Suffolk County
Department of Health
2010-2011

NEW MEDICAID REQUIREMENTS
FOR
ALL PRESCHOOL PROVIDERS

Revised August 27, 2010

Documentation Listing

COUNTY OF SUFFOLK

DEPARTMENT OF HEALTH SERVICES

STEVE LEVY
SUFFOLK COUNTY EXECUTIVE

JAMES L. TOMARKEN, MD
MSW, MPH, MBA, FRCPC, FACP
Commissioner

DATE: August 19, 2010

TO: Preschool Agencies and Related Service Providers

FROM: Susan Hodosky, Principal Financial Analyst
Revenue and Receivables Unit

SUBJECT: **NEW MEDICAID REQUIREMENTS FOR ALL PRESCHOOL PROVIDERS**

On April 26, 2010, the New York State SPA #09-61 for the Preschool/School Supportive Health Services (SSHS) Program was approved by the Centers for Medicare and Medicaid Services (CMS). This SPA requires a new reimbursement methodology and clarifies provider qualifications and documentation requirements in order for the County to claim Medicaid reimbursement.

Billing procedures and requirements have changed significantly. The guidelines are very specific and must be adhered to exactly. We have enclosed the required changes as well as additional information and new forms necessary for your submission of the service data needed for all future Medicaid claiming. Please review this packet completely and begin using the new forms **immediately** for the 2010-2011 school year.

New York State has been conducting mandatory training sessions for all Medicaid-in-Education relevant employees of local school districts, counties and providers that bill Medicaid (directly or indirectly) under the School Supportive Health Services Program (SSHS). The mandatory Medicaid trainings have been organized by each RIC (Eastern Suffolk BOCES and Nassau BOCES) and conducted by the NYS Education Department (SED) and the NYS Department of Health (DOH). In addition to the mandatory trainings, SED is requiring that all district, county, agency, providers and4201 school relevant employees register on the NYSED.gov website by using the following web address: http://www.forms2.nysed.gov/oms/medicaid/shsp.cfm

We have been made aware that many 'relevant employees' **have not** completed the mandatory training requirement at this time. Please be sure that all relevant employees are registered on the NYSED website and also have signed up for training at Eastern Suffolk BOCES or Nassau BOCES. A list of training dates and locations are attached.

It is imperative that all relevant employees be trained ASAP so that Suffolk County Department of Health may bill Medicaid for the 2009-2010 school year and beyond, as well as continue to make payments to the providers seamlessly.

If you have any questions, please contact Rosemarie Pforr, directly at 631-853-3195, fax 631-853-2922, or via email: Rosemarie.Pforr@suffolkcountyny.gov

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

STAC, Special Aids and Medicaid Unit
Reimbursement for Individuals in Special Education
89 Washington Avenue, Room 514 EB
Albany, New York 12234
Tel. (518) 474-7116 · Fax (518) 402-5047
E-mail: MedinEd@mail.nysed.gov

Steven Wright, Coordinator

June 2, 2010

To: All Preschool/School Supportive Health Services (SSHS) Providers

From: Steven Wright, Coordinator – Medicaid Unit

Subject: Tracking Medicaid-in-Education Relevant Employees

As part of the New York State (NYS) Compliance Agreement with the federal government, the NYS Education Department (SED), and the NYS Department of Health (DOH) are developing a mandatory **annual Compliance Training program** for all Medicaid-in-Education relevant employees of school districts, counties and §4201 schools. The training will include a discussion of the contents of the NYS Compliance Agreement, written compliance policies and a briefing on any changes in federal and/or state laws, regulations, policies and procedures. The NYS Education Department is required to ensure that all relevant employees are aware of the standards of conduct for participation in the Medicaid program.

The NYS Compliance Agreement requires each school district, county and §4201 school to provide this office with the names of all their relevant employees. To assist with this process, an **online database (form) has been developed.** This form can be accessed at http://www.forms2.nysed.gov/oms/medicaid/shsp.cfm.
The information will be used to monitor and track all relevant employees for training purposes.

The term "relevant employee" is interpreted to include any person in the school district, county or §4201 school who, in some way, is involved with the Medicaid-in-Education program in New York State. These "relevant employees" can include, but are not limited to:

Teachers of the Speech and Hearing Handicapped
Teachers of Students with Speech and Language Disabilities
Licensed Speech/Language Pathologists
Licensed Psychologists
Licensed Psychiatrists
Licensed Clinical Social Workers
Licensed Masters Social Workers
Licensed Practical Nurses
Registered Nurses

Licensed Nurse Practitioners
Special Transportation Coordinators
Medicaid Billing Clerks
School Business Officials
Special Education Directors
Licensed Physical Therapists
Physical Therapy Assistants
Licensed Occupational Therapists
Occupational Therapy Assistants
Licensed and Registered Physicians
Registered Physician Assistants
Licensed and Registered Specialist Physicians
Licensed and Registered Audiologists
Compliance Officers

(Note: this list is not intended to be all-inclusive)

"Relevant employee" also refers to people contracted by school districts, counties and §4201 schools for Medicaid-in-Education purposes. This includes BOCES employees, consultants hired for Medicaid billings and employees of nonpublic schools involved in Medicaid-in-Education.

The relevant employee online form should be completed by July 1, 2010. Larger districts and counties may find it easier to submit this information electronically in EXCEL or ACCESS using a prescribed format. In those situations, please contact Sheila Costa at 518-474-4178.

SED may decide to pend Medicaid claims if a school district, county or §4201 school fails to register each relevant employee and/or those relevant employees fail to attend a Compliance Training. Your RIC will be scheduling the Compliance Trainings in the near future.

Please direct questions regarding the online form to Sheila Costa at 518-474-4178 or send an e-mail to the New York State Education Department's Medicaid Unit at medined@mail.nysed.gov.

Eastern Suffolk BOCES
NY State Education Department
Medicaid Unit
Certification Class Training 2010

Training Dates	Location Address	Time
7/28	Sherwood	9am - 11:30am
7/28	Sherwood	12:30am - 3pm
7/29	Sherwood	9am - 11:30am
7/29	Sherwood	12:30am - 3pm
8/10	WHB	9am - 11:30am
8/10	WHB	12:30pm - 3pm
8/11	WHB	9am - 11:30am
8/11	WHB	12:30am - 3pm
9/13	Sherwood	1pm - 3:30pm
9/14	Sherwood	9am -1 1:30am
9/14	Sherwood	1pm - 3:30pm
9/17	Sherwood	1pm - 3:30pm
9/20	Sherwood	1pm - 3:30pm

Locations: **Sherwood - 15 Andrea Road, Holbrook, NY 11741**
WHB - 215 Old Riverhead Road, Westhampton Beach, NY 11978

To register for this event, visit us online at http://datacentral.esboces.org
Click on the "Create Account" link in the upper right hand corner of the screen, and proceed to complete the requested information. Once you have created your account, simply go to the Calendar to register.
You will receive an e-mail confirmation of your registration.
If you should need assistance with this registration please contact Karen Fedun at 631-419-1684

Student Data Services

Andrew K. Setzer, Divisional Administrator
Hilna R. Zoob, Program Administrator
Dr. Kristen Turnow, Administrative Coordinator

Eastern Suffolk BOCES does not discriminate against any employee, student, applicant for employment, or candidate for enrollment on the basis of gender, race, color, religion or creed, age, national origin, marital status, disability, or any other classification protected by law. For further information or concerns regarding this statement, please contact the Eastern Suffolk BOCES Department of Human Resources at (631) 687-3029.

