between treating therapists must be done when a recipient

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receives therapies from two separate providers (i.e., school and after-school therapies). Coordination of services allows two treatment therapists to assure maximum benefit of services is achieved for the recipient based on the treatment plans. Therapists have a professional responsibility to keep physicians and families informed of each recipient's progress. In addition, coordination of services may prevent duplication of services.

Duplication of services is defined as two treatment plans from two separate providers that are identical. However, there may be instances when there are some similar recipient goals, but the recipient requires a frequency/intensity of services that one provider cannot address. For example, a recipient has speech-language needs in school that are appropriately addressed by the school therapist, but he also requires additional speech therapy after school. The school therapist and community therapist need to coordinate services to assist the recipient toward meeting his treatment goals. When two separate providers are not coordinating services, the treatment plans may be in conflict with the desired recipient outcome.

Categorization of Two Subgroups: Acute vs. Non-Acute Conditions

There are two subgroups in general outpatient rehabilitation: acute conditions and long-term, non-acute conditions.

- Acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration of less than twelve (12) months, and in which progress toward established goals is likely to occur frequently.
- Long-term, non-acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration of greater than twelve (12) months, and in which progress toward established goals is likely to occur slowly. Habilitative services as well as maintenance therapies may be more appropriate for children depending on the child's condition and if they have long-term, non-acute conditions.

If the recipient is appropriate for the acute sub-group, requiring rehabilitative services for less than twelve (12) months, a recertification (renewal of plan of care/treatment plan) is required at least every sixty (60) calendar days by the licensed practitioner of the healing arts. Any initial plan of care/treatment plan or periodic renewal written by the licensed practitioner of the healing arts must be signed and dated within 21 calendar days of implementation of the plan.

If the recipient is appropriate for the long-term, non-acute sub-group, requiring rehabilitative/habilitative/maintenance services for greater than twelve (12) months, recertification (renewal of plan of care/treatment plan) is required at least annually by the licensed practitioner of the healing arts. The licensed practitioner of the healing arts must sign and date the plan of care/treatment plan at the time of review/renewal prior to the initiation of the continuation of service.

Defining a condition as acute or as long-term, non-acute, is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of

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care/treatment plan remains unchanged. Plans of care/treatment plans must still include measurable, long-term goals with anticipated dates of achievement. Plans of care/treatment plans must be renewed by the licensed practitioner of the healing arts at any time long term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual recipient.

Home Therapies

School divisions that employ their own therapists are allowed to provide home therapies under federal and state regulations (34 CFR §300.350 and 8 VAC 20-131-180 and 8 VAC 20-80-10) and in accordance with IEP requirements.

If a school division is contracting with an outpatient rehabilitation agency to provide rehabilitation/habilitation/maintenance services to special education children in accordance with the IEP, which identifies home-based instruction and rehabilitation therapy services, then home therapies may be provided by the outpatient rehabilitation provider, as long as the provider is licensed as a home health care agency (8 VAC 20-131-180 and 8 VAC 20-80-10). This includes IEP services provided to recipients currently residing in residential treatment centers.

Certification and Recertification

The certification (initial plan of care) and recertification (renewal of the plan of care) statement for physical therapy, occupational therapy, and speech-language pathology services must contain the following information:

- An adequate written record of the reasons for the admission and continued treatment of the patient for rehabilitative/habilitative/maintenance services;
- The estimated period of time the patient will continue to require the services; and
- Any plans, where appropriate, for post-hospital care.

Discharge Planning

Discharge planning must be an integral part of the treatment plan which is developed at the time treatment is initiated. The plan shall identify the anticipated improvement or maintenance of functional status and the probable discharge outcomes. The recipient, unless unable to do so, or the responsible party shall participate in the plan. Changes in the discharge plan shall be entered into the record as the changes occur.

Services must be considered for termination when any of the following conditions are met:

- No further benefit from therapy is demonstrated;
- There is limited motivation on the part of the individual or the caregiver;
- The individual has an unstable condition that affects his or her ability to

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participate in the plan of care;

- Progress toward an established goal(s) cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase or maintain meaningful functional or cognitive capabilities; and/or
- The service can be provided by someone other than a skilled health care professional.

Each discipline must prepare a discharge summary when the recipient's treatment plan is completed or at any time discharge occurs. The summary must document the recipient's progress relative to treatment long-term goals and must identify goals that were and were not met. Recommendations for future care, as appropriate, must be included.

