SECTION IX: ADDENDA

Addendum A: Rhode Island General Law 40-8-18

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ADDENDUM A
RHODE ISLAND GENERAL LAW 40-8-18

§ 40-8-18 Local Education Agencies as EPSDT providers. – (a) It is the intent of this section to provide reimbursement for early and periodic screening, diagnosis and treatment (EPSDT) services through local education agencies for children who are eligible for medical assistance. A local education agency's participation as an EPSDT provider is voluntary. Further, it is the intent that collaboration among the department of human services (DHS), the department of elementary and secondary education and local education agencies (LEAs) will result in state and local funds being used to maximize federal funding for such EPSDT services.

(b) The services available to eligible children under Title XIX of the Social Security Act for early and periodic screening, diagnosis and treatment (EPSDT) may be provided by local education agencies.

(c) Voluntary participation as an EPSDT provider shall require the local education agency to provide the state match to obtain federal financial participation for EPSDT services and associated administrative costs by certifying to the department of human services that sufficient qualifying local funds (local certified match) have been expended for such services and administrative costs; provided, however, that a local education agency shall not be required to provide local certified match for those EPSDT services for which the department of human services, or another state agency, agrees to provide the state match to obtain federal financial participation for EPSDT services.

(2) The local certified match shall be established in the local education agency pursuant to federal Title XIX provisions. Failure of the local education agency to provide the local match shall result in the penalties described in subsection (f).

(3) The department of human services shall pay the local education agency from the federal matching funds for EPSDT services pursuant to fee schedules established by rules and regulations of the department of human services, and for associated administrative costs pursuant to administrative cost reimbursement methodologies to be approved by the federal government, upon certification of the local match by the local education agency in accordance with federal Title XIX provisions. Payments made to the local education agency pursuant to this section shall be used solely for educational purposes and shall not be made available to local communities for purposes other than education. The local fiscal effort to support education referred to in subsection (d) herein shall not be reduced in response to the availability of these federal financial participation funds to the local education agency. These federal financial participation funds must supplement, not supplant, local maintained fiscal effort to support education.

(4) For the purposes of this subsection, the term local education agency shall include any city, town, state or regional school district or the school for the deaf or the William M. Davies, Jr. career and technical high school, the Metropolitan Career and Technical Center, any public charter school established pursuant to chapter 77 of title 16 of the general laws, any educational collaborative established pursuant to chapter 3.1 of title 16 of the general laws, or the department for children, youth, and families (DCYF).

(d) Each community shall maintain local fiscal effort for education. For the purpose of this subsection, to "maintain local fiscal effort" means each community shall contribute local funds to its school committee in an amount not less than its local contribution for schools in the previous fiscal year.

(2) Further, state support for education shall not be reduced from the prior fiscal year in response to local community participation in the EPSDT program.

(e) The department of human services and the department of elementary and secondary education shall effect the interagency transfers necessary to comply with the provisions of this section. The department of elementary and secondary education and the department of human services are authorized to promulgate any and all regulations necessary to implement this section. All local school agencies becoming EPSDT providers shall be required to comply with all provisions of Title XIX, 42 U.S.C. § 1396 et seq., of the Social Security Act relative to responsibilities of a Medicaid provider.

(f) Failure of the local education agency to establish a local certified match under this law sufficient to support its claims for reimbursement of EPSDT services and associated administrative costs will result in the withholding of state funds due that community in accordance with § 16-7-31 in an amount equal to the federal financial participation funds denied by the federal government as a result thereof. The withheld funds will be transferred to the department of human services.

(g) The department of human services with the aid of the department of education shall determine which health care related services are eligible for federal Medicaid reimbursement for health related services provided by local education agencies to children eligible for early periodic screening diagnosis and treatment. The department of human services, with the assistance of the department of administration, shall also develop the following resources in furtherance of the goal of recouping the maximum amount of administrative costs associated with such services;

(1) A time study training manual, which outlines how to complete a time study by school personnel to enhance recovery of administrative costs;

(2) A claiming manual, which outlines the financial information and claim submission requirements that are needed to complete the claim.

ADDENDUM B
DHS OFFICES

If you live in…		Local DHS Office Location	Phone Number/Fax
Coventry Cranston West Greenwich West Warwick		**Cranston DHS** Forand Building 600 New London Ave. Cranston 02920	462-6500 Fax # 462-6504
Foster Scituate Johnston North Providence		**Johnston DHS** 1514 Atwood Ave Johnston 02919	222-5666 Fax # 222-5684
Jamestown Middletown Portsmouth	Newport Little Compton Tiverton	**DHS Family Center** 110 Enterprise Drive Middletown 02842	849-6000 800-675-9397 Fax # 849-9066
East Greenwich North Kingstown Narragansett South Kingstown Exeter Charlestown Hopkinton		**North Kingstown DHS** 7734 Post Road North Kingstown 02852 Richmond Westerly New Shoreham	267-1030 800-862-0222 Fax # 267-1040
Central Falls Barrington Bristol East Providence Pawtucket Warren		**Pawtucket DHS** 24 Commerce Street Pawtucket, RI 02860	729-5400 Fax # 729-8756
Providence		**Providence DHS** 206 Elmwood Avenue Providence, RI 02907	222-7000 TTY 222-7032 Fax # 521-4875
Warwick		**Warwick DHS** 100 Meadow Street Warwick, RI 02888	736-6511 Fax # 737-6557
Glocester Smithfield North Smithfield Woonsocket Cumberland Lincoln	 Burrillville	**Woonsocket DHS** 450 Clinton Street Woonsocket, RI 02895	235-6300 800-510-6988 TTY 235-6490 Fax # 235-6303

ADDENDUM C
SOCIAL SECURITY ADMINISTRATION

Regional Social Security Offices process eligibility for Supplemental Security Income (SSI). SSI is a program that entitles eligible recipients for medical assistance benefits and a monthly cash benefit. There are income as well as disability criteria that an individual needs to meet in order to be determined eligible for these benefits. To find out more information about the Social Security Administration or to start an application for SSI, contact the following:

- Social Security Administration Web site: www.ssa.gov
- Telephone
  - Call toll free number 1-800-772-1213
  - Call toll-free TTY number, 1-800-325-0778
  - Call local office below

Social Security operates its toll-free telephone listed above from 7:00AM to 7:00PM, Monday through Friday. If you have touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. A service option includes identifying and receiving directions to your local SSA office by entering your zip code. People who are deaf or hard of hearing may call the toll-free TTY number listed above between 7:00AM and 7:00PM on Monday through Friday. It is recommended that you have your social security number handy when you call.

Local Offices:

You may call the 1-800-772-1213 toll free number or you may contact the local Social Security Office representing your town. All of the offices listed below are open for business Monday-Friday from 9:00 AM-4:00 PM.

130 Bellevue Avenue
Newport RI 02840
(401) 849-3487

55 Broad Street
Pawtucket RI 02860
(401) 724-9611

2168 Diamond Hill Road
Woonsocket RI 02895
(401) 766-8423

380 Westminster Street
Room 318
Providence RI 02903
(401) 528-4501

30 Quaker Lane
1st Floor
Warwick RI 02886-0111
(401) 822-1463

2 Shaws Cove
Room 203
New London CT 06320
(860) 443-8455

Procedure Codes/MOD	Services	Units Correct	*Diagnosis Code	*IEP	Parental Consent	*Procedure/Activity Note	*Progress Notes	*Provider/Service Logs	*Attendance	*Cert./Lic	*Evaluation	*IHP	*Treatment Plan	*Tuition Rate
	Physical Therapy Services													
97001	**Physical Therapy Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
97110 - GP	**Ind. P.T. W/Licensed PT**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97530 - HM, GP	**Ind. P.T. Program**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97150 - GP	**P.T. Program - Group**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
	Occupational Therapy Services													
97003	**Occupational Therapy Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
97110- GO	**Ind. O.T. W/Licensed O.T.**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97530 - HM, GO	**Ind. O.T Program**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
97150 - GO	**O.T. Program - Group**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
	Speech, Hearing, Lang., Services													
92506	**Speech, Hearing, Lang., Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
92507 -GN	**Ind. S.H.L. w/Speech Lang. Pathologist**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92507	**Ind. S.H.L. Program**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
92508	**S.H.L. Program/Group**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
	Evaluation Services													
90802	**Psychiatric Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A
H0031 -AH	**Psychological Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A
H0031 -AJ	**Social Worker Evaluation**	Y	Y-except for initial	Y-except for initial	y	N/A	N/A	N/A	Y	Y	Y	N/A	N/A	N/A

Procedure Codes/MOD	Services	Units Correct	*Diagnosis Code	*IEP	Parental Consent	*Procedure/Activity Note	*Progress Notes	*Provider/Service Logs	*Attendance	*Cert./Lic	*Evaluation	*IHP	*Treatment Plan	*Tuition Rate
	Counseling Services													
H0004	**Psychiatric Counseling**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
H0004 - AH	**Psychological Counseling**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
H0004 - AJ	**Social Worker Counseling**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
96153	**Counseling Services - Group**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A
	Expanded Behavioral Health Counseling Services													
H0004 - HA	**Psychiatric Counseling**	Y	V705	N/A	y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A
H0004 - AH HA	**Psychological Counseling**	Y	V705	N/A	y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A
H0004 -AJ HA	**Social Worker Counseling**	Y	V705	N/A	y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A
96153 - HA	**Counseling Services - Group**	Y	V705	N/A	y	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A
	Other Services													
T1002	**Nursing Services**	Y	per Spec Ed Census	Y	y	Y	Y	Y	Y	Y	N/A	Y	N/A	N/A
T2003	**Transportation**	Y	per Spec Ed Census	Y	y	N/A	N/A	Y	Y	Y	N/A	N/A	N/A	N/A
X0215	**Case Mgt**	Y	per Spec Ed Census	Y	y	Y	N/A	Y	N/A	Y	N/A	N/A	N/A	N/A
S5125	**Personal Care**	Y	per Spec Ed Census	Y	y	Y	N/A	Y	Y	Y	N/A	N/A	N/A	N/A
E1399	**Assistive Technology Device**	Y	per Spec Ed Census	Y	y	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
97535	**Assistive Technology Service**	Y	per Spec Ed Census	Y	y	Y - except for AT eval	N/A	N/A	Y	Y- if applicable	Y- if applicable	N/A	N/A	N/A
T2048	**Residential Placement Less Education & R. & B.**	Y	per Spec Ed Census	Y	y	N/A	Y	N/A	Y	Y	N/A	N/A	N/A	Y
H2018	**Day Program Services**	Y	per Spec Ed Census	Y	y	N/A	Y	N/A	Y	Y	N/A	N/A	N/A	Y
T1023	**Child Outreach Screening**	Y	V705	N/A	y	N/A	N/A	N/A	N/A	N/A	completed screening	N/A	N/A	N/A
T1023 - TS	**Child Outreach Re-screening**	Y	V705	N/A	y	N/A	N/A	N/A	N/A	N/A	completed screening	N/A	N/A	N/A

ADDENDUM D:
QUALITY ASSURANCE TEMPLATE

1. CONTACT PERSON: Who in the school/district/region should be the contact person for DHS/RIDE on Medicaid reimbursement notices, bulletins, questions, etc? List name, title, address, phone and email information. (Please note that the superintendent is always copied on any correspondence.)