Barbara Sabia 608-6682
Marion Fine 832-2757
Margarita Pieri 832-2708

Nassau BOCES
Medicaid in Education
Medicaid Compliance Training 2010

Training Dates	Location Address	Room	AM/PM Sessions	Target Audience
7/7	Nassau BOCES Admin Center 70 Clinton Road Garden City	LL-B	1-4 pm	*School Business Officials who oversee the Medicaid claiming process *Special Education Director *Medicaid Billing Clerk *Nassau and Suffolk County Providers
7/8	Nassau BOCES Admin Center 70 Clinton Road Garden City	LL-B	1-4 pm	*School Business Officials who oversee the Medicaid claiming process *Special Education Director *Medicaid Billing Clerk *Nassau and Suffolk County Providers
7/20	One Merrick Avenue, Westbury	CR 1,2,3	9am-12pm or 1-4 pm	All other relevant employees *Nassau and Suffolk County Providers
7/21	One Merrick Avenue, Westbury	CR 1,2,3	9am-12pm or 1-4 pm	All other relevant employees *Nassau and Suffolk County Providers
9/22	Nassau BOCES Admin Center 70 Clinton Road Garden City	LL-A LL-B	9am-12pm or 1-4pm	All other relevant employees
9/23	Nassau BOCES Admin Center 70 Clinton Road Garden City	LL-A LL-B	9am-12pm or 1-4 pm	All other relevant employees
10/1	One Merrick Avenue, Westbury	CR 1,2,3	12-3 pm	Special Ed Directors
10/19	One Merrick Avenue, Westbury	CR 1,2,3	9am-12pm or 1-4 pm	All other relevant employees

Note: RSVP via email to: Medicaid@mail.nasboces.org
Please include:

1. Attendee Name
2. District Name, County affiliation, or Agency Name
3. Title

Please indicate a first, second & third choice training session. We will do our best to accommodate you.

Suffolk County
Department of Health
Office of Children with Special Needs
Preschool Special Education Program

The new State Plan for the Medicaid in Education program has revised many of the Medicaid guidelines that we currently work under. **The guidelines are very specific and must be adhered to exactly!**

The Main changes in requirements are as follows:

- **Contemporaneous** Session Notes (Daily Treatment Logs) – Must include description of the procedures used and the progress achieved for each session.
- You **must use** CPT code to designate the type of service provided **for each 15 minute interval (even if duplicated).** The new 2010-2011 Record of Related Service Log Notes will have a place for you to insert the CPT code. Included is a list of the most commonly used CPT Codes. A more extensive list is available on the State website at www.oms.nysed.gov/medicaid/
- **"Under the Direction of" (UDO) –** In the past, only Speech Language Pathologists were required to complete "Under the Direction of" Certification forms and "Under the Direction of" supervision logs. The **New State Plan** requires that these 2 forms be completed when supervision is provided by the following: SLP for a TSHH/CFY, PT for a PTA, OT for a COTA, and RN for a LPN.
- **"Under the Supervision of" (USO) Counseling Services** – The **New State Plan** allows for the reimbursement for counseling services provided by a Licensed Psychiatrist, Licensed Psychologist, Licensed Clinical Social Worker (LCSW). A Master of Social Work (MSW) can provide Counseling services **if supervised by one of the three licensed providers.**
- **Prescription Requirements** – These requirements are for the 2010-2011 school year.

Prescription/Recommendation must include the following information before services can begin:

- **Child's name clearly written and Date of Birth**
- ***School year 7/1/10 - 6/30/11***
- **Service to be provided (OT, PT, ST, NU and Audio Evaluation)**
  Please submit a* separate Rx *for each service
- **ICD9 code / Diagnosis and/or reason/need for ordered services.**
- **Provider's contact information (office stamp or preprinted address & phone #)**
- **Signature of the doctor required-M.D., P.A., or N.P. – *(Stamped signature will NOT be accepted)***
  A recommendation signed by the SLP for Speech services can be substituted for a physician's prescription.
  A recommendation signed by a CPSE chairperson for Counseling services can be substituted for a physician's prescription.
- ***Date the order was written and signed.***
- **License number or NPI#**
- **DO NOT use "per IEP" on the prescription**

VERY IMPORTANT: If you already obtained a prescription for 2010-2011 services and it does not meet the new standards, it is **NOT VALID FOR MEDICAID BILLING.** You must obtain a new prescription **PRIOR** to the start of services. Included is a cover letter and prescription form that you can send to parents to obtain the new prescriptions.

BE SURE YOU CHECK THE PHYSICIAN'S NAME AGAINST THE MEDICAID EXCLUSION LIST BEFORE YOU START SERVICES!

COUNTY OF SUFFOLK

DEPARTMENT OF HEALTH SERVICES

STEVE LEVY
SUFFOLK COUNTY EXECUTIVE

JAMES L. TOMARKEN, MD
MSW, MPH, MBA, FRCPC, FACP
Commissioner

Dear Parents/Guardians,

In order for to provide related services to your child, including nursing; occupational, physical and/or speech therapy, NY State laws require us to collect a current prescription for the school year of 2010-2011 for each related service that your district has approved for your child. As per NYS Preschool Supportive Health Services Program, all scripts must contain the information stated below. We apologize to those parents who have already secured prescriptions prior to this regulation, but the prescription without the information is not valid.

We kindly request that you obtain a prescription that includes the following information, **without which services cannot begin**:

- Child's name clearly written and Date of Birth
- *School year 7/1/10 - 6/30/11*
-
- Service to be provided (OT, PT, ST, NU and Audio Evaluation)
  Please submit a separate Rx *for each service*
- ICD9 code / Diagnosis and/or reason/need for ordered services.
- Provider's contact information (office stamp or preprinted address & phone #)
- Signature of the doctor required M.D., P.A., or N.P. – *(Stamped signature will NOT be accepted)*
  A recommendation signed by the SLP for Speech services can be substituted for a physician's prescription.
  A recommendation signed by a CPSE chairperson for Counseling services can be substituted for a physician's prescription.
- *Date the order was written and signed.*
- License number or NPI#
- DO NOT use "per IEP" on the prescription

For your convenience, we have enclosed a form that your doctor may wish to use to authorize your child's school based related services.

Mail or fax your prescription to:
Agency Address

COUNTY OF SUFFOLK

DEPARTMENT OF HEALTH SERVICES

STEVE LEVY
SUFFOLK COUNTY EXECUTIVE

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Commissioner

PRESCRIPTION/RECOMMENDATION FOR PRESCHOOL BASED RELATED SERVICES

(A SEPARATE PRESCRIPTION IS REQUIRED FOR EACH SERVICE)

Student's Name: _____ DOB: _____

District: _____ School: _____

The child named above has been recommended for the following service by his/her school district:

Service/Therapy (Please check one)	Period of Service
☐ OT ☐ PT ☐ ST ☐ *NU ☐ Aud Eval	*School year 7/1/10 - 6/30/11*

* In addition to the prescription a specific M.D., P.A. or N.P.'s order with detailed instructions is required.

ICD9 code/Diagnosis and/or reason/need for ordered services.	

