Handbook for Local Education Agency Services

Policy and Procedures For Medical Services

Illinois Department of Healthcare and Family Services
Issued December 16, 2025

Revision History

Date	Reason for Revisions
Policies and procedures as of July 1, 2021. Published: December 16, 2025.	Program expansion federally approved in 2023 retroactive to an effective date of July 1, 2021.

Local Education Agency Services

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Foreword

The foundation for the relationship between Medicaid and education was established by the Medicare Catastrophic Coverage Act (Public Law 100-360), as amended in 1988. Illinois has actively supported this relationship since 1992, through the School Based Health Services (SBHS) program. Effective July 1, 2021, Illinois expanded the SBHS program to include reimbursement for all Medicaid-enrolled students. Prior to this expansion, schools could only bill for services for children with an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP).

Any public school district, Special Education Cooperative, charter, or a K12 educational institution (hereafter referred to as local education agencies) may participate in the SBHS program by entering into an intergovernmental agreement (IGA) with the Department of Healthcare and Family Services (HFS or the Department). Local education agencies (LEAs) may obtain a copy of the SBHS IGA from the Bureau of Program and Policy Coordination by emailing HFS.SBHS@illinois.gov.

The SBHS program provides reimbursement to local education agencies (LEAs) for two broad categories of services in accordance with specifications approved by the federal Centers for Medicare and Medicaid Services (CMS):

- Medical services, which allows LEAs to receive reimbursement for delivering direct services to Medicaid-enrolled students. Services must be covered under the Medicaid State Plan or otherwise be available under the Early and Period Screening, Diagnostic, and Treatment (EPSDT) benefit.

- Administrative services, which allows LEAs to receive reimbursement for some of their costs associated with school-based administrative and outreach activities. This is generally referred to as the Medicaid administrative claiming (MAC) component of the SBHS program.

This provider handbook covers LEA policies and processes related to the medical services component of the SBHS program; administrative claiming is not addressed. For information regarding the MAC component, please refer to the Illinois Guide for SBHS Administrative Claiming.

201 Basic Provisions

This handbook has been prepared for the information and guidance of local education agencies (LEAs) who provide healthcare services to eligible students pursuant to an intergovernmental agreement with HFS. The policies contained herein are not applicable to any other provider type, including School Based/Linked Health Centers (SBLHC). For information on SBLHC policies, please refer to the SBLHC Provider Handbook.

It is important both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook will be released as necessary based on operational need and State or federal laws requiring policy and procedural changes. The updates will be posted to the Department's Provider Handbooks webpage. Providers should register to receive e-mail notification when new provider information has been posted by the Department.

Providers are held responsible for compliance with the policies and procedures outlined in the Handbook for Providers of Medical Services, General Policy and Procedures and the policy and procedures contained in this handbook. Providers submitting X12 electronic transactions must refer to the Handbook for Electronic Processing. This handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by HFS.

Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

The billing instructions contained within this handbook apply to LEAs billing for customers enrolled in traditional Medicaid fee-for-service as well as customers enrolled in a HealthChoice Illinois managed care health plan. LEA services are carved out of managed care and claims for managed care customers are billed directly to HFS.

Inquiries regarding coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 877-782-5565. Questions regarding the policies or service requirements outlined within this handbook may be directed to the Bureau of Policy and Program Coordination at HFS.SBHS@illinois.gov.

202 Provider Enrollment

Reimbursement for healthcare services delivered by an LEA is limited to those providers enrolled for participation in the Department's Medical Programs via the web-based provider enrollment system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). For provider enrollment questions, please call 1-877-782-5565, option 1 to speak to a Provider Enrollment Specialist. If you are experiencing issues logging into the IMPACT system, please email the login help desk at IMPACT.Login@illinois.gov

202.1 LEA Enrollment

Entities qualified to enroll as an LEA include:

- Public school districts with an enrolled student population.
- Special education cooperatives and joint agreements.
  - A voluntary association of school districts that join to provide special education services using a shared administrative structure.