Physical Therapy

Physical therapy services are those services provided to a recipient that meet all of the following conditions:

- The services must be included in the IEP and directly and specifically related to an active written plan of care/treatment plan designed by a licensed practitioner of the healing arts, a physical therapist (LPT) licensed by the Virginia Board of Physical Therapy. The Code of Federal Regulations (42 CFR §440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;
- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a qualified physical therapy provider as defined in Chapter II of this manual;
- The services must be provided with the expectation, based on the assessment made by the physician and/or licensed practitioner of the healing arts of the recipient's rehabilitation/habilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Physical therapy that can be performed by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as physical therapy services. If a person is trained by a licensed therapist as a personal care assistant to perform physical therapy services, the school may be reimbursed as personal care assistant services (please refer to Personal Care Services section of this chapter for more information). There is no provision for Medicaid

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reimbursement for students rendering therapy services.

Only a licensed physical therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, develop a plan of care/treatment plan. However, while the skills of a licensed physical therapist (LPT) are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapy assistant (LPTA) functioning under the direct supervision of a licensed physical therapist.

When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 calendar days while therapy is being conducted and document accordingly. The supervising physical therapist must supervise each Medicaid recipient's therapy session on-site every 30 calendar days. The supervisory visit must be documented in the therapy progress notes, which must be signed by the supervising therapist. If the scheduled supervision does not take place on-site, the supervising therapist must document the reason and may complete the supervision by reviewing the record and discussing the case with the assistant in person or by telephone. Results of the supervisory visit/discussion must be documented in the recipient's medical record.

In addition, once the recipient no longer requires therapy services the LPT must complete a discharge summary.

Generally, physical therapy is not required to improve or restore function where a recipient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the recipient gradually resumes normal activities. Physical therapy for temporary loss of function will not be covered.

The more common physical therapy modalities and procedures are illustrated below. These applications are appropriate for intensive rehabilitation services and for outpatient rehabilitation services.

1. Gait Training

Gait evaluation and training provided to a recipient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a licensed physical therapist and constitutes physical therapy, provided that it can reasonably be expected to significantly improve the recipient's ability to walk. Examples of services that do not constitute rehabilitation physical therapy are:

- Repetitious exercises to improve gait, maintain strength, endurance, and assistive walking (such as provided in support for feeble or unstable patients);
- Activities appropriately provided by supportive personnel (e.g., aides or nursing staff); and
- Activities that do not require the skills of a licensed physical therapist or

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licensed physical therapist assistant.

2. Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specific diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the recipient, which may be performed safely and effectively only by a licensed physical therapist, or a licensed physical therapy assistant under the direct supervision of a therapist, will be considered rehabilitation therapy that is reimbursed. Examples of services that do not constitute rehabilitation physical therapy are:

- Range of motion exercises not related to the restoration of a specific loss of function that can be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), and do not require the skills of a licensed physical therapist or licensed physical therapy assistant; and
- Passive exercises to maintain range of motion in paralyzed extremities which can be carried out by physical therapy aides or nursing staff.

3. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the direct supervision of a licensed physical therapist and, therefore, constitute covered physical therapy.

4. Therapeutic Exercises

Therapeutic exercises (e.g., strengthening, stretching, tilt table activities, etc.), performed by or under the direct supervision of a licensed physical therapist due to either the type of exercise employed or the condition of the recipient constitute covered physical therapy and can be reimbursed.

5. Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

The skills, knowledge, and judgment of a licensed physical therapist may be required in giving such treatments or baths (e.g., where the recipient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications).

Occupational Therapy

Occupational therapy services are those services provided to a recipient that meet all of the following conditions:

- The services must be included in the IEP and directly and specifically related to an active written plan of care/treatment plan designed by a licensed practitioner

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of the healing arts, an occupational therapist registered (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The Code of Federal Regulations (42 CFR §440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a qualified occupational therapy provider as defined in Chapter II of this manual.
- The services must be provided with the expectation, based on the assessment made by the physician and/or licensed practitioner of the healing arts of the recipient's rehabilitation/habilitation potential, that the condition of the recipient will improve significantly in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Occupational therapy that can be performed by supportive personnel (such as occupational therapy aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as occupational therapy services. If a person is trained by a licensed therapist as a personal care assistant to perform occupational therapy, the school may be reimbursed as personal care assistant services (Please refer to Personal Care Services section of this chapter for more information). There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, develop a plan of care/treatment plan. However, while the skills of a registered and licensed occupational therapist are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist.