Physician/P.A./Nurse Practitioner Information/SLP (please print or use stamp):

Name:	
Address:	
Phone Number:	
License Number / NPI #:	

_____ _____

Signature of Physician/P.A./Nurse Practitioner/SLP(for speech only) Date
(**Must be original signature**)

STAMPED SIGNATURE WILL NOT BE ACCEPTED

Suffolk County
Department of Health
Office of Children with Special Needs
Preschool Special Education Program

2010-2011 INSTRUCTIONS
CLAIMS FOR ALL MEDICAID ELIGIBLE SERVICES

Billable Services Include: Audiological, Psychological, Medical and Medical Specialist Evaluations; Physical Therapy; Occupational Therapy; Speech Therapy; Psychological Services; Skilled Nursing and Transportation.

In order to support these claims, verification is required.

1. **Record of Related Services Log Notes – New form is attached.**. In order for the County to bill Medicaid, the Record of Related Services Log Notes form must be filled out completely. Please note that the date of service box, the appropriate CPT code, start and end time must be documented. All dates of services must be fully supported by this record of related services log notes along with child school attendance and provider time sheets. (This additional documentation will be requested during an Audit.)
2. **SIGNATURES on RECORD OF RELATED SERVICES LOG NOTES –** The witness signature line **DOES NOT** have to be signed when the record or related services log notes are being used by a Center-based (Tuition) program. The therapist signature and the supervising therapist if working "Under the Direction of" both have to sign and date each date of service
3. Attached are common CPT codes; these may be modified when the State issues final guidance on the new State Plan.
4. **All providers must obtain signed Parental Consent forms.**

SUFFOLK COUNTY PRESCHOOL SPECIAL EDUCATION PROGRAM
RECORD OF RELATED SERVICES LOG NOTES

Suffolk County NPI # 1760586978 Voucher # Voucher Date

1. Student's Name (Last, First) DOB _____ M__ F__		2. School District, Month/Year of Service	
3. Name of Service Provider Agency & NPI # (if applicable)		4. Name of Individual Service Provider, License #, Expiration Date:	
5. IEP Dates: Start Date–End Date	6. Treating Therapist NPI #	7. Location of Service Delivery:_____ Individual __ Group __	8. IEP Frequency & Duration
9. Type of Related Service		Rx/Recommendation Received (if applicable) [ ]	

Date of Service: _____ Make-up Session: Yes [ ] No [ ] Session Time In: _____ Session Time Out: _____

CPT Code(s): _____ _____ _____ _____

Goal(s) targeted: _____

Activity/Lesson: (Including objectives and measures of success) _____

_____

_____

Response (s) of Child: _____

_____

DO NOT SIGN BLANK LOG NOTES

Print name of Parent/Caregiver: _____Relationship to Child: _____

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caregiver _____Date:_____

(Only NON CB services require a verifying witness signature)

I certify that the above services were provided on the dates and times indicated in accordance with the Student's IEP and the Related Service Agreement. _____

Signature of Related Service Provider

I certify that I have reviewed the above services:

_____**Date:** _____

USO/UDO Supervisor Signature, Credentials, License, ASHA # (if appropriate)

Date of Service: _____ Make-up Session: Yes [ ] No [ ] Session Time In: _____ Session Time Out: _____

CPT Code(s): _____ _____ _____ _____

Goal(s) targeted: _____

Activity/Lesson: (Including objectives and measures of success) _____

_____

_____

Response (s) of Child: _____

_____

DO NOT SIGN BLANK LOG NOTES

Print name of Parent/Caregiver: _____Relationship to Child: _____

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caregiver _____Date:_____

(Only NON CB services require a verifying witness signature)

I certify that the above services were provided on the dates and times indicated in accordance with the Student's IEP and the Related Service Agreement. _____

Signature of Related Service Provider

I certify that I have reviewed the above services:

_____**Date:** _____

USO/UDO Supervisor Signature, Credentials, License, ASHA # (if appropriate)

SUFFOLK COUNTY PRESCHOOL SPECIAL EDUCATION PROGRAM
RECORD OF RELATED SERVICES LOG NOTES

Suffolk County NPI # 1760586978 Voucher # Voucher Date

1. Student's Name (Last, First) DOB _____ M__ F__ **A**		2. School District, Month/Year of Service **B**	
3. Name of Service Provider Agency & NPI # (if applicable) **C**		4. Name of Individual Service Provider, License #, Expiration Date: **D**	
5. IEP Dates: Start Date–End Date **E**	6. Treating Therapist NPI # **F**	7. Location of Service Delivery:_____ Individual __ Group __ **G**	8. IEP Frequency & Duration **H**
9. Type of Related Service **I**		Rx/Recommendation Received (if applicable) [ ] **J**	

Date of Service: _____ Make-up Session: Yes [ ] No [ ] Session Time In: _____ Session Time Out: _____

CPT Code(s): _____**K**_____ _____ _____ _____

Goal(s) targeted: _____**L**_____

Activity/Lesson: (Including objectives and measures of success) _____**M**_____

_____

_____

Response (s) of Child: _____**N**_____

_____

DO NOT SIGN BLANK LOG NOTES

Print name of Parent/Caregiver: _____**O**_____Relationship to Child: _____**P**_____

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caregiver _____**Q**_____Date:_____

(Only NON CB services require a verifying witness signature)

I certify that the above services were provided on the dates and times indicated in accordance with the Student's IEP and the Related Service Agreement. _____**R**_____

Signature of Related Service Provider

I certify that I have reviewed the above services:

_____**S**_____**Date:** _____

USO/UDO Supervisor Signature, Credentials, License, ASHA # (if appropriate)

Date of Service: _____ Make-up Session: Yes [ ] No [ ] Session Time In: _____ Session Time Out: _____

CPT Code(s): _____ _____ _____ _____

Goal(s) targeted: _____

Activity/Lesson: (Including objectives and measures of success) _____

_____

_____

Response (s) of Child: _____

_____

DO NOT SIGN BLANK LOG NOTES

Print name of Parent/Caregiver: _____Relationship to Child: _____

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caregiver _____Date:_____

(Only NON CB services require a verifying witness signature)

I certify that the above services were provided on the dates and times indicated in accordance with the Student's IEP and the Related Service Agreement. _____

Signature of Related Service Provider

I certify that I have reviewed the above services:

_____**Date:** _____

USO/UDO Supervisor Signature, Credentials, License, ASHA # (if appropriate)

Please follow these instructions carefully for completion of all Related Service Log Notes.
Effective 9/1/2010 this log note now applies to all center-base services as well.
If you have questions please call the Coordinator of Preschool Services.

Add this new information to your Related Service Manual and discard the old information. Also begin using these forms **as of September 1, 2010** and discard all the old Log Note Forms.
Any submission of old forms after September may be subject to being returned without payment until new forms are submitted.

Section A - Print or type the child's name, Date of Birth and check the correct Gender.

Section B - Print or type the child's school district with the current month and year of service.

Section C - Print your agency's name (if appropriate) and their NPI#

Section D - Print or type your name, License # and expiration date

Section E - Start and End dates as listed on the IEP - i.e. 9/5/10-6/20/11

Section F - Your NPI#

Section G - Location of Service - i.e. home, day care, etc. and check whether Individual or Group.

Section H - Frequency and Duration as listed on the IEP

Section I - Type of related service you provide - i.e. Speech, OT, PT., etc.

Section J - If you have prescription check the box - If not you should not be providing services. **Always check the dates of the script which should be the school year you are providing services in. Date signed by Doctor, P.A. must be prior to service start date.**

Section K - All CPT codes for the period you are treating at 15 minute intervals.

Section L - General description of the goals you are treating - You do not have to write the whole goal.

Section M - Description of the actual lesson you are doing with the child. What you are doing and methodologies. Include how you measure success.

