Medicaid in Schools Questions

Charter/Private Schools

1. Is there a detailed process available for charter and private schools to enroll as Medicaid providers and their providers to enroll as rendering providers at the school?
2. When will schools be able to enroll Psychologists, Social Workers, Mental Health Counselors, Certified Behavior Technicians, Speech Language Pathologists, Physical Therapists, Occupational Therapists, and Registered Nurses as "84" provider types? Currently, only the following rendering providers can be enrolled: specialty 813: Occupational Therapy Assistant, specialty 814: Physical Therapy Assistant, specialty 815: Speech-Language Pathology Assistant, specialty 816: School Guidance Counselor, specialty 817: Licensed Practical Nurse, specialty 818: School Health Aide.
3. Can charter and private schools retroactively submit claims, up to one year, once a rendering provider is enrolled if the school was enrolled at the time the service was delivered?
4. Why are charter and private schools not allowed to participate in the Administrative Claiming Program?
5. Why are schools not receiving the appropriate fee schedule rate in rule 59G-4.002, Provider Reimbursement Schedules and Billing? What is the timeline to correct the issue? Currently, charter and private schools are not receiving the full fee schedule amount in rule 59G-4.002, Provider Reimbursement Schedules and Billing instead receiving the FMAP rate.
6. If a charter or private school is enrolled as a school district, how can they correct their specialty type to ensure they are properly enrolled?
7. Where can schools find the Medicaid school-based services delivered by private and charter schools program policy referenced in the February 19, 2021 email from AHCA? In the February 19, 2021 email from AHCA titled "Recent changes regarding Florida Medicaid's Certified School Match program and school-based services" it was stated there are three programs for Florida Medicaid school-based services.
8. Will charter and private schools receive a separate fee schedule promulgated in rule?

Certified School Match Program

9. When can districts expect to receive the updated coverage policy for the Medicaid Certified School Match Program? HB 81 has passed and was signed by the governor on June 23, 2020.
10. Will AHCA be collaborating with school district personnel and FDOE personnel in drafting the updated coverage policy for the Medicaid Certified School Match Program?
11. Type of service is defined in rule 59G-4.035 Medicaid Certified School Match Program as therapy, behavior, nursing or transportation, which is identified through the procedure code, correct?
12. Will the modality of service (individual or group) be removed as a plan of care requirement on the FFS monitoring instrument, since it is not a requirement in rule 59G-4.035 Medicaid Certified School Match Program? This creates a significant barrier for school districts to capture reimbursements for therapy services, creates confusion ex: "billing for a group of one" etc. Indicating group/individual is also not an ESE requirement, and this information is not likely to be included on the student's IEP—and in the case of speech language services creates a huge barrier by causing the therapist to have to create a separate document only to satisfy the AHCA monitoring report requirement. The licensed therapist must work within the scope of their Practice Act and professional standards, which already prohibits them from providing inappropriate/unprofessional therapy. Due to the nature of the school setting, it is virtually

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inconceivable that therapists would have the time or availability to provide additional/unnecessary therapy out of convenience to themselves or anyone for that matter.

13. Please confirm AHCA and FDOE provided formal confirmation that school districts may begin seeking reimbursement for school based services outside of the IEP delivering these services in accordance with the requirements specified in the Medicaid Certified School Match Program Coverage Policy as of July 1, 2020.
14. Since districts are using the requirements in rule 59G-4.035 Medicaid Certified School Match Program based on the February 19, 2021 email from AHCA and the FDOE memo dated April 16, 2021, are the plan of care requirements for behavior the same as the plan of care requirements for therapy?
15. If transportation is referenced as a service in the student's plan of care and meets one of the three criteria for specialized transportation, are schools required to use the same ICD 10 code as the service delivered on the same day transportation was provided?
16. Since a plan of care would not be created prior to need, can districts bill for unscheduled services for the purpose of resolving an immediate crisis situation (Behavioral) or emergency health care (Nursing) without having a plan of care in place? Is there a timeline that a plan of care must be in place by for a service to be reimbursable?
17. Is the plan of care flexible to reflect the appropriate medical need of the students at any given time as the plan of care cannot be adjusted every time the child is seen? With some of our more involved students the plan which includes individual and group may vary based on the child's need that day.
18. If a district has two Behavior Interventionists that work in the district who are not Certified Behavior Analysts where one is a master's Level, but her degree is in Educational Leadership and the other one is a bachelor's level, can they bill under the supervision of our director who is a Licensed Mental Health Counselor?
19. If a School Social Worker is a bachelor's level, can they bill under the supervision of the director who is a Licensed Mental Health Counselor?
20. Will new procedure codes be added to the fee schedule in rule to identify non-IEP services?
21. Can the evaluation report be the plan of care? Ex. SLP evaluates a (non ESE/ Medicaid eligible) student to determine if he is eligible for ESE, but testing shows he does not qualify for services. Can we bill for the evaluation using the report as the plan of care?
22. Will a new monitoring tool be created to incorporate the Medicaid expansion?
23. If a teacher is providing social emotional learning for a student with mental health minutes, can that teacher bill for that student?
24. Can a district submit a claim for a student's initial evaluation if they do not qualify for services and do not have a plan of care?
25. Will gifted evaluations be billable if delivered by a qualified Medicaid provider and result in a plan of care, or does it need to coexist with a medical condition?
26. Must UAP (Unlicensed Assistive Personnel) have the actual School Health Aide title in order to bill for the services they provide? These UAPs meet all the School Health Aide qualifications found in the district handbook and all services are performed under the direction of a licensed registered nurse, as governed by the state nurse practice act.
27. Can a Threat Assessment be considered a plan of care if it meets all the requirements in rule 59G-4.035 Medicaid Certified School Match Program?

