School Based

Program overview

The Nevada Medicaid School Based Child Health Services program allows enrolled school districts to receive Medicaid payment for providing qualifying health-related services identified in a student's Individual Education Plan (IEP).

Student requirements

In order to receive services, a student must be enrolled in Nevada Medicaid and be at least age 3, but under age 21.

State policy

For complete coverage and limitations, refer to Medicaid Services Manual (MSM) Chapter 2800 on the DHCFP website at dhcfp.nv.gov.

Service requirements

All required evaluations and records must be complete in order for Medicaid to issue payment for services. Duplicate services are not allowed when multiple providers perform the same or similar procedures.

In addition, services must be:

- Provided in accordance with an active IEP that specifies the type, amount, duration, frequency and location of services.
- Consistent with the intent of the IEP's services and planned goals.
- Provided to address and correct or ameliorate the student's physical, mental and/or emotional disability as identified in the IEP.
- Deemed medically necessary and appropriate.
- Ordered by a physician (M.D. or D.O.) or other licensed practitioner of the healing arts within the scope of his/her state licensure.
- Provided by a qualified practitioner.

Prior authorization

School Based Child Health Services do not require prior authorization. See the Provider Type 60 Fee Schedule for a list of available procedure codes.

Third party liability (TPL)

If another insurer (public or private) is legally responsible for payment, Medicaid pays the claim and then attempts to recover the paid amount from the legally responsible payer. This does not relinquish the school district's responsibility to obtain and disclose all available insurance information and obtain parental consent to bill public and private insurances.

Claim submission instructions

Submit claims monthly. Submit claims by using Direct Data Entry (DDE) through the Electronic Verification System (EVS) secure Provider Web Portal or by using a Trading Partner or billing agent. See EVS Chapter 3 Claims and the electronic billing companion guides for claim submission instructions.

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Use of a billing agent

Schools may use a billing agent rather than submitting claims directly to Nevada Medicaid provided that the appropriate business partner agreements are in place. The school is responsible for all claims submitted by its billing agent and must maintain documentation that billing was reviewed and approved prior to its submission to Nevada Medicaid.

To remain current with Nevada Medicaid rules and policies, it is recommended that providers and billing agents review both DHCFP and Nevada Medicaid provider websites for publication updates, web announcements and newsletters.

Incorrectly billed claims

If a claim is paid and Medicaid later discovers that the service was incorrectly billed, incorrectly paid, or invalid in some other way, federal law requires Medicaid to recover overpayment, regardless of the cause.

Modifiers

The following modifiers identify the type of service performed. Proper use of these modifiers is indicated in the sections that follow and in the Provider Type 60 Fee Schedule.

Modifier	Definition
AH	Clinical Psychologist
AM	Physician's Assistant
GN	Outpatient Speech Language
GO	Outpatient Occupational Therapy
GP	Outpatient Physical Therapy
SA	Nurse Practitioner
TD	Registered Nurse

Units

The servicing provider must document the amount of time spent for each service. For codes that specify a time segment in their description, e.g., each 15 minutes or each 30 minutes, each of these timed segments equals one unit. Enter the number of units on the claim; do not enter time spent on the service.

If more than half of a timed segment is performed, round up to the next unit. If less than half of a timed segment is performed, round down. For example, if a code is timed in 15-minute segments, partial timed segments must be at least eight minutes long in order to round the time up to the next unit.

- 22 minutes = 1 unit + 7 remaining minutes: Bill 1 unit.
- 23 minutes = 1 unit + 8 remaining minutes: Bill 2 units.

If a code does not specify a time segment in its description, it is considered an encounter or occurrence code. Bill one unit for the procedure, regardless of time spent.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the

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Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Electronic Claims instructions: When reporting the provider who ordered services such as diagnostic and lab, use Loop ID-2310A. For ordered services such as Durable Medical Equipment, use Loop ID-2420E. For detailed information, refer to the 837P FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx

Direct Data Entry/Provider Web Portal instructions: On the Service Detail line enter the OPR provider's NPI in the Referring/Ordering Provider ID field, and select "Yes" or "No" to indicate it if is an Ordering Provider. For further instructions, see the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

Rates

The Provider Type 60 Fee Schedule includes a list of covered codes, prior authorization requirements, service limitations and current Nevada Medicaid rates. The fee schedule is online at http://dhcfp.nv.gov/Resources/Rates/RatesDisclaimer/

If you have questions regarding rates, please refer to MSM Chapter 700, Reimbursement, Analysis and Payment.