When services are provided by a COTA, the OTR must conduct a supervisory visit at least every 30 calendar days while therapy is being conducted and document accordingly. The supervising occupational therapist must supervise each Medicaid recipient's therapy session on site every 30 calendar days. The supervisory visit must be documented in the assistant's progress notes, which must be signed by the supervising therapist. If the scheduled supervision does not take place, the supervising therapist must document the reason and may complete the supervision by reviewing the record and discussing the case with the assistant in person or by telephone. Results of the supervisory visit/discussion

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must be documented in the recipient's medical record.

In addition, once the recipient no longer requires therapy services the OTR must complete a discharge summary.

Occupational therapy may involve some or all of the following procedures:

1. The evaluation and reevaluation, as required, to assess a recipient's level of function by administering diagnostic and prognostic tests;
2. The selection and teaching of task-oriented therapeutic activities designed to restore physical function (e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns or injury);
3. The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, assist with memory loss and reality orientation in a neurologically impaired recipient);
4. The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke recipient with functional loss resulting in a distorted body image); and
5. The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a recipient who has lost the use of an arm dressing skills with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a spinal cord injured recipient new techniques to enable him or her to perform feeding, toileting, and other activities as independently as possible).

Speech-Language Pathology

Speech-language pathology services are those services provided a recipient that meet all of the following conditions:

- The services must be included in the IEP and directly and specifically related to an active written plan of care/treatment plan designed by a practitioner of the healing arts, a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology. The Code of Federal Regulations (42 CFR §440.110) require that the therapist meet licensure requirements within the scope of practice under state law;
- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a qualified speech-language pathology provider as defined in

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Chapter II of this manual.

When services are provided by a speech-language assistant, a licensed CCC/SLP or SLP must make a supervisory on-site visit at least every 30 calendar days while therapy is being conducted. The supervisory visit must be documented in the progress notes, which must be signed by the supervising therapist. If the scheduled supervision does not take place, the supervising therapist must document the reason and may complete the supervision by reviewing the record and discussing the case with the assistant in person or by telephone. Results of the supervisory visit/discussion must be documented in the recipient's medical record.

The identity of the unlicensed assistant (and the fact that they do not meet qualification requirements to bill Medicaid) shall be disclosed to the recipient, parent, or legal guardian prior to treatment and this disclosure shall be documented and made part of the recipient's record. These speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets DMAS' licensure requirements.

In addition, once the recipient no longer requires therapy services the licensed SLP must complete a discharge summary.

- The services must be provided with the expectation, based on the assessment made by the physician and/or licensed practitioner of the healing arts of the recipient's rehabilitation/habilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Speech-language pathology services that can be performed by supportive personnel (such as speech aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as speech-language pathology services. If a person is trained by a licensed therapist as a personal care assistant to perform speech-language therapy, the school may be reimbursed as personal care assistant services (Please refer to Personal Care Services section of this chapter for more information). There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a licensed speech-language pathologist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, develop a plan of care/treatment plan. However, while the skills of a licensed speech-language pathologist are required to evaluate the recipient's level of function and develop a plan of

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care/treatment plan, the implementation of the plan may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, and speech-language assistants as identified in Chapter II of this manual. The plan of care/treatment plan must be developed and signed only by the licensed speech-language pathologist.

Speech-language pathology services include the following procedures:

1. Evaluating patients to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech-language pathologist of a recipient with aphasia following a recent stroke to determine the need for speech-language pathology services;
2. Providing rehabilitative services for speech and language disorders; and
3. Providing rehabilitative services for swallowing disorders, cognitive problems, etc.

Reimbursement for speech-language pathology services is limited to those services related to a medical diagnosis.

Therapy Guidelines

The following are guidelines designed to assist with determination of appropriate services:

- Therapy services under EPSDT guidelines must correct or ameliorate a child's health condition. Therefore, the services must be medically necessary and based on a plan of treatment that will result in either a significant practical improvement in the child's level of functioning within a reasonable period of time, or maintenance/management of the child's health condition to prevent the child's functioning from deteriorating. When a child is not progressing toward the treatment goals within a reasonable period of time and the treatment service is still needed, the treatment plan should be revised so that the goals meet the child's treatment needs.
- Therapy that is determined to not require the skills of a qualified therapist to carry out an activity is not covered. For example, Medicaid will not reimburse for a qualified therapist to work with the child, if the child's therapy needs may be met by a trained personal care assistant or parent/caregiver. Please refer to the personal care assistant section of this chapter for more information.

