



Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

School-Based Skills Development Services

Division of Integrated Healthcare

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Table of Contents

1	General Information.....	4
1-1	General Policy	4
2	Fee for Service or Managed Care	4
3	Provider Participation Requirements	5
4	Record Keeping	5
5	Provider Sanctions	5
6	Member Eligibility.....	5
7	Member Responsibilities.....	5
8	Program Coverage.....	5
8-1	Definitions.....	5
8-2	Authority	7
8-3	Program Eligibility	8
8-4	Scope of Services.....	8
8-5	Covered Direct Services.....	8
8-5.1	Evaluation and Assessment	8
8-5.2	Motor Skills Development.....	9
8-5.3	Communication Skills Development.....	9
8-5.4	Personal Care.....	9
8-5.5	Skilled Nursing.....	10
8-5.6	Behavioral Health Services	11
8-5.7	Vision and Hearing Adaptation Services	11
8-6	Telehealth	11
8-7	Service Categories and Service Plans.....	12
8-8	Credentials and Supervision	12
8-9	Service Coordination.....	13
8-10	Documentation	13

8-10.1 Document of Medical Necessity	13
8-10.2 Rendering and Supervising Providers	13
8-10.3 Clinical Notes	14
8-10.4 Documentation Retention	14
9 Limitations and Non-covered Services	14
10 Prior Authorization	15
11 Service Payment.....	15
11-1 Billing Authority.....	15
11-2 Claims Processing	15
11-3 Cost Reporting.....	16
11-3.1 Direct Care Payment.....	16
11-3.2 Annual Direct Care Cost Reports.....	16
11.3.3 Cost data	17
11-3.4 Quarterly Administrative Cost Reports	17
11-3.5 Maximum Allowable Costs	18
11-3.6 Random Moment Time Study	19
11-3.7 Medicaid Administrative Claiming.....	20
11-4 Interim Payment.....	21
11-5 State Match and Administrative Fee	21
11-6 Cost Settlement.....	22
12 Coding.....	23
12-1 Billing Codes, Usage, Limitations, and Specifications	23
12-2 Billing for Time	23
12-2.1 Nursing Time.....	23
12-3 ICD-10 Diagnosis Codes	24

1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information](#), Chapter 1, General information.

1-1 General Policy

School-based skills development services are Medicaid-covered medically necessary diagnostic, preventative, and treatment services. These services include therapeutic interventions designed to ameliorate motor impairments, sensory loss, communication deficits, and/or psycho-social impairments. These services are specifically designed to enhance a student's health and functional abilities and/or prevent further deterioration. They are necessary for the student to benefit from educational services.

2 Fee for Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members.

For more information about Accountable Care Organizations (ACOs), refer to [Section I: General Information](#), Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to [Section I: General Information](#), Chapter 2-1.2, Prepaid Mental Health Plans, and the *Behavioral Health Services Provider Manual*.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the [Medicaid](#) website.

3 Provider Participation Requirements

Refer to [Section I: General Information](#), Chapter 3, *Provider participation and requirements*.

4 Record Keeping

Refer to [Section I: General Information](#), Chapter 4, *Record keeping*.

5 Provider Sanctions

Refer to [Section I: General Information](#), Chapter 5, *Provider sanctions*.

6 Member Eligibility

Refer to [Section I: General Information](#), Chapter 6, *Member eligibility*, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For additional information regarding member responsibilities including establishing eligibility and co-payment refer to [Section I: General Information](#), Chapter 7, *Member responsibilities*.

8 Program Coverage

Procedure codes, with accompanying criteria and limitations, are now found on the [PRISM Coverage and Reimbursement Code Lookup Tool](#).

8-1 Definitions

The following definitions apply to this program:

Administrative fee: The fee assessed to cover costs incurred by the Department of Health and Human Services to administer the Medicaid program.

Clean claim: A claim that can be processed as submitted without obtaining any additional information from the provider of the service or from a third party.