2. RESPONSIBILITY FOR DOCUMENTATION: Who in the school/district/region is responsible for the maintenance of the Medicaid documentation required for each service submitted, as referenced on the "Medicaid Self-Audit Matrix" Please list name, title, address, phone and email information.

3. REPORTING: Who in the district is responsible for compiling the "Certification of Funds Letter" (as described in the *Medicaid Direct Services Guidebook for Local Education Agencies*) that is sent to DHS quarterly?

4. IEP: Once an IEP is in place, how does your district determine if any of the services in the IEP are eligible for Medicaid reimbursement? How is this documented and how are those services billed? Is IEP current, complete and are all services listed? List the policies & procedures that you have in place to address appropriate documentation.

5. BILLING PRACTICES: Please describe your district's Medicaid billing process, beginning with the point of service and ending with the reconciliation of the EDS remittance advice. Describe in detail the business practices that the district will implement to assure appropriate documentation.

6. ATTENDANCE RECORDS: Since assuring accurate attendance records is a major purpose in an audit, please describe your district's practice for ensuring that a service billed for a specific claim is supported by attendance records, including late/early dismissals or arrivals.

7. DOCUMENTATION AVAILABILITY AND ACCESSIBILITY: For each item listed on the first row of the "Medicaid Self-Audit Matrix" (attached), please describe your district's practices to ensure legibility of records, personnel knowledge of record storage area(s), accessibility to storage area(s), and length of storage. If your Medicaid billing is regionalized, you must be certain that the documents are accessible for an auditor. (Medicaid records must be legible, stored for seven years, and be accessible in the event of an audit.)

8. QUALITY ASSURANCE: Districts should conduct routine reviews as a method of ensuring adequate internal controls. For each item listed below, please describe the frequency and responsible party for these reviews:

Regularly scheduled reviews performed to verify completeness and correctness of:	**Performed by (name, title, contact information)**	**Frequency and Dates**
Attendance records		
Diagnosis codes		
Activity notes		
Progress notes		
Provider/Service logs		
Provider Certification/Licensure		
Transportation logs		
Treatment plan		
EDS remittance advice		

Addendum D: Sample On-Site Technical Review Tool

2008 LEA On-Site File Reviews

LEA Reviews:

Date:

Staff Present:

						1	2	3	4	5	6	7	8	9	10	11	12	13	14		
#	Demographic Information			Procedure Codes/MOD	Units Billed	Units Correct	Diag	IEP	Parental Consent	Procedure/ Activity Note	Progress Notes	Provider/ Service Logs	Attendance	Cert./Lic Present	Cert./Lic Checked	Evaluation	IHP	Treatment Plan	Tuition Rate	Score ___ / ___	Notes
Record	Student Name	MID	Service Date			Y/N	Y/N/NA	Y/N/NA	Y/N/NA (2007 - Checked but not scored)	Y/N/NA	Y/N/NA	Y/N/NA	Y/N	Y/N	Y/N	Y/N/NA	Y/N/NA	Y/N/NA	Y/N/NA	P/F/NA	
1																					
2																					
3																					
4																					
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17																					
18																					

Glossary Terms

Units Correct	The number of service units submitted for payment (documented on service log) should be checked for accuracy against the number of service units actually payed (detailed on Remittance Advice)
Diagnosis Code	A medical diagnosis is necessary for billing the Medicaid program. The student's primary special education disability reported to RIDE in the census for Special Education should be used for all reimbursment. This is true even if the diagnosis on the claim form does not seem directly related to the service being provided so long as the service being provided is clearly defined in the child's Individualized Education Program.
IEP	All services must be provided in accordance with a valid Individual Education Program. IEPs must conform to all requirements of Individuals with Disabilities Education Act (IDEA) and RI state regulations governing special education.
Procedure/Activity Note	The provider should write a description of the service provided to the child on that date. Providers should use their professional judgment to create a brief note that adequately documents the nature/extent of the service provided. The documentation of each medical encounter with the student should include or provide reference to: the reason for the encounter, and as appropriate, relevant history; and current status, as it relates to the therapy/service being provided.
Progress Notes	The inclusion of a progress note is imperative to document the medical necessity of the service provided and billed to Medicaid. **The state Medicaid agency is only permitted to pay for services that are medically necessary**. If the progress note required by the Department of Education captures the medical necessity and progress of this child, it may be used for Medicaid service description purposes. **If the progress note does not capture the medical necessity and progress of the student, it is essential that the provider compose a separate progress note documenting the child's**
Provider/Service Logs	Refer to Addendum H of the Guidebook. The provider/service log captures the basic components needed to create a claim for Medicaid reimbursement. There are other documentation requirements needed to ensure this is a viable claim, e.g. progress notes, procedure/activity notes, attendance, cert./lic. etc. (who, what, when, where, how long) *Evaluation services - 1 unit equals the completed evaluation, therefore, the provider log is not applicable.
Attendance	Attendance records must be maintained and indicate that a student is present on date of service, exceptions may include evaluations provided off-site.
Certif./Licensures	A valid copy of/or original certification/licensure of all providers (contracted/employees) must be accessible at all times. It is recommended that LEA's maintain an annual file with copies of staff certification/licensure of all contracted employees, who's services are submitted for Medicaid reimbursement.
Evaluation	Evaluation services include administering psychological and educational tests, interpreting assessment results; obtaining, integrating , and interpreting information about students behavior and conditions related to learning; planning and managing a program of psychological services, including psychological counseling for children; assisting in developing positive behavioral intervention strategies as they relate to the child's learning.
Individualized Health Care Plan (IHCP)	A comprehensive plan for care of children with special health care needs developed by the certified school nurse teacher in collaboration with the student, parents/guardians, school staff, community, and health care provider(s), as appropriate.
Certif./Licensures Check	All DOH licensures are subject to suspensions, restrictions or revocation. Districts should check all provider licensures against the DOH licensure verification website at http://www.health.state.ri.us/hsr/professions/license.php to ensure validity .
Treatment Plan	A treatment plan is required for Expanded Behavioral Health claims. Refer to Addendum K in the Guidebook for specific documentation requirements.
Tuition Rates	The tuition rates for day and residential programs **must** be broken down into daily treatment, education, room, and costs, as appropriate.

ADDENDUM E:
ELECTRONIC TRADING PARTNER AGREEMENT

Based on the following recitals. The Rhode Island Department of Human Services (hereinafter referred to as "DHS") it's fiscal agent, Electronic Data Systems (hereinafter referred to as "EDS"), and

_____

(Provider's Full Name)

(hereinafter referred to as "the Trading Partner"), enter into this Agreement to facilitate business transactions ("Transactions") by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents and to assure that such Transactions are not legally invalid or unenforceable as result of this use of available electronic technologies for the mutual benefit of the Trading partners.

ARTICLE I - PURPOSE

1.0 EDS has developed, under the state of Rhode Island Medical Assistance Program, a paperless transaction system that will process Rhode Island Medical Assistance Program electronic transactions submitted through the designated electronic media.

1.2 EDS is the fiscal agent for DHS and the State of Rhode Island Medical Assistance Program. Although EDS operates the computer systems through which electronic transactions flow, DHS retains ownership of the data itself. Trading Partners access the pipeline network over which the transmission electronic data occurs. Accordingly, providers are required to transport data to and from EDS. Additionally, contracted vendors and/or billing services must identify the providers they represent so that proper reporting of claims processing may occur.

1.3 This agreement delineates the responsibilities of EDS and its Trading partners in regard to the Rhode Island Medical Assistance Program.

ARTICLE II - PARTIES

2.0 **STATE OF RHODE ISLAND DEPARTMENT OF HUMAN SERVICES**
600 New London Avenue
Cranston, RI 02920

2.1 **ELECTRONIC DATA SYSTEMS CORPORATION**
171 Service Ave. Bldg. 1 Suite 100
Warwick, RI 02886

2.2 **TRADING PARTNER**

Name:_____

Address: _____

_____

Contact Name: _____

Phone Number:_____

Email address: _____

NPI/MA Provider Number: _____
Please list which number (can be both) you would like linked to your Trading Partner Number

ARTICLE III - GENERAL PROVISIONS

3.0 Prerequisites

Document Standards. Each party may electronically transmit to or receive from the other party any of the transaction sets listed in this Electronic Trading Partner Agreement (TPA), and transaction sets which the parties, by written amendment agree to add to this TPA. Electronic transmission of all data ("Documents") shall be in strict accordance with the standards set forth in this TPA and as defined by the Health Insurance Portability and Accountability Act (HIPAA)

3.1 Third Party Service Providers

3.1.1 Documents will be transmitted electronically to each party either directly or through a contracted third-party service provider. Either party may modify its election to use, not use or change a third-party service provider upon prior written notice to the other party to this TPA.

3.1.2 Each party shall be responsible for the costs of any third party service provider with which it contracts, unless otherwise set forth in this TPA.

3.2 Security Procedures

Each party shall properly institute and adhere to those security procedures including any special security procedures specified in this TPA, which are reasonably calculated to provide appropriate levels of security for the authorized transmission of documents and to protect its business records and data from improper access.

3.3 **Termination**

This TPA shall remain in effect until terminated by either by DHS or the Trading Partner with not less than thirty (30) days prior written notice to the other party. Such notice shall specify the effective date of termination and shall not affect the respective obligations or rights of the parties arising prior to the effective date of termination. If EDS determines that the submission of documents fails to conform to the paperless transactions specifications agreed to within thus TPA or relevant guidelines governing the submission of electronic transactions then EDS may, with the approval of DHS, terminate this TPA five (5) business days after the Trading partner has received a written termination notice for EDS. Additionally, the TPA will be terminated, with the approval of the State of Rhode Island, if any of the following events occur:

a. The State of Rhode Island requests EDS to stop processing claims for the Trading Partner or its agent.

b. The contract between EDS and the State of Rhode Island expires or terminates.