CRITERIA FOR AUDIOLOGICAL SERVICES

The individual must have a medical need for audiology and hearing services as documented on the IEP or as part of the IEP assessment. All audiological services must be provided by a licensed audiologist. When medically necessary, multiple assessments may be provided on the same day.

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A qualified audiologist may provide the following services:

- Identification of children with hearing loss;
- Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing;
- Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation;
- Creation and administration of programs for prevention of hearing loss;
- Counseling and guidance of children, parents, and teachers regarding hearing loss; and
- Determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, evaluating the effectiveness of amplification.

Non-Covered Services

The following are non-covered services through audiological services:

- Hearing Screenings: 92551 and 92552 (which is a covered service by a physician, physician assistant or nurse practitioner).
- Services not provided by an audiologist.

CRITERIA FOR SKILLED NURSING SERVICES

Skilled nursing services are to be rendered in accordance with the licensing standards and criteria of the Virginia Board of Nursing. Services are to be performed by a Virginia licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN in accordance with Board of Nursing regulations.

Skilled nursing is deemed medically necessary by an attending physician, physician assistant or nurse practitioner, to assess, monitor, and provide medical interventions to treat or maintain the individual's medical condition. Services will be of a complexity and sophistication (based on assessment, planning, implementation and evaluation) which are consistent with skilled nursing services. These skilled nursing services include but are not necessarily limited to: tube feedings, dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

The individual must have documented nursing care needs that are required to support and manage a health condition that requires nursing to ensure the health and welfare of the individual. Services performed that exceed the physician, physician assistant or nurse practitioner's written order for skilled nursing services will not be reimbursed by DMAS.

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The licensed RN must conduct a supervisory visit at least every 30 calendar days while LPN services are being conducted and document accordingly. The supervising RN must supervise each Medicaid recipient's LPN service session on-site every 30 calendar days. The supervisory visit must be documented in the student log/progress notes, which must be signed by the supervising RN.

Skilled nursing services will not be used to specifically monitor medically controlled disorders or to provide unskilled care. DMAS reimbursable skilled nursing services are provided on a regularly scheduled basis according to medical necessity. The nurse may delegate procedures to augment care for individuals as medically appropriate. Services such as Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) care are not nursing services and will not be approved as nursing service units by DMAS unless a concurrent nursing service is being provided to the individual. The approved nursing units may include both nursing and personal care time if the personal care tasks are incidental to the nursing care.

All time that a nurse spends conducting activities with the child that is included in the child's IEP may be submitted to DMAS for reimbursement.

Service Units and Service Limitations

The unit of service for skilled nursing is 15 minutes. Services are limited to 6.5 hours per day or 26 units per day. As the school year is 180 days, the annual maximum number of service units is 4680.

To calculate monthly units billed, take the average amount of time for the procedure, multiply by the number of times a month the service is delivered and then divide by 15 (a unit) to get the total number of units to be billed.

For example, it takes 5 minutes to give a recipient his medication and the medication is given 18 times a month. The total time per month would be 90 minutes (5 x 18 = 90). The total units billed would be 6 (90 divided by 15).

CRITERIA FOR PSYCHIATRIC AND PSYCHOLOGICAL SERVICES

Psychiatric and psychological services provided in a school setting shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by a licensed practitioner within the scope of practice as defined under state law or regulations. These services are covered as physicians' services under 42 CFR §440.50 or medical or other remedial care under §440.60 or rehabilitative services under §440.130. Covered services include individual, group and family medical psychotherapy and psychological and neuropsychological testing when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. For specific provider requirements, please see Chapter II of this manual.