Document of Medical Necessity (DMN): A document approved by the Utah State Board of Education as a medical plan of care used to demonstrate a student's need for medical services in the school environment during school hours. This document must state the following: the medical diagnosis or medical need, a start and end date, the scope of the service, the frequency of the service, and the duration of the service. The document must be signed and dated by a provider whose licensure allows.

Examples of DMNs include but are not limited to the following: IEP, IFSP, 504 plan, health plan, Behavior Intervention Plan, prescribed services.

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, designed to ensure Medicaid eligible recipients from birth through age twenty have access to needed medical care.

Federal financial participation (FFP): The federal share of Medicaid payments authorized and directed under Section 1903(a) of the Social Security Act.

HIPAA: The federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs.

Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP): A written plan for a student with a disability developed and implemented in accordance with the Utah State Board of Education Special Education Rules.

Local Education Agency (LEA): The Utah school districts, the Utah Schools for the Deaf and Blind (USDB), and all Utah public charter schools that are established under state law that are not schools of an LEA.

Maximum allowable costs: The percentage of costs incurred by the LEA to deliver covered skills development services to the Medicaid population.

Medicaid administrative claiming (MAC): is a means by which the states' LEAs are able to claim partial reimbursement for administrative activities that support and ensure the integrity and delivery of Medicaid services provided both within the school setting and through coordination with community Medicaid providers.

Medically necessary service: A service that is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, are causing suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap, and there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

Paraprofessional: An individual who is not a licensed healthcare provider; however, has been trained to perform certain healthcare tasks under the supervision of a licensed medical or behavioral professional.

Related services: Developmental, corrective, and other supportive services required to assist a student with a disability to benefit from educational services. Related services are identified in the Individuals with Disabilities Education Act (IDEA), Part B Regulations, 34 CFR Section 300.34. Not all related services are considered medically necessary.

Skilled nursing services: School-based skills development services provided to medically fragile students who require continuous, one-to-one skilled nursing throughout their school day, in accordance with a physician or other qualified healthcare professional's order.

State match: The current percentage of the State's share of Medicaid expenditures as defined in [42 CFR 433.10](#).

Utah Health Information Network (Uhin): a nonprofit, broad-based coalition of Utah healthcare insurers, providers, and others, including local government entities that provides a private and secure gateway for electronic data exchanges.

8-2 Authority

The Medicaid Catastrophic Coverage Act of 1988, Section 411(k)(12) permits Medicaid to pay for Medicaid covered services included in a Medicaid eligible recipient's

Document of Medical Necessity (DMN) when services are medically necessary and are covered in the Medicaid State Plan, for students who are 3 to under 21 years old.

8-3 Program Eligibility

LEAs may bill Medicaid for covered services rendered by qualified providers to students when the LEA is an enrolled provider with Utah Medicaid and has a current signed contract and provider agreement with the Department of Health and Human Services. The covered service must be stated in the student's DMN. The student must be Medicaid eligible and be between the ages of 3 and 21.

The LEA may check Medicaid eligibility by sending a student list to the school-based program manager, using the Eligibility Lookup Tool or by calling 1-801-538-6155 or 1-800-662-9651, and following the prompts.

8-4 Scope of Services

The direct services outlined in this section must be rendered in accordance with a provider order, except personal care. The student's DMN may be used as the provider order if the information stated includes the provider's recommendation for services, the scope, frequency, duration of services, and the provider's signature and date.

LEAs not wanting to use the DMN as a provider order must complete a provider order separate from the DMN.

8-5 Covered Direct Services

Direct care services must be rendered by a provider whose scope of license legally allows them to do so, or by a paraprofessional under the supervision of a provider whose scope of license legally allows them to supervise the rendered service.

8-5.1 Evaluation and Assessment

Evaluations and assessments are performed for the purpose of identifying and documenting a student's medical service need. Both initial evaluations and assessments, along with re-evaluations and assessments, are covered by Medicaid, as long as the evaluated and/or assessed service results in DMN placement.

Evaluations and assessments that do not result in DMN placement for the evaluated or assessed service are not covered by Medicaid.

8-5.2 Motor Skills Development

Motor skills development services are rehabilitative, active or restorative therapies designed to enhance a student's fine and gross motor skills including muscle coordination and strength, ambulation, range of motion, grasp and release, and oral motor functioning. These services may be provided in an individual or group setting.