3.4 **Modifications**

This TPA constitutes the entire agreement of the parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information and or documents, all of which are hereby incorporated by reference. Any change to this Agreement will be effective only when set forth in writing and executed by all parties.

ARTICLE IV - CONFIDENTIALITY, PRIVACY AND SECURITY

4.0 EDS and the Trading Partner will conform with all appropriate federal and state laws and regulations pertaining to the confidentiality, privacy, and security applicable to each party.

4.1 The Trading Partner agrees to safeguard all DHS information within its possession, whether verbal, written, or otherwise, received from EDS, or acquired by the Trading partner in performance of this TAP, recognizing all such information as privileged. The use or disclosure of information concerning Rhode Island Medicaid beneficiaries shall be limited to purposes directly connected with the administration of the Rhode Island Medical Assistance Program.

ARICLE V - SUBMITTED CHARGES

5.0 The Trading Partner attests that all services for which payment will be claimed shall be provided in accordance with all federal and state laws pertaining to the Rhode Island Medical Assistance Program.

5.1 The Trading partner agrees that any payments made in satisfaction of claims submitted electronically will be delivered from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution applicable under federal and state law.

5.2 The Trading partner shall allow EDS access to its claims data and shall make all reasonable efforts to ensure that authorized personnel will submit claims data. The Trading Partner also agrees to promptly notify DHS, through its agent EDS, any and all erroneous payments received by the Trading partner regardless of the reason for such erroneous payments, and to promptly refund the subject erroneous payments to EDS.

5.3 The Trading Partner understands that all other terms and conditions of participation as set forth in the Provider Agreement Form with the Rhode Island Medical Assistance program remain in effect and unchanged by this TPA.

5.4 EDS, as the DHS Fiscal Agent for the Rhode Island Medical Assistance Program, has been granted the authority to approve and enroll Trading Partners participating in the electronic transmission of documents.

ARTICLE VI - TESTING

6.1 Proof that transactions meet X12N 4010A standards is required prior to testing. Please submit documentation with this completed TPA.

Please check one:

	Pre-Certification	**Agency or Product Name:**
	Using Provider Electronic Solutions	EDS
	Certified by Independent Agency	
	Translator Compliance Check	
	Utilizing Certified Vendor/Clearing House	
	Other (Describe)	

ARTICLE VII - MEDICAL TRANSACTION STANDARDS

Rhode Island Medical Assistance Program Transaction Standards

Selected **ASC X 12N Version 4010A** standards include, as applicable, all data dictionaries, segment dictionaries and transmission controls referenced in those standards, but include only the Transaction Sets listed in the section below. The information provided will be utilized to route transactions to the Medicaid Management Information System and back to Trading Partner directories. Remittance files (835) and Pended Claims Reports (277) will be available only to one trading partner. If authorizing one Trading partner for claims submission and another for downloads each party must complete a separate TPA.

Check all that apply:

	837 Professional	277 Unsolicited Claim Status
	837 Institutional	997 Functional Acknowledgement
	837 Dental	835 Remittance Advice
	270 Eligibility Inquiry	271 Eligibility Response
	276 Claim Status Inquiry	NCPDP 1.1 Batch Pharmacy Claim Response
	NCPDP 5.1 Batch	

Specific Software:

	Software	**Vendor**
	Provider Electronic Solutions	EDS
	Other	

Method of Transmission: _____

Guidelines
HIPAA—Health Insurance Portability and Accountability Act. In the event of any conflict, HIPAA standards and Implementation Guides shall control.

Please list the name(s) and phone number(s) of person(s) authorized to resolve problems regarding electronic transmissions:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____
E-mail address

ARTICLE VIII - RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS

Please list the names and the RI Medical Assistance Program provider numbers of thos providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider please make copies of Article VIII.

* Please list which number (can be both) you would like linked to your Trading Partner Number

1. _____
NPI/Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

2. _____
NPI/Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

3. _____
NPI/Medical Assistance Provider Number

Provider Name: _____

Authorized Signature: _____

Date: _____

Trading partner Execution:
TRADING PARTNER

_____
Signed

_____
Name

_____
Title

_____

DONOT FAX

Please mail this certification to the Following Address:

EDS
Attn: EDI Coordinator
P.O. BOX 2010
Warwick, RI 02887-2010

ADDENDUM F 049 Linkage Forms

THE RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Dear Provider,

Thank you for your interest in the Rhode Island Medical Assistance Program. Enclosed are the forms and information necessary to enroll as a performing provider within an established group. Please send those that are marked mandatory for enrollment processing:

- Local Education Agency (LEA) Provider Linkage Form
- Current copy of your practice's form of licensure
- Provider Agreement and Addendums I & II
- NPI e-mail confirmation

Completed enrollment forms should be mailed to:

EDS
Provider Enrollment Unit
PO Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at **1-401-784-8100** for instate and long distance callers or 1-800-964-6211 for instate toll callers and border communities.

IMPORTANT NOTE: **Please DO NOT send any claims with your application.** Wait until you have received your provider number and a billing manual. If you are an out-of-state provider, wait for your provider number, manual and Prior Authorization before sending in any claims.

An incomplete application will be returned.

ADDENDUM F 049 Linkage Forms

LEA Enrollment Instructions

The following fields must be completed:

PROVIDER NAME: Enter your individual or facility name.

SERVICE LOCATION ADDRESS: Enter the complete physical address where service is being conducted.

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by CMS (Centers for Medicare/Medicaid. If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY (ies) – Enter the Taxonomies established by CMS

PROVIDER TYPE/SPECIALTY: Indicate the specific service you provide. e.g., MD –Psychiatrist; Therapist – Social Worker, Psychologist, etc. (Disregard if you provided your NPI & Taxonomy/ies)

PROVIDER PHONE NUMBER: Enter the area code and telephone number of the location where service is being conducted.

LICENSE NUMBER: If your are required to be licensed to provide services, enter your license or certification number. A copy of the current valid license or certification letter must be submitted with the application.

NATIONAL PROVIDER IDENTIFIER (NPI): Enter the NPI number established by CMS (Centers for Medicare/Medicaid) for the School department you are joining.

TAXONOMY (ies): Enter the Taxonomies established by CMS for the School department you are joining.

SCHOOL DEPT. NAME: Enter the name of the school department.

SCHOOL DEPT GROUP MA PROVIDER NUMBER: Enter the provider number(s).

SCHOOL DEPT. TAX IDENTIFICATION NUMBER: Enter the Federal Employer Identification Number (FEIN).

SCHOOL DEPT PAY TO ADDRESS: Enter the address where you want checks and/or Remittance Advice(s) sent.

SCHOOL DEPT MAIL TO ADDRESS: Enter the address where all other program information should be sent.

EFFECTIVE DATE: Enter the date you will begin servicing the students.

FAX NUMBER – Enter the office fax number

EMAIL ADDRESS – Enter the office email address for the actual provider (doctor) to receive future correspondences via email

PROVIDER SIGNATURE AND DATE: Application must be signed by the Individual Applicant along with the date of signature. Stamped or photocopied signatures are not acceptable.

AUTHORIZED SIGNATURE OF SCHOOL DEPARTMENT REPRESENTATIVE, TITLE, AND DATE: A Representative from the School Department must sign and date the form to indicate that they wish to be affiliated with the provider listed on the application.

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
LOCAL EDUCATION AGENCY (LEA) PROVIDER LINKAGE FORM

Provider Name:_____

Service Location Address: _____

National Provider Identifier NPI:_____

Taxonomy (ies): _____

Provider Type/Specialty: (please circle) if other, please specify:
(Disregard if you provided your NPI & Taxonomy/ies)

OT **PT Speech Social Worker**

Psychiatrist RN **Psychologist**

Transportation **Personal Care Attendant**

Residential Placement **Other** _____
the

Provider Phone Number: _____

License #:_____

National Provider Identifier (NPI):_____
(School Dept. NPI)

Provider Taxonomy (ies):_____
(School Dept. Taxonomy/ies)

School Dept Name:_____

School Dept Group MA Provider Number:_____

School Dept Tax Identification Number: _____

School Dept Pay to Address:_____

School Dept Mail to Address:_____

Effective Date: *_____
Indicate the effective date when the Provider began providing services to

School Department

email address_____ **fax #**_____

_____
Provider Signature **Date**

_____
Authorized signature of School Department Representative **Title** **Date**

For EDS Use Only
Census Track:_____
Town Code:_____

County Code:_____
Location Code:_____

Town Code:_____

Location Code:_____

ADDENDUM G

SAMPLE CERTIFICATION OF FUNDS LETTER

_____
Date

Ms. Sharon Reniere
Assistant Administrator
Department of Human Services,
Center for Child and Family Health
600 New London Avenue
Cranston, RI 02920

Dear Ms. Reniere,

I certify that sufficient state funds and/or local education funds were available in the quarter ending _____, to meet state match requirements.

Sincerely,

_____ _____
Superintendent's Signature Date
Superintendent's Printed Name
Address
School Department

ADDENDUM H

Fully Documented Record for Medicaid Claiming Purposes

States are also required in Section 1902 of the Social Security Act to "provide for agreements with every person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving medical assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request." This requirement is also reiterated in the Code of Federal Regulations (CFR) Section 431.107, which describes "Required provider agreement."

State Medicaid Law requires that records used to support Medicaid claims must be retained for 7 years. Secretary of State Record Retention Schedule requires that education records must be retained for least 10 years. The following records must be retained to fully document a Medicaid Claim:

1) IEP indicating the need for a Medicaid covered service

2) Copy of the appropriate provider licensure, certification, etc. as required by state and federal law, as described by service/provider type in the CFR and state regulations

3) Referral/prescription, as required by state and federal law (in some states an IEP signed by an appropriate medical professional may suffice), as described by service/provider type in the CFR and state regulations

4) Provider/Service Log:
   a) Student's Name
   b) Provider's Name and Signature
   c) Date of Service
   d) Type of Service Provided
   e) Length of Encounter (must include Start Time)
   f) Group or Individual Setting
   g) Place of service
   h) Description of Service – including activity/procedure note for each date of service and supplemented by quarterly progress note, or as often as otherwise indicated educationally/medically

5) Documentation that services are being appropriately provided, as applicable, "under the supervision/guidance of" and meeting all federal and state oversight requirements

6) Other appropriate documents kept by schools, such as: child attendance records, school operating calendars (including snow days and other unscheduled school closings), or employee attendance record, etc.