Covered services

Medicaid covers the following services provided in a school or other community site.

MSM Chapter 2800 and the sections that follow provide detailed coverage information on each service.

- Audiology services and supplies
- Evaluation/Diagnostic services
- IEP services
- Medical supplies
- Nursing services
- Psychological counseling
- Therapy services (physical therapy, occupational therapy, speech therapy)

With the exception of DME provider type 33, providers must document all face-to-face time. Consults, monitoring and coordination are not paid separately.

The following sections list Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes and modifiers that school districts must use when billing. Billing must be in accordance with Nevada Medicaid billing instructions and national billing standards.

Audiology services and supplies

Covered audiology services and supplies are listed on the Provider Type 60 Fee Schedule. These services and supplies must be documented in the recipient's IEP in order to receive payment.

Evaluation/diagnostic Services

Use the following codes to bill for evaluation/diagnostic services.

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- With the exception of modifier GN for codes 92521, 92522, 92523 and 92524, these codes do not require use of a modifier.
- Codes 96150-96155 cannot be billed with CPT codes 90801-90899.
- Codes 92620 and 92621 cannot be billed with CPT code 92506.

Code	Description	Service limitations
T1001	Nursing assessment and evaluation (RN only)	Encounter = 1 unit Limited to 2 units per day (Limited to 16 units per calendar year)
90801	Psychiatric diagnostic interview examination	Encounter = 1 unit (Limited to 2 units per calendar year)
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	Encounter = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Encounter = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Encounter = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92524	Behavioral and qualitative analysis of voice and resonance	Encounter = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92610	Evaluation of oral and pharyngeal swallowing function (For use by qualified Speech therapist)	Encounter = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92620	Evaluation of central auditory function, with report, initial 60 minutes (For use by a qualified Audiologist)	60 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
92621	Evaluation of central auditory function, with report, each additional 15 minutes (code 92620 is the initial hour) (For use by a qualified Audiologist)	15 minutes = 1 unit Limited to 4 units per day (Limited to 8 units per calendar year)
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	60 minutes = 1 unit (Limited to 8 units per calendar year)

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Code	Description	Service limitations
96110	Development testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report (For use by a qualified Psychologist)	Encounter = 1 unit (Limited to 2 units per calendar year)
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	60 minutes = 1 unit Limited to 1 unit per day (Limited to 8 units per calendar year)
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with patient; initial assessment	15 minutes = 1 unit Limited to 8 units per day (Limited to 16 units per calendar year)
96151	Re-assessment (code 96150 is the initial assessment)	15 minutes = 1 unit Limited to 6 units per day (Limited to 8 units per calendar year)
97161	Physical therapy evaluation, low complexity: Typically face-to-face with the patient and/or family	20 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97162	Physical therapy evaluation, moderate complexity: Typically face-to-face with the patient and/or family	30 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97163	Physical therapy evaluation, high complexity: Typically face-to-face with the patient and/or family	45 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97165	Occupational therapy evaluation, low complexity: Typically face-to-face with the patient and/or family	30 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97166	Occupational therapy evaluation, moderate complexity: Typically face-to-face with the patient and/or family	45 minutes = 1 unit, Limited to 1 unit per day (Limited to 2 units per calendar year)
97167	Occupational therapy evaluation, high complexity: Typically face-to-face with the patient and/or family	60 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)

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IEP services

Use the following codes to bill for participation in IEP development, review and revision for medical-related services (educational services and goals are excluded).

- All providers, except audiologists, must use a modifier on the claim to appropriately describe their professional vocation (refer to the Modifiers section above).
- The claim's date of service is the date on the IEP.
- Each provider may bill a maximum of 8 IEP service units per calendar year (i.e., codes 99366, 99367 and 99368 combined).
- Codes 99367 and 99368 cannot be billed for the same IEP meeting.

Code	Description
99366	Medical team conference with interdisciplinary team of health care professionals, face–to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional. Limited to 1 unit per day
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more, participation by physician. Limited to 1 unit per day
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more, participation by non-physician health care professional. Limited to 1 unit per day

Medical supplies

Covered medical supplies are listed on the Provider Type 60 Fee Schedule. Medical supplies must be documented in the recipient's IEP in order to receive payment.