Section N - How did the child do? Be descriptive. Examples: "…responded well to hand over hand methodology 9 out of 10 times." - "…didn't like touching the playdough…." - "…..behavior increased when I held his hand and he……..".

Section O - Print Name of Parent or Caregiver - If caregiver is signing the log notes you must have written permission from parent for them to sign.

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
INSTRUCTIONS FOR RELATED SERVICE LOG NOTES (continued)

Section P - Relationship of the person signing i.e. Parent, Teacher, Foster Parent, Grandmother etc.

Section Q - Signature of Parent/Caregiver and date. DO NOT ASK A PARENT TO SIGN A BLANK LOG NOTE.

Section R - Sign you name as an attestation that you actually performed therapy for that child on the date and time you indicated.

Section S - If you can only perform your therapy "Under the Direction of …. or Under the Supervision of……" then your Supervisor must sign under each service date on the log note as well as all quarterly reports and all annual reports.

Please note that effective September 1, 2010 you will no longer tally up the units on the bottom of each log note. Instead you will enter all billing information on the new billing form and attach that to the voucher and log notes when you submit it to Expenditures Department.

For center-base therapy you will now have to used the same log note as the one used by related service providers. For Center-base services only; you will not have to have the parent sign any part of the notes.

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
PROVISION OF SERVICES BILLING RECORD

Month/Year:_____8)_____

Student Name/DOB	Freq & Dur	Service Type	Dates of Service	Rate	Units	Total
1)	2)	3)	4)	5)	6)	7)

Rate X Units = Total

Page Totals

9)	10)	11)

Instructions for Related Service Billing

1) Enter the child's name and date of birth.
2) Enter the Frequency and Duration of Service as provided in accordance with the child's IEP
3) Type of Service i.e.: Speech , OT, Psych, etc…..
4) Dates that service was actually provided i.e. 2/3/10, 2/4, 2/9, 2/11, etc…
5) Insert appropriate rate ($25.00, $30.00, $45.00) for discipline and service.
6) Total units for that child
7) Total amount of Rate X Units
8) Place the month and year you are claiming on this sheet
9) Insert appropriate rate.
10) Insert total of units for this page
11) Insert total of rate x total units

You may tally each session on the log note if you choose but are not required to. You must fill out this billing record and attach it to the log notes and voucher when submitting for payment.

Commonly Used CPT Codes

Applicable CPT Codes		
Speech	**92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder - **Individual**
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; **group**, 2 or more individuals
	92526	Treatment of swallowing dysfunction and/or oral function for feeding
Physical Therapy	**97110**	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion & flexibility - **Individual**
	97150	Therapeutic procedure (s), **group** 2 or more individuals
	97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
	97542	Wheelchair management(eg, assessment, fitting, training), each 15 minutes
Occupational Therapy	**97110**	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of **motion** & flexibility **- Individual**
	97150	Therapeutic procedure(s), **group** (2 or more individuals)
	97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
	97542	Wheelchair management(eg, assessment, fitting, training), each 15 minutes
Psychological Counseling	**90804**	**Individual** psychotherapy, insight oriented, behavior modifying and /or supportive, in an office or outpatient facility, **20 to 30 minutes**, face to face with the child.
	90806	**Individual** psychotherapy, insight oriented, behavior modifying and /or supportive, in an office or outpatient facility, **45 to 50 minutes**, face to face with the child.
	90810	**Individual** psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for non verbal communication, in an office or out patient facility, approximately **20-30 minutes**, face to face with child.
	90812	**Individual** psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms for non verbal communication, in an office or out patient facility, approximately **45 to 50 minutes**, face to face with child.
	90853	**Group** psychotherapy
	H0004	Behavioral health counseling and therapy, per 15 minutes
Nursing Services	**T1001**	Nursing assessment. To be done by the RN only
	T1002	RN Services, up to 15 minutes
	T1003	LPN services, up to 15 minutes
Services are billed in 15 minute increments (Except for Speech)		

Commonly Used Evaluation CPT Codes

Applicable CPT Codes		
Evaluations		
Audiological	**92506**	Audiological Evaluation - Used by SLP or Audiologist when billing for the IEP multi-disciplinary assessment.
Speech	**92506**	**Evaluation** of speech, language, voice, communication, and/or auditory processing
Psychological	**90801**	**Psychological Testing** - used by the Psychologist when billing for the evaluation when the psychological testing is performed as part of the evaluation process
Psychological	**96101**	**Psychological Testing** - used by the Psychologist when billing for the evaluation when the psychological testing is performed as part of the evaluation process
Psychological	**96116**	**Neurobehavioral Status Exam** - used by the psychologist when billing for the evaluation when the neurobehavioral status exam is performed as part of the evaluation process.
Psychological	**96118**	**Neuropsychological testing** - used by the psychologist when billing for the evaluation when the neuropsychological testing is performed as part of the evaluation process.

Suffolk County
Department of Health
Office of Children with Special Needs
Preschool Special Education Program

EVALUATION - MEDICAID INSTRUCTIONS

When evaluation documentation is requested for a Medicaid eligible child, complete the Medicaid Evaluation Summary Report form for the child and attach the appropriate referral/prescription, as explained below. The evaluation should be retained in the child's file.

DO NOT ATTACH A COPY OF THE EVALUATION TO THE REPORT.

NOTE: You will be required to **ADD** the **CPT CODES** on the Medicaid Evaluation Summary Report for each evaluation. (See attached list of commonly used Evaluation CPT CODES.) **DO NOT ACCEPT** THE PRESCRIPTION UNLESS IT MEETS THE **NEW MEDICAID MANDATES** AS EXPLAINED BELOW.

A. **Speech Evaluation:** **Approved Medicaid Evaluator –** NYS licensed SLP and must have a **Medical Diagnosis or Purpose** for the evaluation

   You must complete this form on each and every Suffolk County Pre-School child that you evaluate. Retain in child's file until requested. **(The Revised Speech Referral/Recommendation for Evaluation/Services form is attached and must include the diagnosis/purpose)**

B. **Audiological Evaluation:** **Approved Medicaid Evaluator –** NYS licensed Audiologist who is also ASHA Certified. **You must obtain a prescription for each and every Suffolk County Pre-School child prior to the Audiological evaluation.** A Prescription must be signed by a Physician, Physician's Assistant or Nurse Practitioner and **include the diagnosis/purpose**. Retain in child's file until requested.

C. **Psychological Evaluation:** **Approved Medicaid Evaluator –** NYS licensed psychiatrist or a NYS licensed psychologist, whose credentials allow them to open a private practice in the community. **You will need a referral signed by an appropriate school official (copy of signed referral from CSE/CPSE to document that the evaluation was part of the IEP Process) it must include the diagnosis/purpose.** Retain in child's file until requested.

D. **Specialist Evaluation:** **Approved Medicaid Evaluator –** NYS licensed physician specialist, physician assistant, specialist assistant or nurse practitioner. (Neurological, Orthopedic, Psychiatric etc.). **You will need a referral by an appropriate school official (copy of signed referral from CSE/CPSE - to document that the evaluation was part of the IEP Process) must include the diagnosis/purpose OR prescription from Primary Care Practitioner that includes the diagnosis / purpose.** Retain in child's file until requested.