7) Other state specific or professional association requirements, as applicable.

DHS Provider Log Elements

School/Billing Unit:
This should capture the name of the school where the services where provided

Time Period: Month/Quarter/Year:

Student Name:
This should include the student's complete, legal name.

Date of Birth:
This should record the student's complete date of birth

Provider Name:
This should capture the complete name of the medical professional, paraprofessional, (in legible manner) that is actually delivering services to the child. This individual is responsible for completing the provider/service log, procedure/activity note and progress notes completely and accurately and his/her signature attests to the validity of the documentation.

Provider Type:
This should record the professional capacity of the medical provider. For example, one would record here "licensed physical therapist" or "physical therapy assistant." If the provider type is paraprofessional, it is imperative that the supervisory professional (under whose direction the paraprofessional is providing services) review and co-sign the procedure/activity note, provider/service log and progress notes and clearly state their professional affiliation.

Date of Service:
Date when service was provided to student

Length of Encounter:
This should indicate the start and end time in hours and minutes or the start time and duration of the service. Examples: 9:00-9:30 or 9:00/30 minutes

Procedure/ Activity Note:
The provider should write a description of the service provided to the student on that date. Providers should use their professional judgment to create a brief note that adequately documents the nature/extent of the service provided. The documentation of each medical encounter with the student should include or provide reference to:

a) The reason for the encounter, and as appropriate, relevant history.
b) Current status-as it relates to the therapy/service being provided.

Individual/Small Group:
Reimbursement for school based services may be dependent on the setting in which the services were provided. In accordance with state specifications, please indicate if the service was delivered to the child on an individual basis or in a small group and where services were rendered.

Signatures:

By signing his/her name to the documents, the service provider is attesting to the veracity of the records. The medical professional/paraprofessional is assuring that services were provided in accordance with all relevant state and federal law and within professional standards and guidelines. He/she is verifying that all entries are accurate records of Medicaid billable services provided to the appropriate Medicaid beneficiary. This is a legally binding document, the submission of which will lead to an expenditure of state and federal dollars.

When applicable, services may be provided "under the direction of" a professional. In such situations, each student's care must be under the supervision of a qualified professional (as indicated by federal/state law) who is directly affiliated with the entity providing the billed medical services. To meet this requirement the supervising certified/licensed professional must see the student at least once, prescribe the type of care provided, and periodically review the need for continued services. He/she must assume professional responsibility for the services provided and assure that such services are medically necessary. The concept of professional responsibility implicitly supports face-to-face contact by the supervising certified/licensed professional at least at the beginning of the treatment and, in addition, during the delivery of services. By co-signing documentation created by the paraprofessional, the supervising medical professional is assuring that the above conditions have been met and are assuming responsibility for the child's care.

Addendum H

Sample Provider Log

School Name:	Time Period: month/quarter/year
Student Name:	DOB:
Provider Name:	Provider Type:
Service Type:	

Date	Procedure/Activity Note	Evaluation/ Individual/ SmallGroup	Length of Encounter (Start/End Time in hours and minutes or Start time/ length of encounter)

Provider Signature

Supervisor Signature (if applicable)

Title/Position Date

Title/Position Date

Addendum H RIDE Census Log

RI DEPARTMENT OF EDUCATION SPECIAL EDUCATION CENSUS

SCHOOL YEAR 2006-2007 Page 1

SCHOOL NAME:

SERVICE LOG FOR:

TEACHER:

SERVICE:

MONTH:

Last Name	First Name	D.O.B	Hours/Day	Service Date	Service Type	Start Time	Time in Minutes

DIRECTIONS: ENTER THE DATE(S) YOU SAW THIS STUDENT AND THE TYPE OF SERVICE THAT YOU PROVIDED

KEY FOR

G = GROUP THERAPY I =

E = EVALUATION C =

==========

COMMENTS/PR SIGNAT DA

ADDENDUM I

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAM

SINGLE ADJUSTMENT REQUEST FORM

1. CLAIM INTERNAL CONTROL NUMBER	Detail No.	EDS USE ONLY	
2. RECIPIENT NAME	3. RECIPIENT MEDICAL ASSISTANCE NUMBER		
4. PROVIDER NAME AND ADDRESS	5. FROM DOS	6. TO DOS	
	7. BILLED AMT.	8. PAID AMOUNT	**9. R/A DATE**
10. PLEASE SPECIYFY REASON FOR ADJUSTMENT			
IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED AND THE APPROPRIATE REMITTANCE ADVICE IS ATTACHED			
11. SIGNATURE	CONTACT NUMBER	DATE	
******EDS USE ONLY******			
EXAMINER	DATE	ACTION TAKEN	
REMARKS:			

MAIL TO:
EDS
ADJUSTMENTS
P.O. BOX 2010
WARWICK, RI 02887-2010

ADDENDUM I

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAM

MULTIPLE ADJUSTMENT REQUEST FORM

1. PROVIDER NAME: _____

2. PROVIDER NUMBER: _____

3. REASON FOR ADJUSTMENT (MUST BE SAME FOAR ALL ATTACHED):

EDS USE ONLY	4. CLAIM INTERNAL CONTROL NUMBER	5. MEDICAL ASSISTANCE RA DATE	6. RECIPIENT NAME FIRST/LAST	7. RECIPENT MEDICAL ASSISTANCE NO.
0				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS THIS FORM IS COMPLETED AND THE APPROPRIATE REMITTANCE ADVICE IS ATTACHED.

SIGNATURE	CONTACT NUMBER	DATE

******EDS USE ONLY******

EXAMINER	DATE	ACTION TAKEN

REMARKS:

MAIL TO:
EDS
ADJUSTMENTS
P.O. BOX 2010
WARWICK, RI 02887-2010

MULTIPLE ADJUST FORM

ADDENDUM J: Primary Special Education Disability and Diagnosis Codes

Primary Special Education Disability	Diagnosis Code
Speech or Language Disorder	V401
Learning Disabled	V400
Emotionally Disordered	V403
Developmentally Delayed	V793
Mentally Retarded	V402
Orthopedically Impaired	V495
Autistic	V409
Traumatic Brain Injury	V488
Other Health Impaired	V419
Deaf/Blind	V418
Hearing Disabled/Deaf	V412
Hearing Disabled/Hard of Hearing	V413
Blind or Visually Impaired	V410
Multi-Handicapped	V498
Other	V705

Other – V705, should only be used for those claims where there is no primary special education disability, e.g. Child Outreach Screening, Child Outreach Rescreening, Expanded Behavioral Health Counseling and initial evaluations.

Claiming Hints

- Use whole units: do not use fractions
- Minimum length of time for hour evaluations (PT, OT, SLP) is 60 minutes
- Complete each unit and fee entered with a number-do not use dittos
- Use complete from and to date of service in 6-digit MMDDYY format
- Diagnosis Code used for Medicaid billing should be primary disability code reported to RIDE in the Census for Special Education

Note regarding HIPPA Administrative Simplification: Electronic Transactions and Code Sets

The identification of National Code Sets, comprising National standards for formats and data content are part of the Administrative Simplification requirement of the Health Insurance Portability and Accountability Act. Using the same health care transactions, code sets, and identifiers as other providers across the country was intended to give the health care industry a common language to make it easier to transmit information electronically. The Department of Human Services and its fiscal agent, EDS, completed a crosswalk of all "state-only" codes to an established national code list. Included in this activity were the state-only codes used for services reimbursed by Local Education Agencies. All state-only codes, with the exception of X0215, were converted to a code from the National Code Set. The following table lists the Medicaid applicable procedure codes, national definitions and corresponding local usages, as well as units, rates and provider qualifications.

ADDENDUM J: SERVICES, UNITS, QUALIFICATIONS AND CODES

PHYSICAL THERAPY SERVICES

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Physical Therapy Services						
97001	Physical Therapy Evaluation	Physical Therapy Evaluation	1 unit equals 1 hour Max units equals 3 units per day	$85.00 per hour	Physical Therapist licensed by the Department of Health	Page 31
97110 GP	Therapeutic Procedure, One or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Ind. P.T. W/Licensed PT	1 unit equals 15 minutes Max units equals 12 units per day	$15.74 per 15 minutes	Physical Therapist licensed by the Department of Health	Pages 31 - 33
97530 HM GP	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Ind. P.T. Program	1 unit equals 15 minutes Max units equals 6 units per day	$12.00 per 15 minutes	Physical Therapy Assistant (PTA) licensed by the Department of Health working under the supervision of a Licensed Physical Therapist	Pages 31 - 33
97150 GP	Therapeutic procedure(s), Group (2 or more individuals), 15 minutes	P.T. Program - Group	1 unit equals 15 minutes Max units equals 8 units per day	$9.50 per 15 minutes per Medicaid eligible child(ren)	Phyical Therapist licensed by the Department of Health Or Physical Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Physical Therapist	Pages 31 - 33

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Occupational Therapy Services						
97003	Occupational Therapy Evaluation	Occupational Therapy Evaluation	1 unit equals 1 hour Max units equals 3 units per day	$85.00 per hour	Occupational Therapist licensed by the Department of Health	Page 34
97110 GO	Therapeutic Procedure, One or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Ind. O.T. W/Licensed O.T.	1 unit equals 15 minutes Max units equals 8 units per day	$14.50 per 15 minutes	Occupational Therapist licensed by the Department of Health	Pages 34 – 36
97530 HM GO	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Ind. O.T Program	1 unit equals 15 minutes Max units equals 8 units per day	$12.00 per 15 minutes	Certified Occupational Therapy Assistant (COTA) licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist	Pages 34 – 36
97150 GO	Therapeutic procedure(s), Group (2 or more individuals), 15 minutes	O.T. Program - Group	1 unit equals 15 minutes Max units equals 8 units per day	$9.50 per 15 minutes per Medicaid eligible child(ren)	Occupational Therapist licensed by the Department of Health Or Certified Occupational Therapy Assistant licensed by the Department of Health working under the supervision of a Licensed Occupational Therapist	Pages 34 – 36