Examples of these services are occupational therapy and physical therapy.

8-5.3 Communication Skills Development

Communication skills are speech, language, and hearing services designed to enhance a student's ability to communicate through the development of functional expressive speech, functional use of adaptive equipment and devices, or improved oral-motor functioning. These services may be provided in an individual or group setting.

Examples of this service are speech language pathology or hearing screenings.

8-5.4 Personal Care

The following services must be performed under proper supervision per the Final Supervision and Licensure Appendix 3 and in accordance with [Utah Code section 58-1-307](#) and [Admin Code R156-31b-701b](#). The student's DMN may serve as the service plan for personal care services.

- Activities of Daily Living (ADLs) such as toileting, hand washing, eating, and bathing
- Administer over-the-counter medications according to the manufacturer/FDA directions
- Administer prescription ointments per a licensed health care provider order/prescription
- Administer non-controlled medications per a licensed health care provider order/prescription
- Administer medication through tubes per a licensed health care provider order/prescription
- Administer eye/ear drops: prescribed or over the counter

- Administer gastrostomy tube feeding: changing empty bags and clipping/unclipping the feeding line to the port (but not replacing a port)
- Tasks related to stoma care, including pouch changes, measuring intake and output, and skin care around the stoma area
Changing a catheter bag
- Oxygen management: assisting with applying nasal cannulas, adjusting the flow of O2 within prescribed parameters, and the temporary removal of O2 tubing to facilitate ADLs.
- Measure and record electronic vital signs (such as pulse oximeter or blood pressure) and take weights and temperatures.
- Perform routine ventilator respiratory care but may not adjust settings.
- Clean established trach tubes and routine surface suctioning but may not provide deep suctioning.
- Nail care: clipping and filing toe and fingernails (for non-diabetic individuals)
- Personal care services shall not be performed as a group service; however, one or more students may be served one-at-a-time sequentially.

8-5.5 Skilled Nursing

Skilled nursing services require the provider to have appropriate licensure per the Final Supervision and Licensure Appendix. In addition to the services stated under the personal care section, these providers may render skilled nursing services in accordance with their licensing and training as outlined in [Utah Code section 58-1-307](#) and [Admin Code R156-31b-701a](#).

Nursing services that are considered observational or stand-by in nature are not covered.

Skilled nursing services must be in accordance with a prescribed provider order and be stated in the student's plan of care. The order may be signed by a physician or other qualified healthcare professional.

For information regarding other qualified healthcare professionals, refer to the [Section I: General Information](#) provider manual.

Nursing services include but are not limited to:

- Routine respiratory care, including management of ventilator settings. Standard tracheotomy care includes cleaning and suctioning, whether surface or deep suctioning.
- IV management
- Evaluations and assessments (RNs only)
- Emergency interventions
- Seizure monitoring
- Asthma management
- Diabetes management
- Scoliosis screening
- Height and weight screening

8-5.6 Behavioral Health Services

Behavioral health services are designed to mitigate behaviors such as aggression, self-abuse, property destruction, severe non-compliance or withdrawal when, and to the extent, those behaviors significantly impact a student's ability to benefit from educational services. These may be provided in an individual or group setting.

Examples of these services include behavioral redirection, counseling, and psychological services.

8-5.7 Vision and Hearing Adaptation Services

Vision and hearing adaptation services are necessitated by a student's absence or loss of vision and/or hearing. They are specifically designed adaptation training services to develop/enhance a student's functional abilities to assist him or her to benefit from educational services.

Examples of these services are orientation and mobility as well as aural/auditory rehabilitation.

8-6 Telehealth

Utah Medicaid covers medically necessary, non-experimental, and cost-effective services provided via telehealth. Telehealth is a two-way, real-time interactive communication to facilitate contact directly between a student and a provider. This electronic communication uses interactive telecommunications equipment that

includes, at a minimum, audio and video equipment that complies with HIPAA and UHIN privacy and security standards for telehealth.

