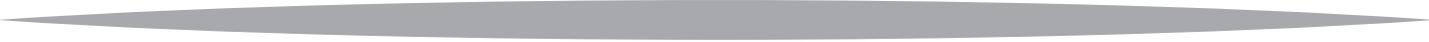


# **SCHOOL HEALTH SERVICES PROGRAM PROGRAM MANUAL**



## **SECTION 1 GENERAL INFORMATION**



## Section 1: General Information

The Colorado [School Health Services \(SHS\) Program](#) administered by the [Department of Health Care Policy and Financing \(the Department\)](#) allows school districts and Boards of Cooperative Educational Services (BOCES), herein referred to as “district,” to access federal Medicaid funds for delivering Medicaid allowable school health services to Medicaid eligible children. Districts may also receive federal funding through the Medicaid Administrative Claiming (MAC) component for performing administrative activities which include service coordination, outreach, enrollment and administrative functions that support the Medicaid program. Reimbursement received by a district through the SHS Program shall be used by the district to provide additional and expanded health services.

The SHS Program serves clients up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Services Plan (IFSP). School health services provided through the SHS Program must be medically necessary (defined in [Section 1.2](#)) and prescribed in the client’s IEP or IFSP.

### 1.1 Client Eligibility and Requirements

To be eligible for SHS Program benefits, the client must meet all of the following criteria:

1. Enrolled in Medicaid;
2. Enrolled in a public school or a participating district or BOCES;
3. Under the age of 21;
4. Has a disability or is considered medically at risk; and
5. Received a referral for school health services according to an IEP or IFSP.

Districts participating in the SHS Program can verify client Medicaid eligibility through one of three electronic methods:

1. Colorado’s Web Portal
2. Fax-Back: 1-800-493-0920
3. Client Medicaid Eligibility Response System (CMERS): 1-800-237-0044

Information regarding the Web Portal can be found at:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542697178>

Instructions on how to use the Fax-Back and CMERS systems can be found at:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542320888>

### 1.2 Medical Necessity Criteria

School health services provided to the client shall be medically necessary. A medically necessary service is:

1. Reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability;

2. Intended when there is no other equally effective or substantially less costly course of treatment suitable for the child's needs;
3. Determined as the result of a service furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, by a qualified health professional operating within the scope of his/her practice; and
4. Referred by a physician or qualified licensed practitioner of the healing arts.

### **1.3 Overview of Covered Services**

School health services include the following services:

- Physician
- Nursing
- Personal Care
- Psychology, Counseling and Social Work
- Orientation and Mobility
- Speech, Language and Hearing
- Occupational Therapy
- Physical Therapy
- Specialized Transportation
- Targeted Case Management (TCM)

### **1.4 Service Expectations and Requirements**

School health services may be performed in the school, at the client's home or at another site in the community by a Qualified Personnel or a Qualified Health Care Professional. A Qualified Personnel is an individual who meets the [Colorado Department of Education \(CDE\)](#) recognized certification, licensing, registration or other comparable requirements of the profession in which they practice.

A Qualified Health Care Professional is an individual who is registered, certified or licensed by the [Colorado Department of Regulatory Agencies \(DORA\)](#) as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional must be registered or certified by the relevant national professional health organization and must be allowed to practice if the provider is qualified per State law.

Refer to [Appendix A.2](#) for provider qualifications and credentials associated with each type of service.

In order to claim for a school health service, the district must ensure that the service is prescribed in the client's current IEP or IFSP and includes the following level of detail for each service:

- Authorization by a physician or licensed practitioner of the healing arts (updated annually)
- Service Location
- Amount, Frequency and Duration

- Annual Goals and Short-Term Objectives
- Progress Reports
- TCM Care Plan - for TCM Services
- Health Plan - for Nursing Services
- Specialized Transportation Designation - for Transportation Services

In addition, the district must retain service logs, clinical notes, attendance records, transportation logs and other relevant documentation that support claims for Medicaid school health services, including the following details:

- Date of Service
- Service Provided
- Provider Type
- Location

The SHS Program adheres to the [Centers for Medicare and Medicaid Services \(CMS\)](#) Healthcare Common Procedural Coding System (HCPCS) to identify Medicaid services and the *Physicians' Current Procedural Terminology* (CPT) manual for procedure codes. Annually, the Department publishes a procedure code specific rate schedule.

**Section 2** outlines the procedure codes and descriptions for school health services. Some codes represent a treatment session without regard to its length of time, so each code is correctly billed as one session or one billable unit. Billing greater than one unit is incorrect. Other codes that specify a unit of time should be billed incrementally as timed units; service times are based on the time it generally takes to provide the service. If the procedure code specifies "up to 15 minutes", the service may be billed in a unit of time from 1 to 15 minutes. If the procedure code specifies a unit of time "per 15 minutes", the code may be billed when the service time equals the specified unit of time.

### **1.5 Coordination of Care**

Coordination of care shall occur to ensure there is not duplication of services or activities being provided to a client.

- The participating district shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.
- The participating district shall refer clients to their primary care provider, health maintenance organization or managed care provider for further diagnosis and treatment that may be identified as the result of an EPSDT screen or service.
- When the client is receiving Medicaid services from other health care providers and the participating district, the participating district shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client, or the district shall show cause as to why coordination did not occur.
- When the client of the targeted population is receiving case management services from another provider agency as the result of being a member of other covered targeted groups, the participating district shall ensure that case management activities are coordinated to avoid unnecessary duplication of Medicaid services.

- The participating district shall inform a family receiving case management services from more than one provider that the family may choose one lead case manager to facilitate coordination.
- The participating district shall complete and submit to the Department for approval a Care Coordination Plan for the delivery of TCM services. The participating district shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the Care Coordination Plan.
- Included in the Care Coordination Plan shall be the provision for coordination of benefits and case management across multiple providers to:
  1. Achieve service integration, monitoring and advocacy.
  2. Provide needed medical, social, educational and other services.
  3. Ensure that services effectively complement one another.
  4. Prevent duplication of Medicaid services.