E. **Occupational Therapy or Physical Therapy Evaluation:** **Approved Medicaid Evaluator –** NYS licensed Physical Therapist (PT) graduated from a CAPTE accredited PT Education Program / NYS licensed Occupational Therapist (OT). A Prescription that **includes the diagnosis/purpose** must be signed by a Physician, Physician's Assistant or Nurse Practitioner. **You must obtain a prescription for each and every Suffolk County Pre-School child prior to the OT or PT evaluation.** Retain in child's file until requested. **(Clarification Pending)**

Please note: Occupational Therapy and/or Physical Therapy evaluations, updates will be sent once Medicaid Clarification is received.

If you have any questions, contact Rosemarie Pforr, Health Program Analyst, directly at 631-853-3195, or by fax at 631-853-2922 or via email: Rosemarie.Pforr@suffolkcountyny.gov

Suffolk County Department of Health - Office of Children with Special Needs

Preschool Special Education Program

Medicaid - E V A L U A T I O N S U M M A R Y

STUDENT INFORMATION **Parental Consent Attached** YES _____ NO _____

Last Name: _____ **First Name:** _____

Date of Birth: _____ **ICD9 Code:** _____ **School District:** _____

EVALUATION INFORMATION (*DO NOT ATTACH COPIES OF EVALUATIONS*):

A. **Audiological Evaluation - PRESCRIPTION MUST BE ATTACHED** — **CPT Code:**

Date completed: _____ Evaluator Name: _____

Title: _____ License #: _____

B. **Psychological Evaluation - Signed copy of the referral from CPSE or referral signed by other licensed practitioner acting within his/her scope of practice - MUST BE ATTACHED to document as part of the IEP Process** — **CPT Code:**

Evaluation Performed by (Check One):

☐ Licensed Psychologist ☐ School Psychologist Date completed: _____

Evaluator Name: _____ License / Certification #: _____

D. **Medical Evaluation (Complete Physical) copy of the referral from CPSE - MUST BE ATTACHED to document as part of the IEP process** — **CPT Code:**

Date completed: _____ Evaluator Name: _____

Title: _____ License #: _____

E. **Medical Specialist Evaluation - copy of referral from CPSE or Prescription from Primary Care Practitioner - MUST BE ATTACHED to document as part of the IEP process** — **CPT Code:**

Specify Type(s): _____(Neurological, Orthopedic, Psychiatric etc.)

Date completed: _____ Evaluator Name: _____

Title: _____ License #: _____

F. **Speech Evaluation - SPEECH REFERRAL or PRESCRIPTION MUST BE ATTACHED** — **CPT Code:**

Date completed: _____ Evaluator Name: _____

Title: _____ License #: _____ ASHA Cert # _____

G. **Occupational Therapy Evaluation - PRESCRIPTION MUST BE ATTACHED** — **CPT Code:**

Date completed: _____ Evaluator Name: _____

H. **Physical Therapy Evaluation - PRESCRIPTION MUST BE ATTACHED** — **CPT Code:**

Date completed: _____ Evaluator Name: _____

I hereby certify that the list of evaluations provided on this form is a true and accurate representation of the facts.

Print Agency Name **Signature and Title** **Date**

SCDHS Medicaid Eval 9-1-10

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, New York 11788

Speech Referral / Recommendation for Evaluation

A Speech and Language referral for an ☐ **evaluation** in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: _____

Date of Birth: _____

School District: _____

Provider: _____
(Service Provider Agency)

DIAGNOSIS / ICD9 Codes/
Or Purpose of Treatment or Evaluation_____

_____

_____ _____
Print Name and Title Signature (**Must be original signature**)

License Number: _____ Date Signed: _____

Expires: _____

Note: Medicaid requires that speech evaluations and services be recommended by a NYS Licensed Speech Pathologist, Physician, Physician's Assistant or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, New York 11788

Psychological Counseling Referral for Evaluation / Services

A referral for psychological ☐ **evaluation** and / or psychological counseling ☐ **services** is recommended in accordance with the request by the Committee on Pre-School Special Education.

Services, when provided, will be in accordance with the Individualized Education Program designed by the Committee.

Student Name: _____

Date of Birth: _____

School District: _____

Provider: _____
(Service Provider Agency)

DIAGNOSIS / ICD9 Codes/
Or Purpose of Treatment or Evaluation_____

_____

_____ _____
Print Name and Title Signature (**Must be original signature**)

License Number (if applicable): _____

_____ _____
Title Date signed

Note: Medicaid requires that psychological counseling services be recommended by an appropriate school official , such as a school administrator or chairperson of the CPSE or other licensed practitioner acting within his or her scope of practice, on or before the start of services.

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, New York 11788

Medical Referral (Prescription) for Evaluation

Based on a review of the child's records, I am referring this child for the following evaluation(s):

Student's Name: _____ DOB: _____

School District:_____

Type Of Evaluation (Please check all that apply)
☐ Audiological ☐ Occupational Therapy ☐ Physical Therapy ☐ Other (please specify) _____

ICD9 code/Diagnosis/Purpose of Evaluation	

Physician/Physician's Assistant/Nurse Practitioner Information (please print or use stamp):

Name:	
Address:	
Title:	
Phone Number:	
License Number / NPI #:	

_____ _____
Signature of Physician/Physician's Assistant/Nurse Practitioner Date
(**Must be original signature**)

INSTRUCTIONS
SPEECH REQUIRING "UNDER THE DIRECTION OF"

Guidelines for submitting documentation for speech services provided by a Teacher of Speech & Hearing Handicapped (**TSHH)** being supervised by a Speech Language Pathologist **(SLP):**

These forms are to be attached to your normal 1st quarter submission for each and every Medicaid child you are servicing. (There are TWO forms due per child. Please put child's name at the Bottom of the Certification form.)

A. Speech "Under the Direction of" Certification form
B. Speech "Under the Direction of" Log

ADDITIONAL REQUIREMENTS FOR SPEECH "Under the Direction of": To meet the requirements for speech "under the direction of", the SLP must have initial and subsequent periodic face-to-face contact with each student that is being serviced by a Teacher of Speech and Hearing Handicapped. This face to face contact **MUST** take place within the first two weeks of start of service. Any services done prior to the initial face to face cannot be claimed for Medicaid reimbursement.

The SLP must be able to document that they provided this type of "supervision" through notes in accordance with the " Under the Direction of" guidelines (see attached) It is not good enough to say a SLP is doing "Under the direction of", the SLP must be able to document it. (i.e. phone logs, meetings, logs)

A. Assure the delivery of speech services in accordance with the IEP:

This can be done by having the SLP initial a copy of the IEP *or* sign a statement indicating that the IEP was reviewed; **and** sign the monthly service records.

B. Be available to the TSHH for assistance and consultation, but need not be on the premise 100 % of the time:

If contact is by phone, record the date and time of call, who the SLP talked to and the scope of the conversation.

If contact is through a meeting, provide the date, time, and attendees at the meeting; the minutes of the meeting should be signed and dated by the SLP and retained.

C. Review the progress notes prepared by the TSHH:

Sign or initial the progress notes or monthly statements of the students' whose progress notes were reviewed.

Speech services provided directly by a speech language pathologist are billable if the SLP is licensed with the NYS Office of Professionals. This license must be current; if it lapsed, the services will not be billable unless the SLP is co-supervised by a licensed SLP, just as if he/she were a TSHH.
A CFY must also to be supervised by a SLP.