There are no geographic restrictions for telehealth services. Providers at the originating site receive no additional reimbursement for the use of telehealth services.

Reporting requirements for provided telehealth services are the same as those provided when the student is present (in person).

Covered telehealth services include but are not limited to the following:

- Consultation services
- Evaluation and management services
- Mental health services

For more information regarding telemedicine, please refer to Medicaid's *Section 1: General Information* provider manual.

8-7 Service Categories and Service Plans

Services that may be stated in a student's DMN as a category, i.e., social skills, transition skills, functional skills, daily living skills, self-help, etc., must be broken down. The Medicaid covered services to be rendered must be stated. Example: if social skills services include behavioral interventions, the LEA can state "behavior" as the covered service in the DMN.

Services that may be stated in a student's DMN as a plan, i.e., health plan, must be broken down. The Medicaid covered services to be rendered must be stated. Example: If a DMN states, "health plan", but the actual service to be rendered is speech, then the DMN should say "speech".

8-8 Credentials and Supervision

The Supervision and Licensure Appendix 3 outlines the licensure, certification, and other credentials required to deliver and/or supervise the delivery of Medicaid covered school-based skills development services.

8-9 Service Coordination

The LEA is responsible for coordinating the provision of School-Based Skills Development services with students' primary and specialty providers.

Utah Medicaid providers should be familiar with coverage of preventative, diagnostic, treatment, and outreach services for EPSDT-eligible recipients in order to assist families to appropriately utilize Medicaid benefits available.

8-10 Documentation

The LEA must maintain sufficient records to fully justify the Medicaid covered services rendered, its claims submitted to Medicaid, and its reported costs.

8-10.1 Document of Medical Necessity

The DMN must demonstrate that the student received services pursuant to a DMN. The DMN must demonstrate the following:

- The dates of the DMN cover the billing month on the claim.
- The Medicaid covered services rendered to the student during the month match the services outlined in the DMN.
- The CPT/HCPCS codes included in a claim are pursuant to a service stated in the DMN.

8-10.2 Rendering and Supervising Providers

The rendering provider(s) have required licensure, certification, or other criteria described in the Supervision and Licensure Appendix 3 or be supervised by an individual who met the requirements per Appendix 3.

The documentation must demonstrate the following:

- The rendering provider has signed and dated the service documentation
- The signature is handwritten or electronic
 - Electronic signatures are acceptable when the LEA has a system to maintain an auditable signature record, and when the LEA has a way to protect against modification of the record after the signature.
 - The LEA and the person whose name is represented by the electronic signature, are responsible for the authenticity of the signature.
- The signature is legible

- The rendering provider and the supervising provider (if applicable) have signed and dated the documentation.
- The documentation clearly indicates who rendered the service
- The documentation clearly indicates who supervised the service

8-10.3 Clinical Notes

The LEA must maintain clinical documentation to justify the costs reported to Medicaid. Clinical notes must include the exact activities performed with the student and must be in line with the standards of practice for each rendering and/or supervising provider's specialty. The exact activities demonstrate how the service was rendered.

Clinical notes must include the following:

- Student's name
- Service rendered
- Date the service was rendered
- Duration of time spent rendering the service
- Clinical description of the services rendered

8-10.4 Documentation Retention

All documentation pertinent to a claim submitted by the LEA to Medicaid must be kept for a period of five years after the date of payment. Records must be retained even after a student leaves the LEA.

9 Limitations and Non-covered Services

The following services and activities are outside of the scope of the School-Based Skills Development services and are not reimbursable under this program:

- Durable and non-durable medical equipment (including assistive technology devices), appliances, and supplies.
 - When medically necessary, these items are available to a Medicaid eligible student through other programs and enrolled providers.
- Services provided prior to the implementation (or subsequent to the expiration) of a student's DMN.
- Medicaid covered services, which are not specified in a student's DMN.

- Services specified in a student's DMN but the nature of the activity is academic or educational.
- Services stated in a DMN but the nature of the activity is vocational or relates to job training.
- Activities that are extracurricular in nature.
- Any other service that may be appropriate for a DMN according to USBE standards but are not covered Medicaid services as outlined in this manual.