To enroll with HFS, LEAs must complete and submit a Facility/Agency/Organization (FAO) enrollment application through the IMPACT system, selecting the following Provider Type/Specialty/Subspecialty combination:

Provider Type Name	Specialty	Subspecialty
Education Agencies	Local Education Agencies	No Subspecialty

LEAs must have a Type 2 (Organizational) National Provider Identifier (NPI) to enroll. Information about obtaining an NPI is located on the CMS website.

When completing the IMPACT application, LEAs will be required to enter their Region County District (RCD) code issued by the Illinois State Board of Education during the step titled "Add License/Certifications/Other."

202.2 Ordering, Referring, Prescribing Practitioner Enrollment

Certain services provided by LEAs require an order or referral from a qualified practitioner (i.e., occupational therapy, physical therapy, speech therapy, audiology services). Individual practitioners that order, refer, or prescribe any of these services for a student must enroll as an individual practitioner or claims for these services will reject. Individual practitioners should refer to the appropriate HFS provider handbook for their provider type for information on how they must enroll in IMPACT.

202.3 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data as it appears on the

provider's enrollment in the Department's files. The provider is to review this information for accuracy immediately upon receipt. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department file. If any information is incorrect, the provider must notify HFS immediately via IMPACT.

Enrollment of a provider is subject to a provisional period and shall be conditional for one-year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or disenroll the provider from the Medical Assistance Program without cause.

202.4 Enrollment Denial

When enrollment is denied, the provider will receive written notification of the reason for denial. Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of enrollment are set out in 89 Ill. Adm. Code 140.14. Department rules concerning administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

202.5 Provider File Maintenance

The information in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated. The provider should ensure that all information in the IMPACT system is accurate and up to date at all times. Provider Enrollment Services (PES) is the section within HFS responsible for reviewing and approving any modifications to provider enrollment records.

202.5.1 Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any changes in provider information or inaccuracies found on the Provider Information Sheet must be corrected by submitting a modification in IMPACT.

The IMPACT modification function is available to notify the Department of updates to required enrollment information for the following categories:

- National Provider Identifier (NPI)

- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)
- Add a billing provider
- End date a billing provider
- Close enrollment
- License information

Failure of a provider to properly update the IMPACT provider enrollment system with corrections or changes may cause an interruption in participation and payments.

202.5.2 Department Responsibility

When a provider submits a modification in IMPACT, the Department will review the request and either reject or approve the modification. The Department will generate an updated Provider Information Sheet reflecting the modification and the effective date of the modification, if appropriate. The updated sheet will be sent to the provider's office address and to all billing providers associated to the provider in IMPACT.

203 Provider Reimbursement

Payment for covered healthcare services delivered by LEAs is made according to a federally approved reimbursement methodology that is cost-based, district-specific, annually reconciled, and cost settled.

LEAs submit claims to HFS on a regular basis for each covered service delivered to Medicaid-enrolled students and in turn receive interim claim payments. On an annual basis a district-specific cost reconciliation to the district's final and audited cost reported is conducted. A subsequent cost settlement is processed, with under payments paid out and overpayments recouped directly from the LEA. This section provides information on these LEA reimbursement processes and outlines the policies LEAs are required to adhere to.

HFS contracts with a vendor, Public Consulting Group (PCG), to conduct the cost reconciliation and cost settlement processes. Additional details on these processes and technical assistance for LEAs is available from PCG. LEAs can contact PCG via email at ilmac@pcgclaimingsystem.zendesk.com or by calling 833-976-1847.

203.1 Interim Payments via Required Claims Submission

LEAs are required to submit procedure-specific direct healthcare service claims for all Medicaid allowable services (see Section 205). These claims are required to monitor the services provided, the Medicaid eligibility of the student, and to provide an audit trail. Claims are to be submitted to the Department only after the services have been provided. HFS will monitor LEA claim volume to ensure this mandate is followed; LEAs suspected of non-compliance with this requirement will be contacted by HFS to identify potential issues or barriers and to devise a plan for correction.