If you have any questions, contact Rosemarie Pforr, Health Program Analyst, directly @ 631-853-3195 or Fax 631-853-2922 e-mail Rosemarie.Pforr@suffolkcountyny.gov

Regulations for Speech "Under the Direction of"

Speech services may be provided by a New York State Certified Teacher of the Speech and Hearing Handicapped. In order to claim Medicaid however, the speech services may only be provided by or under the direction of a New York State Licensed Speech-Language Pathologist. "Under the direction" is defined as follows:

"Under the direction of" means that speech-language pathology services may be provided by a teacher of the speech and hearing handicapped or a teacher of speech and language disabilities under the direction of a New York State licensed speech-language pathologist where appropriate, as defined in the New York State Social Services regulations, Chapter 11, Part 505.11. The speech-language pathologist providing the direction may be in the employ of the local school district/county or on a contractual basis.

Unless otherwise mandated by statute or regulation the speech-language pathologist providing direction must:

- Assure the delivery of speech-language pathology services as per the student's IEP

- SLP **MUST** have an initial and subsequent periodic face to face contact with each student that is being serviced by a TSHH "under the direction of".

- Assure that the services are medically appropriate. The New York State Social Services Law. Part 305(a) 2 governs medical necessity and allows payment through Medicaid for care, services or supplies which will either treat a disability or overcome a condition which interferes with the capacity for normal activity. (Part 305(a) 2 of NYSSI.)

- Be readily available, as needed, to the teacher of the speech and hearing handicapped for assistance and consultation but need not be on the premises; and

- Review periodic progress notes prepared by the teacher of speech and hearing handicapped, consult with the teacher and make recommendations, as appropriate.

DOCUMENTATION REQUIREMENTS FOR "UNDER THE DIRECTION OF"

- A Certification of Speech form is required by the Licensed Speech Pathologist that he/she is providing "Under the Direction" to the following Teachers of Speech and Hearing Handicapped and/or Teachers of Speech and Language Disabilities (List the teachers.)

- Speech "Under the Direction of" Log must be completed.

- In addition, the Licensed Speech Pathologist must have outlined the manner in which he/she will be accessible to the Teacher of the Speech and Hearing Handicapped and or the Teacher of Speech and Language Disabilities.
  Examples of this are:
  - √ Supervisory Log Notes
  - √ Initial and Subsequent periodic face to face contact with student
  - √ Weekly team meetings.
  - √ Access by telephone on a scheduled basis.
  - √ Individual meeting with teachers routinely or on request, or
  - √ Any other method where accessibility is demonstrated.

CERTIFICATION
OF SPEECH

UNDER THE DIRECTION AND ACCESSIBILITY

School District/Agency _____

I, _____, Licensed Speech-Language Pathologist, with current

License number_____, certify that I am providing "Under the Direction of" services to

the following Certified Teachers of the Speech and Hearing Handicapped (Therapist) for

the _____ - _____ school year:

Child's Name: _____ Date of Birth: _____

Name of TSHH	Certification Number

I am providing accessibility to the Teachers of the Speech and Hearing Handicapped in the following manner: (e.g. overlapping schedules, telephone, on-site)

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student** etc.)

_____ _____

Signature of Licensed Speech Language Pathologist **Date**

SPEECH "Under the Direction of" LOG

CHILD NAME _____ DOB_____ SCHOOL YEAR _____

SPEECH SERVICES MANDATED _____

ASSIGNED TSHH _____ CERTIFICATION # _____

SUPERVISING SLP _____ LICENSE # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	SLP & TSHH SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION – Face to Face with Child				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION – Face to Face with Child				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The supervising SLP **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH "under the direction of ". The SLP must have on file the manner in which he/she has provided supervision to the TSHH for each and every child being serviced.

INSTRUCTIONS
PHYSICAL THERAPY REQUIRING "UNDER THE DIRECTION OF"

Guidelines for submitting documentation for physical therapy services provided by a Physical Therapy Assistant (PTA) being supervised by a Physical Therapist:

A. Physical Therapy Assistants must work under the direction of a NYS Licensed Physical Therapist. A PT must co-sign all physical therapy service reports, record of related services log notes and quarterly progress notes. (In accordance with 42CFR 440.110(b) and applicable State and federal laws and regulations)

- **This direction shall be** on-site direction and not necessarily direct personal supervision, especially when the program is one of maintenance.

B. The PT ensures that individuals working under his or her direction have contact information to permit the assistant direct contact with the supervising therapist as necessary during course of treatment and keeps supporting documentation**.**

- **The PT sets all goals**, establishes the plan of care, and determines on an on-going basis whether a child is appropriate to receive services of a PTA, with joint visits of PT and PTA periodically.

- **The PT monitors** the need for continued services, spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice.

C. The PT must complete a Certification of Under the Direction for each PTA being supervised. An "Under the Direction of" (UDO) log must be used to record direct supervision of PTA. Note that it is child specific and must be prepared for each child. Keep all written documentation of such direction, including Certification and UDO Log. (See attached sample form and instructions.)

D. One PT can not supervise more than 4 PTAs (section 3738 a)

E. Providers must request a new prescription each year. RX must cover the summer as well as the school year, as appropriate.

Services are NOT to be provided without a prescription.

INSTRUCTIONS
OCCUPATIONAL THERAPY REQUIRING "UNDER THE DIRECTION OF"

Guidelines for submitting documentation for occupational therapy services provided by an Occupational Therapy Assistant (OTA) being supervised by an Occupational Therapist.

A. Occupational Therapy Assistants must work under the direction of a licensed Occupational Therapist. An OT must co-sign all occupational therapy service reports, record of related services log notes and quarterly progress notes. In accordance with 42CFR 440.110(b) and applicable State and federal laws and regulations

- **This direction shall be** on-site direction and not necessarily direct personal supervision, especially when the program is one of maintenance.

B. The OT ensures that individuals working under his or her direction have contact information to permit the assistant direct contact with the supervising therapist as necessary during course of treatment and keeps supporting documentation.

- **The OT and OTA** must provide an initial joint visit with the child and subsequent periodic face to face contact for each student being serviced by OTA.

- **The OT sets all goals,** establishes the plan of care, and determines on an on-going basis whether a child is appropriate to receive services of OTA, with joint visits of OT and OTA periodically.

- **The OT monitors** the need for continued services, spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice.

C. The OT must complete a Certification of Direction for each OTA being supervised. An "Under the Direction of" (UDO) log must be used to record direct supervision of OTA. Note that it is child specific and must be prepared for each child. Keep all written documentation of such supervision, including Certification and UDO Log. (See attached sample form and instructions.)

D. Providers must request a new prescription each year.

Services are NOT to be provided without a prescription.

CERTIFICATION
OF
OCCUPATIONAL AND PHYSICAL THERAPY

SUPERVISION AND ACCESSIBILITY

School District/Agency _____

I, _____, licensed ☐ Occupational Therapist or

☐ Physical Therapist with current license number _____ certify that

I am providing supervision to the following Occupational Therapy Assistant or Physical Therapy Assistant for the _____ - _____ school year:

Child's Name: _____ Date of Birth: _____

Name of OTA /PTA	License #

I am providing supervision and accessibility in the following manner:

- Participate in the development of the child's IEP program, signing and dating the treatment plan.
- Monitor the mandated delivery of OT services.
- Be readily available to the OTA/PTA for assistance and consultation, thru phone, email or fax.
- Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA with each student in the provision of services.
- Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA thru regular monthly meetings and make recommendations, as appropriate.
- Review service sheets used for Medicaid billing.