10 Prior Authorization

For information regarding prior authorization, see [Section I: General Information, Chapter 10, Prior authorization](#). Additional resources and information may be found on the [Utah Medicaid](#) website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to [the PRISM Coverage and Reimbursement Code Lookup Tool](#).

11 Service Payment

11-1 Billing Authority

The LEA, along with the education authority, is solely responsible to ensure that it is legally authorized to submit a claim to Medicaid in accordance with all state and federal laws.

11-2 Claims Processing

LEAs must be able to submit claims using HIPAA compliant software using the UHIN tool. The LEA is responsible for submitting clean claims to Medicaid and for working through rejected claims with its clearinghouse and/or UHIN when appropriate.

Submitted claims must contain the following information:

- The name of the Medicaid eligible student who received Medicaid covered services during the billing period.
- The student's date of birth and social security number or Medicaid identification number
- The number of units of covered service(s)
- The dates of service during the billing month

Providers should not be listed individually on School-Based Skills Development claims.

11-3 Cost Reporting

11-3.1 Direct Care Payment

Utah LEAs may claim Federal Financial Participation (FFP) through Medicaid for a share of the costs incurred to render covered direct care services to Medicaid eligible students.

Medicaid's regulations prohibit payments to governmental agencies in amounts which exceed an agency's costs to provide a service. LEAs, as governmental entities, are not allowed to make a profit.

The objective of the direct care payment reimbursement process is to isolate and identify only those LEA costs that are associated directly with rendering Medicaid covered direct care services.

A cost settlement is used to assure LEAs are reimbursed for the maximum allowable cost. All reported costs and payments are subject to a review and takeback process per [Utah Code 26b-1-213](#) and [Administrative Rule R414-1-14](#).

11-3.2 Annual Direct Care Cost Reports

On an annual basis LEAs must submit a report outlining the costs associated with rendering covered direct care services to students that are eligible for this program.

The annual reports should include salaries and benefits for both direct care and contracted staff. Salaries and benefits may only be included for staff that have participated in the time study and only for the period in which they participate. Contracted staff must also participate in the time study.

The expense should be broken out to reflect the percent that is funded through state/local funds, IDEA, and other federal funds.

LEAs may also submit expenses for allowable materials and supplies used to provide direct care services.

11.3.3 Cost data

Cost data is submitted by the district quarterly. Calculations from the cost data are used to support the quarterly administrative claim. The information used is provided either by the LEA or the USBE or derived from calculations completed by the time study/cost reporting vendor.

The following elements are used to calculate the administrative claim:

- Employee level salary data
- Employee benefit data
- Contracted staff costs
- The LEA's indirect cost rate
- The LEA's Medicaid discount factor
- The statewide time study percentages related to Medicaid administrative services for each of the staff cost pools.
 - This will be calculated separately for each of the three staff cost pools and then will be combined and reduced by 50% to isolate the federal share of the administrative FFP.

11-3.4 Quarterly Administrative Cost Reports

On a quarterly basis LEAs must submit a report outlining the costs associated with administering this program.

The quarterly reports should include salary and benefits for staff rendering direct care services to students as well as the salary and benefits for staff providing administrative support for the program.

The expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.

Salary and benefit expense may only be included for staff that have participated in the time study and only for the period in which they participate in the time study. Contracted staff must also participate in the time study.

LEAs may also submit expenses for allowable materials and supplies used to provide direct care services.

Other costs may include staff travel and training costs, as well as staff professional dues and fees.

11-3.5 Maximum Allowable Costs

The maximum allowable cost is calculated using the annual cost report data for direct care costs. The information used is provided either by the LEA or the USBE or derived from calculations completed by the time study/cost reporting vendor.

- Employee level salary data
- Employee benefit data
- Contracted staff cost
- The LEA's indirect cost rate
- The LEA's Medicaid IEP student ratio
- The LEA's Medicaid eligibility ratio
- Statewide direct care time study percentage for each direct care staff cost pool.