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Speech, Hearing, Lang., Services						
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	Speech, Hearing, Lang., Evaluation	1 unit equals 1 hour Max units equals 3 units per day	$85.00 per hour	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE or an Audiologist licensed by DOH	Pages 37 - 40
92507 GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Ind. O.T. W/Licensed O.T.	1 unit equals 15 minutes Max units equals 8 units per day	$15.86 per 15 minutes	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE or an Audiologist licensed by the Department of Health	Pages 37 - 40
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Ind. S.H.L. Program	1 unit equals 15 minutes Max units equals 8 units per day	$12.00 per 15 minutes	A paraprofessional working under the supervision of a A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by the RIDE	Pages 37 - 40
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals	S.H.L. Program/Group	1 unit equals 15 minutes Max units equals 8 units per day	$9.50 per 15 minutes per Medicaid eligible child(ren)	A Speech- Language Pathologist licensed by the Department of Health Or A SLP who is certified by RIDE Or an Audiologist licensed by the Department of Health or A paraprofessional working under the supervision of a SLP licensed by the Department of Health Or A SLP certified by the RIDE	Pages 37 - 40

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Evaluation Services Psychological						
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication	Psychiatric Evaluation	1 Unit equals the completed evaluation, including the report writing Max unit equals 1 unit per day	$135.00 per completed evaluation	Board Certified Psychiatrist	Page 41
H0031 AH	Mental health assessment, by non-physician	Psychological Evaluation	1 Unit equals the completed evaluation, including the report writing Max unit equals 1 unit per day	$126.68 per completed evaluation	Clinical Psychologist Licensed by the Department of Health	Pages 41 - 42
H0031 AJ	Mental health assessment, by non-physician	Social Worker Evaluation	1 Unit equals the completed evaluation, including the report writing Max unit equals 1 unit per day	$135.49 per completed evaluation	LICSW, LCSW or a Certified School Social Worker	Pages 42 - 43

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Counseling Services Psychological Counseling						
H0004	Behavioral health counseling and therapy, per 15 minutes	Psychiatric Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$22.50 per 15 minutes	Board Certified Psychiatrist	Page 44
H0004 AH	Behavioral health counseling and therapy, per 15 minutes	Psychological Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$20.00 per 15 minutes	Clinical Psychologist Licensed by the Department of Health	Page 44
H0004 AJ	Behavioral health counseling and therapy, per 15 minutes	Social Worker Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$16.93 per 15 minutes	LICSW, LCSW by the DOH or a Certified School Social Worker	Page 44
96153	Health and behavior intervention, each 15 minutes, face to face; group (2 or more patients)	Counseling Services - Group	1 unit equals 15 minutes Max units equals 8 units per day	$10.00 per 15 minutes per Medicaid eligible child(ren)	Small group session conducted by any of the above	Page 44

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Expanded Behavioral Health						
H0004 HA	Behavioral health counseling and therapy, per 15 minutes	Psychiatric Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$22.50 per 15 minutes	Board Certified Psychiatrist	Page 45
H0004 AH HA	Behavioral health counseling and therapy, per 15 minutes	Psychological Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$20.00 per 15 minutes	Clinical Psychologist Licensed by the Department of Health	Page 45
H0004 AJ HA	Behavioral health counseling and therapy, per 15 minutes	Social Work Counseling	1 unit equals 15 minutes Max units equals 6 units per day	$16.93 per 15 minutes	LICSW, LCSW by the DOH or a Certified School Social Worker	Page 45
96153 HA	Health and behavior intervention, each 15 minutes, face to face; group (2 or more patients)	Counseling Services - Group	1 unit equals 15 minutes Max units equals 8 units per day	$10.00 per 15 minutes per Medicaid eligible child(ren)	Small group session conducted by any of the above	Page 45

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Other Services						
T1002	RN nurse service per 15 minutes	Nursing Services	1 unit equals 15 minutes Max units equals 40 units per day	$15.44 per 15 minutes	A Certified School Nurse Teacher	Page 46
T2003	Non-emergency transportation; encounter/trip	Transportation	Round trip transportation Max units equals 2 units per day	$10.00 per round trip	Transportation provided in accordance with federal and state law and as defined in Section V	Pages 51
X0215	Medical Case Management	Medical Case Mgt	1 unit equals 15minutes Max units equals 6 units per day	$17.50 per 15 minutes **	Designated case manager within school who provides activities described in Section V of the Guidebook	Pages 52 - 55
S5125	Attendant care services per 15 minutes	Personal Care	1 unit equals 15 minutes Max units equals 24 units per day	$5.69 per 15 minutes	Appropriately credentialed paraprofessional working under the supervision of the classroom teacher or other school staff	Pages 56 - 57
E1399	Durable medical equipment, miscellaneous	Assistive Technology Device	1 unit is equal to the purchase of one device Max units equals 3	Variable rate: rate is the cost of the item	Appropriately credentialed staff order the device	Page 59
97535	Self care/home management training direct one on one contact by provider, each 15 minutes	Assistive Technology Service	1 unit is equals 15 minutes Max units equals 20 units per day	$15.07 per 15 minutes	Appropriately credentialed staff provide the service	Page 58-59

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
Other Services						
T2048	Behavioral health; long-term care residential, with room and board, per diem	Residential Placement Less Education & R. & B.	1 unit equals 1 day in attendance in the program Max units equals 1 unit per day	Variable rate determined by the treatment costs of the individual program and the costs for room and board only in JCAHO accredited facilities	Approved residential treatment programs	Pages 49 - 50
H2018	Psychosocial rehabilitation services, per diem	Day Program Treatment	1 unit equals 1 day in attendance in the program Max units equals 1 unit per day	Variable rate determined by the treatment costs of the individual program	Providers can be another Local Education Agency (LEA) or a program approved by the RIDE	Pages 47 - 48
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Child Outreach Screening	1 unit equals the completed screening Max units equals 1 unit per day	$60.00 per completed screening	Appropriately licensed staff perform the screening	Page 60
T1023 TS	Screening to determine the appropriateness of consideration of an	Child Outreach Re-screening	1 unit equals the completed re-screening	$30.00 per completed re-screening	Appropriately licensed staff perform the re-screening	Page 60

Procedure Code with modifier	Service Description	CPT Definition	Units	Rate	Provider Qualifications	Chapter 5 Reference
	individual for participation in a specified program, project or treatment protocol, per encounter		Max units equals 1 unit per day			

ADDENDUM K

Sample Expanded Behavioral Health Plan

Child's Name: _____

Service Provider: _____

Date of Birth: _____

Presenting Problem/ Diagnosis: _____

Plan of Treatment:

_____
_____
_____
_____

Intervention:

_____
_____
_____
_____
_____

Goals and Objectives:

_____
_____
_____
_____

Progress Notes:

_____
_____

_____ _____

Provider Signature **Date**

DATE (Month/Day/Year)	COMMENTS	RECOMMENDATIONS

Provider Signature **Date**

ADDENDUM L

HIPAA

FREQUENTLY ASKED QUESTIONS

Prepared by

Denise Achin, M.Ed

Medicaid Specialist
R.I. Technical Assistance Project
Rhode Island College
Judith A. Saccardo, Ed.D. Director

Prepared for

R.I. Department of Education
Thomas P. DiPaola, PhD
Director, Office of Special Needs

Acknowledgements

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References:

www.cms.hhs.gov/hipaa/
http://www.dhs.state.ri.us/dhs/dhipaa.htm
"Standards for Privacy of Individually Identifiable Health Information", OCR HIPAA Privacy, December 3, 2002, Revised April 3, 2003

Disclaimer

The material contained in this document is intended for general information and guidance regarding the implications of the Health Insurance Portability and Accountability Act on local education agencies in Rhode Island. This document does not necessarily reflect the legal opinions of the U.S. Department of Education or its Office for Civil Rights, the U.S. Department of Health and Human Services or its Office for Civil Rights, the R.I. Department of Education, or Rhode Island College. This document is for general informational purposes only and is not intended to provide legal advice.

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BACKGROUND

Q: What is HIPAA?

A: HIPAA is the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Q: What is the intent of the HIPAA law?

A: This law was passed to protect individual's rights to health insurance coverage (Portability) and to promote standardization and efficiency in the health care industry (Accountability).

Q: What is the "Portability" component of the HIPAA law?

A: The portability component of HIPAA includes important new-but limited-protections for Americans and their families. HIPAA may lower your chance of losing existing coverage, enhance your ability to switch health plans and/or help you buy coverage on your own if you lose your employer's plan and have no other coverage available. This may result in health coverage continuity for pre-existing conditions when there is a change in health insurance coverage do to a change in jobs or in new employer-sponsored coverage.

HIPAA:

- May increase your ability to get health coverage for yourself and your dependents if you start a new job;
- May lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
- May help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
- May help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Q: What is "Administrative Simplification" within the HIPAA law?

A: HIPAA mandated that Congress, or by default the Department of Health and Human Services (HHS), establish and implement the four parts of the Administrative Simplification component of HIPAA. These are: the Privacy Rule; Security Rule; Standard transactions and code sets; and National Identifier System.

Privacy Rule

Q: What are the privacy standards?

A: The HIPAA privacy standards are regulations approved by Congress to protect the privacy of protected health information (PHI) in oral, written or electronic format by covered entities. These

standards set parameters for the use and disclosure of PHI. They went into effect for most providers April 14, 2003 and for small providers (those with annual receipts less than $5 million) compliance must be met by April 14, 2004.

Q: Why is the HIPAA Privacy Rule needed?

A: In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. Prior to HIPAA Privacy regulations, hospitals, doctors' offices, insurers or third party payers relied on a patchwork of Federal and State laws. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws that provide stronger privacy protections will continue to apply over and above the new Federal privacy standards.

Q: What does the HIPAA Privacy Rule create?

A: The HIPAA Privacy Rule, for the first time, creates national standards to protect individuals' medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- It strikes a balance when public responsibility supports disclosure of some forms of data, for example, to protect public health.

Q: What does it mean for patients?

A: It means patients being able to make informed choices when seeking care and reimbursement for care based on how personal health information may be used.

- It enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.
- It empowers individuals to control certain uses and disclosures of their health information.

Security Rule

Q: What are the security standards?

A: The HIPAA Security Standards stipulate that health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule outlines the minimum administrative, physical and technical safeguards to protect electronic protected health information in their care to prevent unauthorized access to protected health care information. The security standards work in concert with the final privacy standards adopted by HHS in 2002. The privacy standards have been in effect for most covered entities since April 14, 2003 and small providers have an additional year to meet compliance (April 14, 2004). The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Most providers need to be compliant with the security standards by April 21, 2005 and small providers have an additional year to meet compliance (April 21, 2006).

Q: Do LEAs need to be compliant with the Security standards?

A: A review and analysis of these standards and their application to the LEAs needs to be completed. RIDE will send out notification as soon as this analysis has been done. In the meantime, it is recommended that LEAs: implement computer passwords for users who maintain protected health information, including Medicaid claims; instruct employees to turn off their computers when they leave their work stations; position computer screens away from the view of passersby; maintain electronic data in a secure manner to prevent unauthorized access from computer hackers…

Transactions and Code Sets

Q: What are the national transactions and code sets?