I will keep the appropriate records documenting that supervision activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)

_____ _____

Signature of Licensed Occupational/Physical Therapist **Date**

OCCUPATIONAL / PHYSICAL THERAPY "Under the Direction of" LOG

CHILD NAME _____ DOB _____ SCHOOL YEAR _____

AGENCY_____ **OT / PT** SERVICES MANDATED _____

ASSIGNED **OTA / PTA** _____ LICENSE # _____

SUPERVISING **OT / PT** _____ LICENSE # _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA / PTA)

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	OT / PT SIGNATURE OTA / PTA SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION - Face to Face with Child				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION - Face to Face with Child				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The supervising OTR / PT **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a OTA / PTA.

The **PT** must have on file the manner in which he/she has provided supervision to the PTA for each and every child being serviced. (One PT can not supervise more than four (4) PTA, per Article 136, section 3738 a.)

The **OT** must have on file the manner in which he/she has provided supervision to the OTA for each and every child being serviced. The supervision must be direct supervision.

INSTRUCTIONS
SKILLED NURSING REQUIRING "UNDER THE DIRECTION OF"

Skilled Nursing Services must be provided by:

- **NYS Licensed Registered Nurse** qualified in accordance with the requirements of 42 CFR46a400 and other applicable state and federal laws and regulations acting within his or her scope of practice.

- **NYS Licensed Practical Nurse** qualified in accordance with 42 CFR46a400 and other applicable state and federal law or regulations acting within his or her scope of practice **"under the direction of "**a **Licensed Registered Nurse** a **Physician,** or other licensed health care provider authorized under the Nurse Practice Act.

A. Please attach a copy of the prescription and detailed treatment plan to your 1st quarter's report. All skilled nursing services must be provided in accordance with the Nurse Practice Act. Providers must request a new prescription each year.

Services are NOT to be provided without a prescription.

B. **Skilled nursing services** may include health assessments, medical treatments and procedures, administering and/or monitoring medication needed by the child during school hours and consultation with licensed physicians, parents and regarding the effects of medication.

C. **An individualized Health Care Plan** should be maintained, when appropriate, for the student receiving the Nursing Services signed by a Registered Nurse (RN). Nursing notes should be prepared in accordance with the Nurse Practice Act. Medication/treatment log must be maintained and signed by Nurse providing services.

- Health History Must be on file.

- Medication Log must be maintained

- Written protocols for each procedure should be available when appropriate

- Recorded documentation of Nursing services delivered and dates of service signed and dated by RN.

D. **"Under the Direction of "**means that the **Licensed Registered Nurse, Physician** or other **Licensed Health Care Provider** authorized under the Nurse Practice Act sees the child at the beginning of and periodically during the course of treatment.

- The Supervising RN must co-sign all Nursing reports, daily treatment logs and quarterly progress notes. In accordance with 42CFR 440.110(b) and applicable State and federal laws and regulations.

- The **Supervisor** ensures that **LPN** working under his or her direction has contact information to permit him or her direct contact with the **Supervisor** as necessary during course of treatment and keeps supporting documentation.

- **Supervisor** is familiar with the treatment plan as recommended by the referring Physician or other Licensed Practitioner practicing under State law.

- **Supervisor** has continued involvement in the care provided and reviews the need for continued services throughout treatment.

- **Supervisor** assumes professional responsibility for the services provided under his or her direction and spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice. Maintains documentation supporting the supervision of services and on going involvement in treatment.

- The **Supervisor** must complete a Certification of "Under the Direction of" (UDO) for each LPN being supervised. An "Under the Direction of" (UDO) Log must be used to record direct supervision of LPN. Note that it is child specific and must be prepared for each child. Keep all written documentation of such supervision, including Certification and "UDO" Log. (See attached sample forms and instructions.)

CERTIFICATION

OF

SKILLED NURSING SERVICES

UNDER THE DIRECTION AND ACCESSIBILITY

I, _____, **Licensed Registered Nurse (RN)**, with current license number _____ certify that I am providing "Under the Direction of" services to the following Licensed Practical Nurse (LPN) for the _____ - _____ school year:

Child's Name: _____ Date of Birth: _____

Name of LPN	License Number

I am providing accessibility to the Licensed Practical Nurse in the following manner:

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Direction of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

_____ _____

Signature of Supervisor and Title **Date**

Skilled Nursing Services "Under the Direction of" LOG

CHILD NAME _____ DOB_____ SCHOOL YEAR _____

SKILLED NURSING SERVICES MANDATED _____

ASSIGNED LPN _____ LICENSE # _____

SUPERVISOR _____ TITLE & LICENSE # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	LPN SIGNATURE/ RN SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION – Face to Face with Child				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION – Face to Face with Child				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an **LPN** "under the direction of ". The Supervisor **MUST** have on file the manner in which he/she has provided supervision to the **LPN** for each and every child being serviced.

INSTRUCTIONS
PSYCHOLOGICAL COUNSELING REQUIRING "UNDER THE SUPERVISION OF"

Psychological counseling services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological counseling services in the community.

A. Services may be provided by:

- NYS licensed and registered **Psychiatrist**
- NYS licensed and registered **Psychologist**
- NYS licensed **Clinical Social Worker – LCSW**

- NYS licensed **Master Social Worker – LMSW** – "Under the Supervision of" a NYS Licensed **Psychiatrist**, **Psychologist** or **LCSW**

B. The LMSW apprises the **Supervisor** of the diagnosis and treatment for each child.
The cases are discussed and supervisor provides oversight and guidance in diagnosing and treating child.
The **Supervisor** regularly reviews and evaluates the professional work of the **LMSW.**

C. **The Supervisor** provides at least one hour per week or two hours every other week of in person individual or group clinical supervision provided that at least two hours per month shall be individual clinical supervision.

D. The Supervisor must complete a Certification of Supervision for each LMSW being supervised.
An "Under the Supervision of" (USO) Log must be used to record direct supervision of LMSW.
Note that it is child specific and must be prepared for each child.
Keep all written documentation of such supervision, including Certification and USO Log.
(See Psychological Counseling "Under the Supervision" of section for detailed instructions.)

CERTIFICATION

OF
PSYCHOLOGICAL COUNSELING

UNDER THE SUPERVISION AND ACCESSIBILITY

I, _____, **Psychiatrist**, **Psychologist** or **LCSW**, with current license number _____ certify that I am providing "Under the Supervision of" services to the following Licensed Master Social Worker (LMSW) for the _____ - _____ school year:

Child's Name: _____ Date of Birth: _____

Name of LSMW	License Number

I am providing accessibility to the Licensed Master Social Worker in the following manner:

_____

_____

_____

I will keep the appropriate records documenting that the **"Under the Supervision of"** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student etc**.)

_____ _____

Signature of Supervisor and Title **Date**

Psychological Counseling "Under the Supervision of" LOG

CHILD NAME _____ DOB _____ SCHOOL YEAR _____

PSYCHOLOGICAL COUNSELING MANDATED _____

ASSIGNED LMSW _____ LICENSE # _____

SUPERVISOR _____ TITLE & LICENSE # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	LMSW SIGNATURE/ SUPERVISOR SIGNATURE
IEP REVIEW				
INITIAL OBSERVATION – Face to Face with Child				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
2nd OBSERVATION – Face to Face with Child				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
3rd OBSERVATION - Face to Face with Child				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
4th OBSERVATION - Face to Face with Child				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The Supervisor **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH "under the direction of ". The Supervisor **MUST** have on file the manner in which he/she has provided supervision to the **LMSW** for each and every child being serviced.

PARENTAL CONSENT INSTRUCTIONS

Annually, you must obtain a signed Parental Consent for *each and every Suffolk County Pre-School child* you service whether the child is Medicaid eligible or not.