The IEP student ratio is used for purposes of the annual cost settlement and is applied to the calculation for determining the reimbursement level for services provided to students with an IEP/IFSP. It is calculated by dividing the number of Medicaid eligible students in an LEA with a Medicaid covered service stated on their IEP/IFSP, by the total number of students in the LEA with a Medicaid covered service stated on their IEP/IFSP, regardless of Medicaid eligibility. The LEA must submit a list of students who have a covered service on their IEP by November 30th of each year. The request will come from Medicaid by November 1st of each year.

Example:
$$\frac{(\# \text{ of Medicaid students } /w \text{ qualified services on IEP})}{(\text{Total } \# \text{ of students } /w \text{ qualified services on IEP})}$$

The Medicaid eligibility ratio is applied to the calculation to determine the reimbursement level for direct service costs pursuant to DMNs other than IEPs and IFSPs. This is calculated by dividing the total number of Medicaid eligible students in the LEA by the total number of students enrolled in the LEA.

Example: (# of Medicaid eligible students in the LEA)

(# of students enrolled in the LEA)

The total student enrollment is given to Medicaid by the Utah State Board of Education.

11-3.6 Random Moment Time Study

The random moment time study is a mechanism for identifying and categorizing Medicaid administrative and direct care activities performed by LEA employees. The time study produces statewide percentages for three cost pools associated with three participant categories. It serves as the basis for calculating the maximum allowable cost for the annual cost reconciliation for direct care services and developing claims for the costs of administrative activities that may be reimbursable under Medicaid. LEAs must ensure an 85 percent compliance rate with the time study

- The paraprofessional and clinical provider time studies will result in separate direct care service percentages.
- The paraprofessional, clinical provider, and administrative staff time studies will result in separate administrative activity percentages.

Participating LEAs must participate in the time study for three periods per year.

- The first period is from mid-August to December 31
- The second period is from January 1 to June 30
- The third period is the summer period, beginning July 1 and ending mid-August
 - No time study is generated during the summer period

The sample period will run from the day after the last regular school day until the day before the first regular school day. An average of the two previous sampling periods' time study results will be used to calculate claims for the summer sampling period. No Medicaid funding will be available to an LEA for a quarter in which it failed to complete an approved time study.

LEAs must work with the Department's time study vendor to enroll time study participants into three categories:

- **Paraprofessionals**– Included in this category are:
 - paraprofessionals
 - interveners
 - other aides that provide covered direct care services
- **Clinical providers** – Included in this category are the following:
 - Physical therapists
 - Physical therapy assistants
 - Physical therapy aides
 - Occupational therapists
 - Occupational therapy assistants
 - Occupational therapy aides
 - Orientation and mobility specialists
 - Psychologists
 - Social workers
 - Hearing specialists
 - Audiologists
 - Audiology aides
 - Speech and language pathologists
 - Speech language technicians
 - Speech language pathology aides
 - RNs or LPNs
 - Other qualified healthcare professional
 - Augmentative/assistive communications teams
 - Counselors/mental health practitioners
- **Administrative staff** – Include staff that support this program, but do not render direct care services. These may include the following:
 - Special education directors or coordinators
 - Medicaid coordinators
 - Special education staff assistants

11-3.7 Medicaid Administrative Claiming

LEAs may claim Medicaid administrative Federal Financial Participation (FFP) for a share of the costs incurred to perform activities which support the proper and efficient operation of the Medicaid program in schools. The administrative claim

isolates and identifies only those LEA costs that are associated directly with administrative activities that support the provision of Medicaid covered services. Some or all of the costs of these administrative activities may be reimbursable at a 50 percent match rate. The quarterly cost reports will be used to calculate the administrative claim.

The following criteria must be met for administrative claiming:

- The LEA must be enrolled as a Medicaid provider.
- The LEA must actively bill Medicaid for direct care services.
- The LEA must participate in the Department approved time study.
- The LEA must attend required trainings.
- The supported activity must be necessary for the proper and efficient administration of the Medicaid State Plan.