Nursing services

The following services must be performed by a licensed nurse in accordance with the IEP. Medicaid does not cover nursing procedures that can be delegated to unlicensed assistive personnel by a Registered Nurse (RN) following a competency assessment and proper training.

- Modifiers are not required.
- One unit equals 15 minutes.
- Service is limited to 32 combined units per day (i.e., a claim that lists code T1002 and code T1003 cannot exceed 32 units for both codes in one day).

Code	Description
T1002	Registered Nurse (RN) services, up to 15 minutes (direct services)
T1003	Licensed Practical Nurse (LPN) services up to 15 minutes

Psychological services

Medicaid provides coverage for the following psychology services in accordance with the IEP.

- Modifiers are not required.

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- One unit equals 15 minutes.
- Codes 96150-96155 cannot be billed with codes 90801-90899.

Code	Description
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual Limited to 6 units per day
96153	Health and behavior intervention, group (2-6 individuals per group) Limited to 8 units per day

Physical therapy services

Physical therapy must be provided by or under the supervision of a qualified health care professional in accordance with the IEP.

- All codes below, except code 97164, require the use of modifier GP. Code 97164 is billed without a modifier.
- Codes 97755 and 97116 (gait training) cannot be billed in conjunction when performed on the same extremity.

Code	Description	Service limitations
95831	Muscle testing, manual (separate procedure) with report, extremity (excluding hand) or trunk	Encounter = 1 unit (Limited to 2 units per calendar year)
97164	Physical therapy re-evaluation Typically face-to-face with the patient and/or family	20 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97010	Application of a modality to one or more areas; hot or cold packs	Encounter = 1 unit Limited to 1 unit per day
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility; individual	15 minutes = 1 unit (Limited to 6 units per day)
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	15 minutes = 1 unit (Limited to 4 units per day)
97116	Gait training (includes stair climbing)	15 minutes = 1 unit (Limited to 4 units per day)
97150	Therapeutic procedure(s) group (2-6 individuals per group)	1 encounter = 1 unit (Limited to 1 unit per day)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)

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Code	Description	Service limitations
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one- on-one) patient contact by the provider, each 15 minutes	15 minutes = 1 unit (Limited to 4 units per day)
97535	Self-care/home management training (e.g., activities of daily living (ADLs) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	15 minutes = 1 unit (Limited to 8 units per day)
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, each 15 minutes	15 minutes = 1 unit (Limited to 8 units per day)
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)

Occupational therapy services

Physical therapy must be provided by or under the supervision of a qualified health care professional in accordance with the IEP.

- All codes below, except code 97168, require the use of modifier GO. Code 97168 is billed *without* a modifier.
- Do not bill codes 97755 and 97116 (gait training) in conjunction if performed on the same extremity.

Code	Description	Service maximum
97168	Occupational therapy re-evaluation Typically face-to-face with the patient and/or family	30 minutes = 1 unit Limited to 1 unit per day (Limited to 2 units per calendar year)
97010	Application of a modality to one or more areas; hot or cold	Encounter = 1 unit Limited to 1 unit per day
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility; individual	15 minutes = 1 unit (Limited to 6 units per day)
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	15 minutes = 1 unit (Limited to 4 units per day)

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Code	Description	Service maximum
97116	Gait training (includes stair climbing)	15 minutes = 1 unit (Limited to 4 units per day)
97150	Therapeutic procedure(s) group (2-6 individuals per group)	1 Encounter = 1 unit (Limited to 1 unit per day)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct one-on- one patient contact by the provider, each 15 minutes	15 minutes = 1 unit (Limited to 8 units per day)
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct one- on-one patient contact by the provider, each 15 minutes	15 minutes = 1 unit (Limited to 4 units per day)
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	15 minutes = 1 unit (Limited to 8 units per day)
97755	Assistive technology assessment (e.g., To restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	15 minutes = 1 unit (Limited to 8 units per day)
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	15 minutes = 1 unit (Limited to 6 units per day)

Speech therapy services

Medicaid provides coverage for the following psychology services.

- All codes below require the use of modifier GN.
- One encounter equals one unit.
- Service is limited to one encounter per day.
- Do not report code 92507 on the same day in conjunction with 0364T, 0365T, 0368T or 0369T.
- Do not report code 92508 on the same day in conjunction with 0366T, 0367T or 0372T.

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Code	Description
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder; group (2-6 individuals per group)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function. Limited to 2 per calendar year.