A: National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every covered/hybrid entity that does business electronically to use the same health care transactions, code sets, and identifiers. Transactions and code sets standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically.

By October 16, 2003, all providers will need to utilize standard procedure and diagnosis codes when submitting claims. An extension through December 31, 2003 has been given for the conversion of state-only codes. Between October 16, 2003 and December 31, 2003, LEAs will need to utilize new HIPAA compliant software using the current MMIS (Medicaid Management Information System) codes. Effective January 1, 2004, LEAs will need to utilize the HIPAA compliant software with newly assigned HIPAA procedure codes. It is recommended that LEAs become up to date with their Medicaid claiming to decrease conversion difficulties with the new timelines.

Q: Why does HIPAA require national transactions and code sets?

A: The transactions and code sets component of HIPAA are intended to promote standardization in the Health Care industry across the country, with providers utilizing the same codes in order to simplify billing and to cut down on administrative costs.

Q: What is the implementation date for transactions and code sets?

A: All covered/hybrid entities must utilize HIPAA compliant software and national code sets by October 16, 2003. LEAs will continue to use their existing MMIS procedure codes through December 31, 2003 and will utilize new "HIPAA" procedure codes starting January 1, 2004.

Q: Where can Rhode Island providers acquire HIPAA compliant software?

A: Free Provider Electronic Solutions (PES) software is available from Electronic Data Solutions (EDS) or providers may purchase or have software developed by private entities.

This software is available once a covered entity submits an Electronic Data Interchange Trading Partner Agreement with EDS and the Department of Human Services.

Q: What are the recommended hardware requirements to use the PES?

A: The following are the recommended hardware requirements to use PES:

- Windows 2000, Windows NT or Windows XP
- 128 MB RAM
- 1024 X 768 monitor resolution
- 9600 baud rate modem or faster is preferred
- CD ROM drive
- Printer is preferred

Trading Partner Agreement (TPA)

Q: What is a Trading Partner (Electronic Data Interchange-EDI) Agreement?

A: A Trading Partner (Electronic Data Interchange-EDI) Agreement is an agreement between a provider or a billing company and EDS and the DHS in order to exchange electronic data. A copy of this form and instructions to complete it are available as Addendum A or copies of the TPA can be accessed through the DHS web site at http://www.dhs.ri.gov/dhs/hipaa/hEDI.htm

Q: Who needs to complete a TPA?

A: Anyone who performs an electronic transaction with EDS or DHS needs to complete a TPA with the DHS and EDS. This includes:

- Any provider who verifies patient eligibility through the RI Medicaid Portal

- Any provider or billing agent who will check claim status through the RI Medicaid Portal
- Any Clearing House that bills electronically i.e., Web MD
- Any Billing Agent who will exchange data electronically
- Any provider and /or billing agents checking remittance advice payments
- *Remittance advice/files and Pended Claims reports will be available to only one trading partner.* (LEAs utilizing a billing company need to decide if they will have access or if their billing agent will have access to the Remittance files and pended claims reports).

If you have any questions about completing the TPA, call the EDS Electronic Data Interchange help desk at 1-800-399-0835 or contact Denise Achin at 1-401-222-4600 ext. 2306 or dachin@ride.ri.net

Q: Should an LEA complete a TPA?

A: If an LEA wants to do any of the electronic transactions listed above, then it would need to complete a TPA. If an LEA does not do any of the transactions electronically listed above, it does not have to complete a TPA. If an LEA contracts with a billing service to submit its claims, then the billing service would have to complete a TPA that is signed by the LEA. You do not need to complete a TPA if you submit claims on paper only, and do not wish to access the MMIS Web portal for any other electronic querying, e.g. eligibility, claim status, prior authorization status, or want access to a provider-specific Message Center. However, it is highly recommended that you complete a TPA for future access to these new MMIS Web portal functionalities.

National Identifier

Q: What is the National Identifier?

A: HIPAA will require that health care providers, health plans, and employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN or TIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002. The remaining identifiers are expected to be determined in 2003 with compliance not due until 2005.

Covered Entities

Q: Who must comply with HIPAA regulations?

A: "Covered Entities" must comply with the HIPAA regulations. Under HIPAA, a covered entity is a health care provider, a health care clearinghouse or a health plan that transmits any health information in electronic form in connection with a HIPAA electronic transaction. To determine if you are a covered entity, go to the HIPAA website at www.cms.hhs.gov/hipaa. To access the "Covered Entity Tool", click "Administrative Simplification, scroll down to "General Information" and click "Covered Entity Decision Tools".

Q: Are Local Education Agencies (LEAs) in Rhode Island covered entities?

A: Yes, LEAs that submit claims for Medicaid reimbursement are considered hybrid [covered] entities under HIPAA law.

Q: What is a Hybrid Entity?

A: The term "hybrid entity" is used to describe an organization that has a component that is a health plan, health care clearinghouse, or a covered health care provider, and whose business activities include both covered and non-covered functions. This includes Local Education Agencies, whose covered functions are not its primary functions. While LEAs perform covered functions such as submitting claims for Medicaid reimbursement, the primary function of an LEA and most of its activities revolves around the education of students.

Q: Do LEAs need to comply with the HIPAA privacy standards?

A. Congress specifically exempted records that are covered by the Family Educational Rights and Privacy Act (FERPA) from having to be covered also by the HIPAA privacy rule. Even though LEAs are considered hybrid entities under HIPAA, they do not need to comply with the HIPAA privacy regulations for those records covered by FERPA.

Q: What are a Covered entity's requirements to implement the Privacy Rule?

A: To implement the Privacy Rule, covered entities are required to: designate a privacy official and contact person; develop policies and procedures (including for receiving complaints); provide privacy training to its workforce; implement administrative, technical, and physical safeguards; develop a system of sanctions for employees; meet documentation requirements; mitigate any harmful effect of a use or disclosure of protected health information that is known to the covered entity; refrain from intimidating or retaliatory acts; and not require individuals to waive their rights to file a complaint with the Secretary or their other rights under this Rule.

Family Education Rights and Privacy Act (FERPA)

Q: What is the Family Education Rights and Privacy Act (FERPA)?

A: FERPA is a federal law that applies to an educational agency or institution to which funds have been made available under any program administered by the Secretary of Education (this includes all LEAs).

FERPA sets out the requirements for the protection of privacy of parents and students with respect to educational records maintained by the LEA.

Based on an analysis of applicable HIPAA Privacy Regulations, it has been determined that education records which are subject to FERPA are exempt from HIPAA Privacy Regulations.

Specifically, Section 164.501 of the HIPAA Privacy Regulations defines *Protected Health Information* as:

Individually identifiable health information (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media: (ii) Maintained in any medium described in the definition of *electronic media* at § 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) *Protected health information* excludes individually identifiable health information in: (i) Education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. [34 C.F.R. 164.501, Definitions]

A careful analysis of applicable HIPAA Privacy Regulations and FERPA Regulations indicates that LEAs that adhere to FERPA are exempt form the HIPAA Privacy Regulations. To understand this exemption requires a clear understanding of several definitions in FERPA.

Q: What are Educational Records as defined by FERPA 34 CFR sec. 99.3?

A: The term Educational Records defined by FERPA include:

(a) Those records that are:

(1) Directly related to a student; and
(2) Maintained by an educational agency or institution or by a party acting for the agency or institution.

(b) The term does not include:

(1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.

Q: What is the definition of "Record" in FERPA?

A: The definition of "Record" in FERPA means any information recorded in any way, including but not limited to, handwriting, print, computer media, video or audiotape, film, microfilm, and microfiche.

Q: What is the definition of "Personally identifiable information" in FERPA?

A: Personally identifiable information within FERPA includes, but is not limited to:

(a) The students name;
(b) The name of the student's parent or other family member;
(c) The address of the student or student's family;
(d) A personal identifier, such as the student's social security number or student number;
(e) A list of personal characteristics that would make the student's identity easily traceable; or

(f) Other information that would make the student's identity easily traceable.

Q: How should LEAs maintain records that support Medicaid claiming?

A: Educational records maintained by school districts billing Medicaid through a billing agent are subject to FERPA regulations and, therefore, are not subject to HIPAA Privacy Regulations. In light of this exemption, it is especially important that each LEA strictly and fully implement the FERPA regulations and the confidentiality requirements of, IDEA and the RI Special Education regulations.

LEAs that electronically transmit records that are not subject to FERPA because they do not become educational records will be subject to the Privacy Regulations and Security Regulations of HIPAA.

NOTE: It is important to note that the FERPA regulations are currently in effect and all LEAs must be compliant with these requirements. For technical assistance, please contact the Rhode Island Department of Elementary and Secondary Education legal office at 222-2057 or the Rhode Island Technical Assistance Project at Rhode Island College at 456-4600.

Q: Do School Based Health Centers (SBHCs) in Rhode Island need to be HIPAA compliant?

A: Yes, HIPAA regulations apply to all SBHCs in Rhode Island because SBHCs are administered by covered entities and the records maintained in SBHCs are not considered FERPA records. All SBHCs in Rhode Island are operated independently and are not subject to FERPA because services are provided on a voluntary basis and SBHCs are not providing education or support services.

PROTECTED HEALTH INFORMATION (PHI)

Q: What is protected health information?

A: Protected Health Information includes individually identifiable health information (with limited exceptions) in any form, including information transmitted in oral, written or electronic form by covered entities or their business associates. PHI excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act (FERPA), as amended, 20 USC

PHI is the coupling of an individual's health information with individual identifiers. Individual identifiers include:

Name	*E-mail address*
Address/zip code	Health Plan Subscriber Number
Social Security Number	(Recipient ID number)
Driver's License Number	Vehicle Identification Number (VIN)

Credit Card Number	Device Identifier Numbers (e.g. wheelchair)
Dates (birth, treatment)	Web Universal Resource Locator (URL)
Names of relatives	Internet Protocol Address
Name of employer	Finger or voiceprints
Telephone number	Photographic images
Fax number	any other unique identifier or code

Q: What do the Privacy regulations protect health information from?

A: The regulations put parameters on the release of protected health information by covered/hybrid entities.

Q: Under what circumstances can a covered/hybrid entity disclose protected health information?

A: Covered/hybrid entities may disclose protected health information about the individual to the individual upon request as well as to other entities when authorized to do so by the individual. Covered/hybrid entities may disclose PHI under circumstances known as treatment, payment and other health care operations (TPO), without the authorization of the individual, and for executive (Presidential) and national emergency considerations.