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Criteria for Participation

In order for a recipient to qualify to receive school psychiatric or psychological services and be billable to DMAS, the recipient must meet ALL of the following criteria:

1. Services must be included in the IEP;
2. Must have a DSM-IV-TR psychiatric or Substance Abuse (SA) diagnosis including current mental status documented in the medical progress notes;
3. Recipients of services must have the functional capability to understand and benefit from the counseling intervention. Services are intended to correct or ameliorate the client's mental health condition. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria. Recipients must participate and be compliant with treatment (e.g., some individuals with mental retardation [MR] may not have the ability to understand the treatment);
4. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired;
5. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactivity, poor impulse control, clinical depression, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities;
6. Is at risk for developing or requires treatment for maladaptive coping strategies;
7. Presents a reduction in individual adaptive and coping mechanism or demonstrates extreme increase in personal distress; and
8. Receives special education services or determined eligible for special education services.

Service Limits

The following services are limited to a combined three visits per seven-day period:

- Individual medical psychotherapy coverage is limited to once per day with a maximum of three sessions allowed per seven day period.
- Group medical psychotherapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy sessions. There is a maximum of ten individuals per group session.

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- Family medical psychotherapy is limited to once per day.

Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. In order for school providers to bill DMAS for psychological and neuropsychological testing, the diagnosis must be related to a DSM-IV-TR psychiatric or SA diagnosis. Medical records must document the medical necessity for these tests. DMAS allows one per six-month period and up to seven hours of units. Should the testing exceed the limits of frequency or units, the provider must provide the documentation with the bill as to the medical necessity for the testing and a list of the specific tests conducted.

Special Education federal regulations for children with disabilities (8 VAC 20-80-10) states that psychological and educational tests, other assessment procedures, interpreting assessment results, included in the diagnostic interview examination can only be administered by a qualified psychologist or under the direction or supervision of a qualified psychologist. The regulations allow for all recognized Medicaid psychological providers (noted in Chapter II) to provide therapy services, as allowed within the scope of their individual license.

Non-Covered Psychiatric Services

The following are non-covered services by DMAS:

- Broken appointments;
- Remedial education;
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Teaching “grooming” skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;
- Telephone consultations;
- Mail order prescriptions;
- Psycho-education for the purpose of educating the recipient’s guardian about the diagnosis and any related symptoms/treatment; and
- Teaching parenting skills.

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CRITERIA FOR PERSONAL CARE SERVICES

Individuals receiving personal care through school services must have a demonstrated medical need for personal care. Services covered include, but are not limited to, assistance with toileting, ambulation, transferring, eating and behavioral issues. The personal care aide may also serve as an aide on a specially adapted school vehicle which enables transportation to or from the school or school contracted provider, when documented in the IEP. The services of one aide can be billed for up to six children who require the assistance of an aide during transportation.

Individuals receiving personal care through a home and community-based waiver may receive personal care through school services as indicated on the individual's IEP. School divisions should refer individuals with a need for personal care services outside of school hours to the DMAS website to see if there is a waiver program that meets their needs. Individuals, who need personal care services outside the school setting and do not meet the eligibility requirements for one of the waiver programs, may be eligible for personal care services through EPSDT.

Please note that school divisions may either provide direct services or contract out services. Services in the IEP can only be reimbursed to a school division.

In addition to medical necessity, the following criteria must be met in order for personal care services to be determined appropriate in the school setting:

- The personal care service need must be documented in the student's IEP.
- The individual must have a plan of care developed by a licensed RN, PT, OT, SLP, Psychiatrist or Psychologist as covered in Chapter II of this manual. The plan of care developed by the licensed RN, PT, OT, SLP, Psychiatrist or Psychologist should be consistent with the health conditions and functional limitations documented on the individual's IEP.
- The appropriate licensed RN, PT, OT, SLP, Psychiatrist or Psychologist must conduct a supervisory visit at least every 30 calendar days while personal care services are being conducted and document accordingly. The supervising licensed RN, PT, OT, SLP, Psychiatrist or Psychologist must supervise each Medicaid recipient's personal care service session on-site every 30 calendar days. The supervisory visit must be documented in the student log/progress notes, which must be signed by the supervising licensed RN, PT, OT, SLP, Psychiatrist or Psychologist. If the scheduled supervision does not take place on-site, the supervising licensed RN, PT, OT, SLP, Psychiatrist or Psychologist must

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document the reason and may complete the supervision by reviewing the record and discussing the case with the assistant in person or by telephone. Results of the supervisory visit/discussion must be documented in the recipient's medical record.

Units

The unit of service for personal care is 15 minutes. To calculate monthly units billed, take the average amount of time needed to provide a service, multiply by the number of times a month the service is delivered and then divide by 15 (a unit) to get the total number of units to be billed.