Once you have obtained the signed parental consent form, please retain the original in the child's file.

You will receive a list of Medicaid Eligible children, which have been approved to receive services from your facility, from Suffolk County on a quarterly basis. We will request that you send us the proper documentation so that we may bill Medicaid for the services. Please include the parental consent form along with this documentation at that time.

If you have any questions contact:

Rosemarie Pforr, Health Program Analyst
Department of Health Services-Revenue Unit
225 Rabro Drive East, Hauppauge, NY 11788
Phone 631-853-3195 FAX 631-853-2922 E-Mail Rosemarie.Pforr@suffolkcountyny.gov

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, NY 11788

Dear Parent/ Guardian of _____:

*This is to ask your permission to bill Medicaid for Medicaid reimbursable services that are on your child's individualized education program (IEP). Schools in New York State routinely access Medicaid funding to help meet costs of providing special education services. Please **sign** below.*

I, _____ as the Parent / guardian of

_____ DOB _____,
(Print child's name)

give permission for the school district / municipality to use Medicaid to pay for special education services rendered on behalf of my child for all Medicaid eligible services listed on my child's IEP dated: _____.

I understand that the use of Medicaid insurance for special education services **will not** decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for other services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program and that I **will not** incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependent on my granting consent and that, regardless of my decision to provide this consent; all the required services on my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____ Date: _____

PS 6001 S Parental Consent – English - Spanish

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, NY 11788

Estimado padre/tutor de _____:

Por la presente le solicitamos su permiso (consentimiento) para facturar a Medicaid los servicios sujetos a reembolso que se incluyen en el programa personalizado de educación (IEP, por sus siglas en inglés) de su hijo. Por lo general, las escuelas del estado de Nueva York acceden al financiamiento de Medicaid para ayudar a cubrir los costos de ofrecer servicios de educación especial. Lea y confirme la siguiente información:

Yo, _____, como

padre/madre/tutor de _____, DOB _____
(Escribir el nombre del niño en letra de imprenta)

autorizo al distrito escolar / a la municipalidad para que usen Medicaid para pagar por los servicios de educación especial prestados a mi hijo para todos los servicios que reúnen los requisitos de Medicaid que aparecen en el IEP de mi hijo con fecha: _____.

Comprendo que el uso del seguro de Medicaid para los servicios de educación especial no disminuye la cobertura disponible de por vida, aumenta las primas ni resulta en la suspensión de los beneficios, ni tampoco obliga a mi familia a pagar otros servicios necesarios para mi hijo fuera de la escuela que de otro modo estarían cubiertos por el programa Medicaid, ni de otro modo disminuye los beneficios asegurados de mi familia conforme al programa Medicaid, y que no incurriré gastos de bolsillo, tales como el pago de un deducible o copago.

Doy mi consentimiento voluntariamente y comprendo que puedo retirar mi consentimiento en cualquier momento. También comprendo que el derecho de mi hijo a recibir educación pública gratuita adecuada (FAPE, por sus siglas en inglés) de ningún modo depende de mi consentimiento y que, independientemente de mi decisión de otorgar este consentimiento, todos los servicios necesarios que figuran en el IEP de mi hijo le serán provistos a mi hijo sin costo alguno para mí.

Firma del padre/madre/tutor: _____ Fecha: _____

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, NY 11788

MODÈL FÒM KONSANTMAN POU VOYE BÒDWO BA MEDICAID

Chè Paran/ Gadyen legal _____:

Nou ekri ou pou mande w pèmisyon (konsantman) pou voye bòdwo ba Medicaid pou sèvis ke Medicaid ranbouse ki sou pwogram edikasyon endividyèl (IEP) pitit ou. Lekòl ki nan Eta Nouyòk jwenn aksè regilye nan finansman Medicaid pou ede peye frè pou ofri sèvis edikasyon espesyal. Tanpri li e konfime enfòmasyon ki anba la yo:

Mwenmenm, _____ antan paran/gadyen

legal_____, Date of Birth _____
(Ekri Non timoun nan an lèt detache)

mwen bay pèmisyon pou distri lekòl la / minisipalite a itilize Medicaid pou peye pou sèvis edikasyon espesyal yo bay pitit mwen pou tout sèvis ki kalifye pou Medicaid ki endike nan IEP pitit mwen nan dat: _____.

Mwen rekonèt itilizasyon asirans Medicaid pou sèvis edikasyon espesyal p ap diminye pwoteksyon ki disponib alontèm, li p ap ogmante prim yo oswa li p ap lakòz benefis yo sispann, li p ap lakòz fanmi mwen peye pou lòt sèvis ki nesesè pou pitit mwen deyò lekòl ki ta garanti nan pwogram Medicaid oswa li p ap diminye benefis asirans fanmi mwen nan pwogram Medicaid epitou mwen p ap fè depans konplemantè tankou peman montan yon franchiz oswa kopeman.

Mwen bay konsantman mwen libelibè epi mwen rekonèt mwen ka anile konsantman mwen nenpòt lè. Mwen rekonèt tou dwa pitit mwen genyen pou jwenn edikasyon piblik apwopriye (FAPE) pa depann nan ankenn fason de si mwen bay konsantman mwen epitou, kèlkeswa desizyon mwen pran pou bay konsantman sa a, pitit mwen ap jwenn tout sèvis nesesè ki endike sou IEP li a san mwen pa peye.

Siyati Paran/Gadyen legal: _____ Date: _____

SUFFOLK COUNTY
DEPARTMENT OF HEALTH
DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
50 Laser Court, Hauppauge, NY 11788

Уважаемые родители / опекуны _____ !

Мы просим Вашего разрешения (согласия) на выставление программе Medicaid счетов за оказание Вашему ребенку услуг, предусмотренных его индивидуальной программой обучения (IEP) и подлежащих оплате из средств Medicaid. Доступ к средствам программы Medicaid является стандартной процедурой, которая помогает школам штата Нью-Йорк покрывать расходы по предоставлению специальных образовательных услуг. Пожалуйста, прочтите и подтвердите следующую информацию.

Я, _____ , являюсь родителем / опекуном

_____, DOB _____
(фамилия и имя ребенка печатными буквами),

и даю разрешение школьному округу / муниципалитету воспользоваться программой Medicaid для оплаты предоставляемых моему ребенку специальных образовательных услуг. Разрешение относится ко всем услугам, на которые мой ребенок имеет право по программе Medicaid, и которые перечислены в программе IEP моего ребенка от: _____ (дата).

Я понимаю, что использование страхования Medicaid для оплаты услуг специального образования не уменьшит предоставляемое пожизненное страховое покрытие, не увеличит страховые взносы, не приведет к прекращению предоставления льгот, не обяжет мою семью оплачивать другие услуги, необходимые моему ребенку вне школы, которые иначе покрывались бы программой Medicaid, и не уменьшит каким-либо иным способом страховые льготы, положенные моей семье по программе Medicaid. Я также понимаю, что я не понесу прямые расходы, такие как оплата франшизы или доплаты.

Я даю свое согласие добровольно и понимаю, что могу отозвать его в любое время. Я также понимаю, что право моего ребенка на получение надлежащего бесплатного государственного образования (FAPE) никоим образом не зависит от предоставления мной данного согласия, и что, независимо от моего решения в отношении предоставления данного согласия, все предусмотренные программой IEP моего ребенка услуги будут предоставлены ему бесплатно.

Подпись родителя/опекуна: _____ Дата: _____

PS 6001R Parental Consent – Medicaid, English –Russian