Q: What is "treatment"?

A: Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Q: What is "payment"?

A: Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is considered "health care operations"?

A: These are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business. These are listed at 45 CFR 164.501 and include:

- Conducting quality assessment and improvement activities
- Training, accreditation, certification, licensing, or credentialing activities
- Conducting or arranging for medical review, legal, and auditing services

- Business management and general administrative activities
    - Activities related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules
    - Customer service
    - Resolution of internal grievances
    - Creating de-identified information

Q: What information *is not covered* under the Privacy Rule protections?

A: The following information *is not covered* under the HIPAA Privacy Regulations:

(1) De-identified information
(2) Employment records
(3) FERPA records

Q: Under what circumstances can protected health information be shared *without* authorization?

A: Authorization for the release of PHI *is not* required under the following:

(1) To the individual (or personal representative)
(2) For treatment, payment, and health care operations (TPO)
    - Health Plans can contact their enrollees
    - Providers can talk to their patients
    - Providers can talk to other providers of medical services about shared patients
    - To carry out essential health care functions
(3) Limited data set
    - For research, public health, health care operations purposes
    - Direct identifiers must be removed
    - Allows zip codes and dates
(4) Opportunity to agree or object
    - Facility directories (name, location, general condition, clergy-religious affiliation)
    - To persons involved in care or payment for care and notification purposes
        - Friends or family members can pick up prescriptions
        - Hospitals can notify family members of patient's condition
        - Covered entities can notify disaster relief agencies

Individual Rights and Disclosure of PHI

Q: What are individual's rights under HIPAA privacy regulations?

A: Individuals have the right to:

- A written notice of privacy practices (NPP) from covered entities
- Inspect and obtain a copy of their PHI
- Amend their records
- Request restriction on uses and disclosures
- Accommodation of reasonable communication requests
- Complain to the covered entity and to HHS

Q: Are hospitals able to inform the clergy about parishioners in the hospital?

A. Yes, the HIPAA Privacy Rule allows this communication to occur, as long as the patient has been informed of this use and disclosure, and does not object. The hospital or other covered health care provider may maintain the following information about an individual in a directory and share this information with the clergy:
    - Individual's name
    - Location in the facility
    - Health condition expressed in general terms
    - Religious affiliation

B. Directory information, except for religious affiliation, may be disclosed only to other persons who ask for the individual by name.

Q: Under what conditions may a health care provider use, disclose, or request an entire medical record?

A. The Privacy Rule does not prohibit the use, disclosure, or request of an entire medical record; and a covered entity may use, disclose, or request an entire medical record without a case-by-case justification, if the covered entity has documented in its policies and procedures that the entire medical record is the amount reasonably necessary for certain identified purposes. No justification is needed in those instances where the minimum necessary standard does not apply, such as disclosures to or requests by a health care provider for treatment purposes or disclosures to the individual who is the subject of the protected health information.

Q: When are authorizations required?

A: Authorizations are required for uses and disclosures not otherwise permitted or required by the Rule. Generally, an entity cannot condition treatment, payment, eligibility, or enrollment on an authorization. However, if eligibility for Federal or State healthcare coverage (Medicare/Medicaid) requires documentation of disability or financial condition and this information is not granted, then coverage *can* be denied because eligibility for program determination cannot be made. Authorization must contain core elements & required statements, including an expiration date or event and a statement that authorization is revocable.

Q: What rule applies to the amount of information requested?

A: There is a "Minimum Necessary" standard in HIPAA that requires covered entities make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum amount necessary to accomplish intended purpose.

Q: Are there exceptions to the Minimum Necessary Standard?

A: Yes, the exceptions to the Minimum Necessary standard include: disclosures to or requests by providers for treatment; disclosures to the individual; uses/disclosures with an authorization; uses/disclosures required for HIPAA standard transaction; disclosures to HHSA/OCR for enforcement; and uses/disclosures required by law.

KEY DEFINITIONS

Q: What is a Business Associate?

A: A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. The definition includes agents, contractors, or others hired to do work of or for a covered entity that requires use or disclosure of protected health information. A business associate can also be a covered entity in its own right. [Also, see Part II, 45 CFR 160.103.]

The covered entity must require satisfactory assurance-usually a contract-that a business associate will safeguard protected health information and limit the use and disclosure of protected health information.

Contracts between an LEA and a billing company should include a confidentiality clause addressing the information being shared with the contractor and the use of this information by the contractor.

Q: What are the Centers for Medicare and Medicaid Services (CMS)?

A: CMS is the Health and Human Services (HHS) agency responsible for Medicare and parts of Medicaid. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.

Q: What is Code Set:

A: Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also, see Part II, 45 CFR 162.103.

Q: What is a Covered Entity?

A: Under HIPAA, a covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. To determine if you are a covered entity, go to the HIPAA website at www.cms.hhs.gov/hipaa. To access the "Covered Entity Tool", click "Administrative Simplification, scroll down to "General Information" and click "Covered Entity Decision Tools".

Q: What is a Hybrid Entity?

A: A hybrid entity is a covered entity that also does non-covered functions, whose covered functions are not its primary functions. [This would include LEAs.] Most of the requirements of the Privacy Rule apply to the health care components of the entity and not to the parts of the entity that do not engage in covered functions.

Q: What is a Health Care Provider?

A: A health care provider is a provider of services, a provider of medical or health services, and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.

Q: What is a Health Care Clearinghouse?

A: A health care clearinghouse is a public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Q: What is considered "health care operations"?

A: These are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business. These are listed at 45 CFR 164.501 and include:

- Conducting quality assessment and improvement activities
- Training, accreditation, certification, licensing, or credentialing activities
- Conducting or arranging for medical review, legal, and auditing services
- Business management and general administrative activities
    - Activities related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules
    - Customer service
    - Resolution of internal grievances
    - Creating de-identified information

Q: What is Health Information?

A: Health Information means any information whether oral or recorded in any form or medium, that:

(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Q: What is the Health Insurance Portability and Accountability Act (HIPAA) of 1996?

A: HIPAA is a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, K2 or Public Law 104-191.

Q: What is the Office of Civil Rights (OCR)?

A: OCR is an office that is part of Federal Department of Health and Human Services. Its HIPAA responsibilities include oversight of the privacy requirements.

Q: What is “payment”?

A: Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

Q: What is protected health information (PHI)?

A: PHI includes individually identifiable health information (with limited exceptions) in any form, including information transmitted orally, or in written or electronic form by covered entities or their business associates. Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USC 1232g; (ii) Records described at 20 USC 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer.

Q: What is a Small Health Plan or Small Providers?

A: Under HIPAA, a small health plan or small provider is one with annual receipts of $5 million or less. Small providers have been given one-year extensions to implement HIPAA components, e.g. code sets, privacy regulations, security regulations.

Q: What is Privacy?

A: Privacy is defined as controlling who is authorized to access information (the right of individuals to keep information about themselves being disclosed).

Q: What is Security?

A: Security is defined as the ability to control access and protect information from accidental or intentional disclosure to unauthorized persons and from altercation, destruction or loss.

Q: What are the HIPAA Security Standards?

A: The HIPAA Security Standards stipulate that health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule requires covered entities to implement administrative, physical and technical safeguards to protect electronic protected health information in their care. The security standards work in concert with the final privacy standards adopted by HHS in 2002 and the privacy standards are scheduled to take effect for most covered entities April 14, 2003, small health plans have an additional year to comply. The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply. Covered entities (except small health plans) must comply with the security standards by April 21, 2005, small health plans have an additional year to comply.

Q: What is a Trading Partner Electronic Data Interchange-EDI Agreement?

A: A Trading Partner EDI Agreement is an agreement between a covered/hybrid entity, including billing companies, and EDS and the DHS in order to exchange electronic data. Copies of this form can be accessed through the DHS web site at http://www.dhs.ri.gov/dhs/hipaa/hEDI.htm

Q: What is “treatment”?

A: Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Addendum M

State of Rhode Island and Providence Plantations

DEPARTMENT OF EDUCATION

Shepard Building
255 Westminster Street
Providence, Rhode Island 02903-3400

Peter McWalters
Commissioner

TO: Superintendents
Directors of Special Education, Public/Private
Business Managers

FROM: Kenneth G. Swanson, Director Office of Special Populations

DATE: June 7, 2007

RE: Consent Practice for Accessing Public Insurance (Medicaid)

In May 2007 my office received a letter of clarification from Alexa Posny, Director of OSEP, to the State Directors of Special Education regarding interpretation of the requirement at 34 CFR §300.154 (d) (2) (iv) (A), IDEA 2004, which requires LEAs to obtain parental consent each time the LEA accesses public funds for IEP covered health services. I would like to take this opportunity to provide guidance for obtaining parental consent each time the LEA accesses public funds for IEP covered health services.

Topic: **Parental Consent for Accessing Public Benefits (Medicaid) or Public Insurance**

Discussion: **34 CFR §300.154 (d) (2) (iv) (A), IDEA 2004**

OSEP clarification memorandum highlights:

Parental Consent means:

- The parent has been fully informed of all information relevant to the activity for which the consent is sought, in his or her native language or other mode of communication;
- The parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records that will be released and to whom;
- The parent understands that consent is voluntary on the part of the parent and may be revoked at any time; and
- If a parent revokes consent, the revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent is given and before it is revoked).

OSEP believes that permitting a public agency to obtain parental consent for a specified amount of services for a specified period of time would be sufficient to enable parents to make an informed decision as to whether to provide consent for a public agency to access their or their child's public benefits or other public insurance.

In order for your district to implement 34 CFR §300.154 (d) (2) (iv) (A), IDEA 2004, RIDE advises you to establish a practice within your district to ensure that you receive written informed parental consent from a parent *each* time there are changes to the services identified in an IEP *before* submitting claims for Medicaid reimbursement. This informed consent may be obtained at the time of an initial IEP or each time services are changed to a child's IEP in accordance with 34 CFR §§300.320-300.324, IDEA 2004. However, it is not required to conduct an IEP meeting to obtain this consent for the sole purpose of obtaining parental consent. Once parent consent is received the LEA may begin billing for those identified services.