For example, it takes 30 minutes to assist a recipient with feeding during lunch and the assistance is provided 18 times a month. The total time per month would be 540 minutes ($30 \times 18 = 540$). The total units billed would be 36 (540 divided by 15).

While more than one assistant may attend the student during a school day, the unit for a particular period of the day shall not be billed for the services of more than one assistant.

Non-covered Services

- General supervision; and
- Performance of tasks for the sole purpose of assistance with completion of school assignments.

CRITERIA FOR MEDICAL EVALUATION SERVICES

Medical evaluation services are covered as physicians' services under 42 CFR §440.50 or medical or other remedial care under §440.60. Persons performing these services must be licensed practitioners (physicians, physician assistants, and nurse practitioners) as covered under Chapter II of this manual acting within the scope of practice.

Covered services include:

- Identifying the nature or extent of a recipient's medical or other health related condition (may be through face-to-face exam, chart review or telephonic consultation);
- Review of medical needs related to special education eligibility if determined eligible for special education and documented in the IEP;
- Review of a recipient's initial IEP as necessary to determine the medical necessity for the medical/mental health related services designated by the IEP team;

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- Annual review of a recipient’s IEP as necessary to determine continuing medical necessity for the medical/mental health related services designated by the IEP team;
- Review of additional documents related to at recipient’s medical/mental health status either for consultative purposes or to determine medical necessity for services;
- Participating in meetings with IEP providers or families to provide medical input concerning a recipient’s disability and medical/mental health-related services needed;
- Review of medical needs as related to Special Education eligibility determination if the individual is deemed eligible for special education and documented in the IEP;
- Coordinating medical/mental health related services rendered outside the school setting. For example, talking to a recipient’s primary care physician about medication needs; and
- Completion of referral reports and documentation relative to the IEP.

CRITERIA FOR TRANSPORTATION

Non-emergency transportation provided by a school division is covered for children in special education on days when the child receives a Medicaid covered service, such as physical therapy, skilled nursing, personal care, etc. Special education transportation must be in the child’s IEP.

The transportation is to enable the child to receive the covered Medicaid service. Transportation involves a trip from home to school and the return trip, or from school or home to school contracted provider, and the return trip. Transportation must be rendered only by school division personnel or contractors.

Transportation on a “regular” school bus or car is not covered. The child must require transportation on a specially adapted school vehicle (i.e., bus or van) which meets the needs of the child when the child is unable to ride a “regular” school bus or car.

The school division personnel or contractor must perform the following functions as part of the Special Education requirement as well as Medicaid requirement:

- Obtain parental consent to bill Medicaid.
- Determine the appropriate mode of transport and delivery (e.g. curb-to-curb or door-to-door delivery).

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- Assure compliance with driver and vehicle requirements.
- Develop and implement a bus log for Medicaid transportation (sample Log may be found on www.dmas.virginia.gov).
- Provide administrative oversight.
- Protect recipient confidentiality.
- Maintain adequate staff and facilities.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapters I, III and VI of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these recipients only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the recipient;
- On written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

The primary health care provider must complete a Practitioner Referral Form (DMAS-70) when making a referral to another physician or clinic. The appropriate billing instructions for these situations are covered in Chapter V. Covered outpatient services excluded from this requirement include:

- School Division providers;
- Renal dialysis clinic services;
- Routine vision care services (routine diagnostic exams for recipients of all ages and eyeglasses for recipients under age 21) provided to restricted recipients; (NOTE: Medical treatment for diseases of the eye and its appendages still requires a written referral or may be provided in a medical emergency.)
- Baby Care services (nutrition, care coordination, or nurse midwife services);
- Personal care services (respite care or adult day health care);
- Ventilator-dependent services; and
- Prosthetic services.

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These services must be coordinated with the primary health care provider whose name appears on the recipient's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

CLIENT APPEALS OF THE DENIAL OF SERVICES

Medicaid denial of covered services will not reduce the scope of services being provided by the schools; schools will not stop providing the services because criteria for Medicaid reimbursement were not met. Therefore, copies of Medicaid denials will not be sent to the recipient. All reimbursement denials will be managed through the provider appeal process discussed in Chapter VI.

CLAIM INQUIRIES & RECONSIDERATION

Inquires concerning covered benefits, specific billing procedures or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers
1-804-786-6273 Richmond Area and out-of-state long distance
1-800-552-8627 In-state long distance (toll-free)