11-4 Interim Payment

Due to the fact that payment is based on actual costs, interim payments will be made to the LEAs until a cost settlement can be finalized. In advance of the school year, the interim payment is determined by taking the maximum allowable cost calculation from a previous period and applying that as an estimate of the anticipated cost of the coming year.

In an effort to minimize a payback situation, the LEAs will select to receive 80 percent or 90 percent of the estimated maximum allowable cost to be paid out monthly. At any time during the year, LEAs may request to reduce the interim payments. If billing for direct care services decreases during the year, the Department may hold or reduce interim payments in an effort to ensure the estimated maximum allowable cost is still representative of the current situation.

11-5 State Match and Administrative Fee

The LEA will receive a quarterly bill for the estimated state match pertaining to direct care services. The bill will be sent 45 days prior to the beginning of each new quarter and payment must be made at least 15 days prior to the start of the quarter. State match requirements for administrative services will be accomplished through certified public expenditures (CPE).

The LEA will receive a bill for the administrative fee 45 days prior to the beginning of the fourth quarter of each state fiscal year. The administrative fee will be calculated as a percentage of the total Medicaid payments. It will include both FFP and state match amounts paid to the LEA for School-Based Skills Development services during the state fiscal year.

The administrative fee is calculated as follows:

Fiscal Year Medicaid Payments	Fiscal Year Administrative Fee
\$1-\$500,000	3 percent of total
\$500,000- \$1,000,000	\$15,000 + 2 percent of amount exceeding \$500,000
Greater than \$1,000,000	\$25,000 + 1 percent of amount exceeding \$1,000,000

LEA monthly Medicaid payments will be placed on hold if the state match or the administrative fee is not paid.

11-6 Cost Settlement

At the conclusion of the school year, the Department will perform a cost settlement by comparing the interim payments made throughout the year with the actual maximum allowable costs for the year.

If the maximum allowable cost exceeds the interim payments, the Department will pay the difference to the LEA. If the interim payments exceed the maximum allowable costs, the Department will invoice the LEA for the difference. If the interim payments are equal to the maximum allowable cost, no action is required.

The LEA is responsible for ensuring that the Medicaid funds it receives as part of the program are only used to support and enhance the provision of Medicaid covered services.

12 Coding

12-1 Billing Codes, Usage, Limitations, and Specifications

LEAs must submit claims to Medicaid to justify its reported direct care service costs and receive its monthly interim payment. Claims may only be submitted for dates when a Medicaid covered service is rendered to a student.

LEAs must use correct CPT/HCPCS codes on claims per the School-Based Skills Development Code List Appendix 1 and the School-Based Skills Development Audiology Code List Appendix 2.

12-2 Billing for Time

When submitting the CPT/HCPCS codes for time, the minutes must be rounded. If the resulting time is 0 to less than 8 minutes, do not bill for the time. If the resulting time is 8 to 15 minutes, one unit of services may be billed.

Example: If a nurse rendered services for 34 minutes, bill two units. If a nurse rendered services for 39 minutes, bill three units. Services billed using CPT/HCPCS codes for time may only be billed for the day that the services are rendered. Partial minutes cannot carry over from one day to the next in order to complete a unit.

Example: 9 minutes of nursing services on Tuesday cannot be added to 6 minutes of nursing services on Wednesday to make one whole 15-minute unit.

12-2.1 Nursing Time

LEAs may bill for nursing services during transportation using the appropriate code, when deemed necessary. To bill for nursing services during transportation, the total nursing minutes stated in the DMN must also include the minutes for transportation. Nursing minutes are billed in 15-minute increments.

Simply stating “transportation” in the DMN, or adding time to transportation in the DMN, is not sufficient. This does not clearly identify the expected time associated with the nursing services, nor does it clearly tie the “transportation” activities to a specific service.

Example: Student receives 2,000 weekly nursing minutes at school, and also receives nursing services on a bus for 30 minutes a day, five days a week. The total time stated in the DMN must be 2,150 for the LEA to submit a claim for both services.

12-3 ICD-10 Diagnosis Codes

LEAs will use the full list of ICD-10 diagnosis codes as appropriate for the associated rendered service and include the appropriate diagnosis code on submitted claims to Medicaid.