Enclosed you will find a sampling of consent forms available on the internet or provided to RIDE. Please note that these sample forms are for informational purposes only. It is important to remember any form used or created by your district must include the following:

- Ensure that it is clear to the parent that they have choice about granting permission to access Medicaid funds for IEP services
- Offer parents the choice of granting or denying consent for the district to access their child's Medicaid benefits
- Identify the IEP for which the consent is granted or denied
- Ensure parents that the district accessing Medicaid benefits *does not* affect the benefits available to the child outside the school setting

Enclosures

Telephone (401)222-4600 **Fax** (401)222-6178 **TTY** 800-745-5555 **Voice** 800-745-6575

The Board of Regents does not discriminate on the basis of age, color, sex, sexual orientation, race, religion, national origin, or disability

[Insert School Department]

PARENTAL CONSENT TO CLAIM MEDICAID REIMBURSEMENT

Student Name _____ Birth Date _____

[School Department] participates as a Medicaid Provider for health related services that are identified in an Individualized Education Program (IEP) and are provided in the school setting. These services may include the following: speech and language therapy, occupational therapy, physical therapy, child outreach screenings, nursing, personal care attendants, assistive technology, transportation, day placement, residential placement, case management, and services provided by our therapists, nurses, 1:1 assistants, guidance counselors, social workers, and psychologists.

[School Department] actively seeks Medicaid reimbursement for these services provided to Medicaid eligible students. Accessing a student's Medicaid benefits does NOT in any way affect the family's ability to access services outside the school setting, nor does it affect any Medicaid lifetime benefits for the student. The monies received through this program directly support education in [your community].

[School Department] needs to obtain a parent's signed consent to release information to the RI Department of Humans Services ("Medicaid") and its contractors for the purposes of billing and determining a student's Medicaid status. [If you use a billing company, insert that information here.]

Granting of consent is voluntary on the part of the parent and may be revoked at any time. If consent is revoked, that revocation is not retroactive and will not affect the delivery of services to a child.

* * * * * * * * * * * * * *

I understand that giving my consent allows the [School Department] to verify my child's Medicaid eligibility and to submit claims for reimbursable services identified in his/her IEP dated _____. I understand that my consent is voluntary and I may revoke my consent at any time. I understand my right to deny consent will not affect delivery of IEP services to my child. I also understand that I have the right to request a copy of the records disclosed to the Department of Human Services or its contractors. This consent is valid for the term of the IEP referenced above.

_____ _____

Parent/Guardian Signature Date

_____

Witness

PARENT/GUARDIAN AUTHORIZATION FORM

MEDICAID REIMBURSEMENT FOR STUDENT/CHILD'S INDIVIDUALIZED EDUCATION PROGRAM (IEP) OR INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) SERVICES

Iowa Medicaid allows for Area Education Agencies (AEAs), Early ACCESS (EA) Regional Grantees and Local Education Agencies (LEAs) to request reimbursement for certain covered services in a student/child's IEP or IFSP.

I, _____, hereby authorize the AEA, EA Regional Grantee or LEA
(Parent/Guardian Name)

listed on my student/child's IEP or IFSP to disclose personally identifiable information of

_____ ("student/child") to the Iowa Department
(Student/Child Name)
of Human Services and its contractors, ("Medicaid") for purposes of determining student/child's eligibility for Medicaid, and if student/child is determined to be eligible for Medicaid, for purposes of billing Medicaid for Medicaid-covered health services provided to student/child that are in student/child's Individualized Education Plan or Individualized Family Service Plan.

Should the student/child have other insurance in addition to Medicaid, I understand that Medicaid may forward claims to the other insurance for processing. This process is in compliance with all federal regulations and would not impact the family's existing benefits or impact their access to any services.

I understand that, upon request, I may receive copies of student/child's records that are disclosed pursuant to this authorization.

_____ _____
Parent/Guardian Signature Relationship to Student/Child

Date: _____

_____ I decline to consent for this release of information to Medicaid.

I understand that a photocopy or other reproduction of this signed and completed form shall have the same force and effect as the signed and completed original, unless otherwise prohibited by law.

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), 20 USC § 1232g, 34 CFR §99.31, the school corporation, prior to disclosing personally identifiable information from a student's records to the Iowa Medicaid agency, must obtain "written consent from the student's parents specifying records to be released, the reasons for such release, and to whom, and with a copy of the records to be released to the student's parents and the student if desired by the parents." This signed authorization is valid for a period of one (1) year from the date signed. This form must be maintained and made available for audit purposes.

Addendum N

Rhode Island Medical Assistance NPI Fact Sheet

What is an NPI?

HIPAA mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. The Secretary adopted the NPI. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position.

The number can be either a Type 1 or a Type 2. Type 1 NPIs are for individuals. Type 2 NPIs are for businesses or group practices. The Type 1 NPI will be assigned to the provider and will not change regardless of where he or she practices. The Type 2 NPI will not change if a business changes ownership.

It is accommodated in all standard transactions, and contains no embedded information about the health care provider that it identifies. Effective May 23, 2007, the NPI will be the only healthcare provider identifier that will be accepted/used for identification purposes for standard transactions by covered entities.

What is Taxonomy?

The Health Care Provider Taxonomy code set is an external non medical data code set designed for use in an electronic environment, specifically within the ANSI ASC X12N health care transactions. This includes the transactions mandated under HIPAA.

The Health Care Provider Taxonomy code is a unique, alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.

The National Uniform Claim Committee (NUCC) is presently maintaining the code set. It is used in transactions specified in HIPAA and the National Provider Identifier (NPI) application for enumeration. Effective 2001, the NUCC took over the administration of the code set. Ongoing duties, including processing taxonomy code requests and maintenance of the code set, fall under the NUCC Code Subcommittee. Primary distribution of the code set remains the responsibility of Washington Publishing Company (WPC), through its web site.

- A Taxonomy Code is an additional, unique, 10 position number to be listed on the NPI application
- It provides additional information about the provider. The Taxonomy Code is structured into three distinct “Levels”–Level 1, Provider Type–Level II, Classification–Level III, Area of Specialization

To apply for your NPI:

You can apply for an NPI by any of the following methods:

- Call the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 to request an application
- Electronically file for an NPI from the NPPES Web site at: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Purpose of NPI and Taxonomy

Establishes the standard for the unique health identifier for health care providers to simplify the administration of the health care system. What the rule does:

Establishes the Standard: The National Provider Identifier (NPI) is the unique health identifier for health care providers. The NPI is a 10-digit numeric identifier with a check digit.

Establishes the National Provider System: The National Provider System (NPS) will be the system used to assign unique numbers to health care providers.

Defines Implementation Specifications for Covered Entities: Health Care Providers must obtain an NPI and use it on standard transactions; Health Plans and Health Care Clearinghouses must use the NPI to identify health care providers on standard transactions where the health care provider’s identifier is required.

Defines Compliance Dates for Implementation of the NPI: Health Care Providers, Health Plans (except small health plans), and Health Care Clearinghouses must comply with the NPI implementation specifications no later than May 23, 2007. Small Health Plans must comply with the NPI implementation specifications no later than May 23, 2008.

Do I need to get an NPI?

All health care providers that meet the definition of a covered entity (healthcare providers that conduct certain transactions in electronic form, health plans, or healthcare clearinghouses), as defined in 45 CFR 160.103, are eligible for NPIs. Health care providers who transmit any health information in electronic form in connection with a transaction are required to obtain and use NPIs. Health care providers who are not considered covered entities may also apply and be assigned an NPI. However, entities that do not provide health care (e.g., transportation services) are not eligible to be assigned NPIs because they do not meet the definition of "health care provider" and are not subject to HIPAA regulations.

If you provide services that fall within the realm of "Health Care" as defined by 45 CFR 160.103, you are required to obtain an NPI. This includes care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. Examples include but are not limited to physicians, nurses, hospitals, physical and occupational therapists and pharmacies/pharmacists.

Why do I need to get an NPI?

All healthcare providers who are Health Insurance Portability Accountability Act (HIPAA) covered entities will need to get an NPI to file claims with RIMAP. This includes filing claims using the Web site and/or the Provider Electronic Solutions software after May 23, 2007.

When should I get my NPI?

RIMAP recommends obtaining, and notifying EDS of this number, all associated taxonomies, and the current RI Medicaid Provider ID (Legacy #), as soon as possible. Failure to obtain your NPI by May 23, 2007, could result in nonpayment of claims.

How do I notify RIMAP of my NPI?

Providers should notify RIMAP of their NPI, Taxonomy, and current RI Medicaid Provider ID (Legacy #) by sending the official CMS approval by either fax, 467-9581 Attn: Provider Enrollment or email, RI-CSHelpDesk@eds.com

When may I start using my NPI on submissions of claims to RIMAP?

RIMAP will begin accepting NPI's on May 23, 2007.
For further questions regarding NPI, please contact RIMAP at (401) 784-8877 to leave a voice message. Please include your name, contact phone number, and a brief message. All calls will be responded to within 48 hours/2 business days.

Are there any changes with the paper claim forms?

The State of Rhode Island's Medical Assistance program recommends using both the NPI and taxonomy on all paper claim forms for those providers required to obtain an NPI. This directive will encompass all provider numbers including billing, rendering, performing, and referring. When an NPI is used on a paper claim form then a taxonomy is required.
The CMS-1500 claim form was updated to accommodate the mandated National Provider Identifiers (NPIs). The previous CMS-1500 (12-90) form did not have the fields for reporting of NPIs. Further information on the CMS-1500 form is available through the NUCC web site: http://www.nucc.org
The National Uniform Billing Committee (NUBC) is responsible for updating the UB-92; it has been replaced by the UB-04 paper. You may obtain copies of the CMS-1450 form, which is also known as the UB-04, from the Standard Register Company, Forms Division. HIPAA requires submission of National Provider Identifiers (NPIs) on claims effective May 23, 2007. To accommodate this transition, EDS will continue to accept the old paper claim forms until September 1, 2007. Please consult with your software/billing vendor to ensure that all the necessary charges are made to your system to accommodate billing paper claims on the updated forms.

What changes should I expect to see related to NPI?

Recipient Eligibility Verification System (REVS)
When checking eligibility providers will be able to use either the NPI or the current RI Medical Assistance Provider Id.
If checking payment information on REVS with an NPI, the provider will receive a total dollar amount for the current financial cycle for all Medical Assistance Provider Id's associated with that NPI. If checking payment information on REVS with a Medical Assistance Provider Id, the provider will only receive the total dollar amount for that Medical Assistance Provider Id entered into REVS.

Paper Remittance Advices (RA)
The Paper Remittance Advice will remain unchanged with the exception of printing the NPI number under the RI Medical Assistance Id in the upper left corner of the RA.

835 – Electronic Remittance Advice
The 835 will return claims adjudication information for all RI Medical Assistance Id's associated with the NPI.