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28. Would a referral form to a contracted mental health therapy agency who does not claim Medicaid work as a plan of care if it meets all the requirements in rule 59G-4.035 Medicaid Certified School Match Program?
29. Can an RN or LPN approve Medicaid billing? Per the Nursing Act; a licensed nurse (RN) can delegate a nursing responsibility to another nursing staff while retaining accountability for the outcome. Here is the situation: ESE aides/paraprofessionals are trained per Medicaid guidelines so the district can bill for services rendered through the student's plan of care and MD orders. They put the information into the vendor program, based on what the nurses have given them to bill for. The students care plans are co-signed by the RN as well. Then the RN then has to go thru and check that the codes are correct and paperwork matches up. They then approve the billing to go to Medicaid. This is the part where we need clarification as to RN vs LPN.
30. Do schools need to file Medicaid claims the same day the service is provided or can they be filed at the end of the week? How long do we have to file re-evaluations / evaluations? (3months, 6 months, 1-year)
31. Will audiology be added as a billable service on the fee schedule and as a qualified provider in the new coverage policy? Audiologists spend a lot of time testing and assessing, but also a lot of money on hearing devices, batteries, and upkeep. They write communication plans that may be considered an evaluation.
32. Will ARNPs be added as a qualified provider in the new coverage policy and the fee schedule adjusted to reflect the addition of the ARNP?
33. Will Certified Nursing Assistants be added as a qualified provider in the new coverage policy and the fee schedule adjusted to reflect the addition of the CNA?
34. Will Registered Behavioral Technicians be added as a qualified provider in the new coverage policy and the fee schedule adjusted to reflect the addition of the RBT?

Fee Schedule

35. Should Florida Medicaid health care alerts be used to notify schools of changes in the handbook and the fee schedule in rule?
36. Has AHCA verified all Medicaid Certified School Match Program procedure codes listed in rule 59G-4.002, Provider Reimbursement Schedules and Billing codes have been added to every school's customary charge since it was identified not all procedure codes exist or have end dates causing denied claims?
37. Why is procedure code 97150 GP Physical Therapy Group Session by a Physical Therapist being denied?
38. Will claims denied due to NCCI edits (with dates of service under a year old) be reprocessed or will districts have to resubmit? This issue has remained unresolved since 2016.
39. What is the process for school districts to receive reimbursement for claims exceeding one year due to NCCI edits? This issue has remained unresolved since 2016.
40. When will the fee schedule be corrected to allow 32 units instead of 8 units for 96152, 96152 AH, 96152 HN, 96152 HO, and 96152 UD?
41. What are the correct codes/modifiers for telemedicine?
42. Are comments received via the survey monkey reviewed for corrections to the fee schedule?
43. When will the corrected 2021 fee schedule be published?
44. Can schools bill for 96150AH and 96152AH services received on the same day for the same recipient? If not, why not?
45. Has AHCA issued guidance on how to differentiate between the OT/PT evaluation codes? "Low Complexity, Moderate Complexity, High Complexity"

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46. Will AHCA be adding a re-evaluation code for therapy to address the need in the schools since the fee schedule in rule's maximum allowable units is not in alignment with the Medicaid Certified School Match Handbook?
47. Will AHCA remove the weekly maximum allowable units added to the fee schedule for therapy services which limit reimbursement to districts by reducing the maximum allowable units from 4 per day to 14 per week?
48. Have the H codes listed on the Draft fee schedule been vetted to ensure they are reimbursable for schools? Has AHCA verified each H code has been added to each school's customary charge?
49. When a child needs changes to a wheelchair due to growth, surgeries etc. how can districts seek reimbursement for wheelchair follow-up or fittings since the fee schedule maximum allowable units have been changed to reflect one wheelchair evaluation every 5 years?

Administrative Claiming

50. What is AHCA's claiming workbook timeline to provide the claiming workbook to districts, receive the claiming workbook from districts and provide the claiming invoice?