Districts will only receive reimbursement (referred to as interim payments) for each claim submitted to HFS and positively adjudicated. It is the LEA's responsibility to verify claims are received by the Department and to check claim status. Service claims will be paid out at the district's specific service rates. Reimbursement of interim claims will be issued to the LEA's designated payee once a month.

These interim payments will be utilized for each participating LEA during the annual cost reconciliation process to determine the district's final cost settlement amount to be paid out or recouped.

203.2 Service Rates

Each LEA has their own specific cost-based rate established for each billable procedure code using a federally approved cost calculation methodology. To establish the cost-based rate, the total reported annual cost from the district is divided by the reported number of annual service hours to establish a cost per hour for each service. These cost-based rates are then loaded in the Department's

Medicaid Management Information System (MMIS) and used to calculate the amount in interim payments to be paid to LEAs based on claims submissions.

Cost-based service rates may be recalculated periodically; LEAs will receive written notice of any updates to their service rates. The written notice will identify the effective date and rate for each service, along with information about the LEA's right to appeal the recalculated rate within thirty (30) days after issuance of the written notice.

Questions regarding district-specific service rates should be directed to the Bureau of Program and Policy Coordination at HFS.SBHS@illinois.gov.

203.3 Federal Reimbursement

Reimbursement by the Department is limited to the federal financial participation (FFP) for eligible expenditures incurred by the LEA. FFP is the federal money a state receives for expenditures under its Medicaid program and represents a partial reimbursement of a public expenditure. Reimbursement will be made at the regular Federal Medical Assistance Percentage (FMAP). Claiming for services provided by federally funded personnel is not permitted.

203.4 Random-Moment Time Study (RMTS) Process

All LEAs receiving reimbursement under the SBHS program are required to participate in a statewide random-moment time study (RMTS) conducted by PCG. The RMTS is part of Illinois' federally approved reimbursement methodology for LEAs and drives reimbursement under both the MAC program and the direct services cost settlement process.

The RMTS process polls participating staff on an individual basis at random time intervals over a given time period to determine what activity they are doing during that random moment. The results are then totaled to determine the work effort for the entire population of staff statewide over the same time period. This process serves as a statistically valid means of determining what portion of district staff's workload is spent performing Medicaid reimbursable activities.

Additional detail on the RMTS process and procedures can be found in the Illinois Guide for SBHS Administrative Claiming.

203.5 Cost Reporting

Each LEA must complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due to PCG 365 days after the end of the state fiscal year. The primary purposes of the cost report are to:

1) Document the LEA's total Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on cost allocation methodology procedures; and,
2) Reconcile the LEA's interim payments to its total Medicaid-allowable scope of costs based on federal cost allocation methodology procedures.

The annual SBHS cost report includes a certification of funds statement that must be completed, certifying the district's actual, incurred costs/expenditures. All participating LEAs must submit a cost report to certify to their allowable costs. If a cost report is not submitted, there are no allowable costs, and all interim payments must be returned. All filed cost reports are subject to a desk review by the Department or its designee.

203.6 Cost Reconciliation and Cost Settlement

Annually, HFS or its designee will conduct the SBHS cost reconciliation and cost settlement processes. Through this process, a total Medicaid allowable scope of costs is determined for each LEA based on the state's CMS-approved cost allocation methodology procedures. This total amount is compared to the interim payments made to the LEA for school health services during the reporting period, resulting in a cost reconciliation.

If the actual, certified costs of the LEA for school health services exceed the interim payments, HFS will issue a payment to the district for the federal share of the difference in accordance with the final actual certification. If the LEA's interim payments exceed the actual, certified costs of the district for school health services to Medicaid students, the LEA will be required to return an amount equal to the overpayment. The Department will issue a written notice of settlement to each LEA indicating the amount due to or from the provider and outlining any necessary next steps.

203.7 Failure to Participate in Required Activities

LEAs that fail to participate in any required activities pursuant to the CMS-approved federal reimbursement methodology (i.e., cost reports, interim claims submission, RMTS) in required timeframes may be subject to corrective action, including repayment of federal dollars. Repeated failure to comply with program requirements may result in a district's termination of participation in the SBHS program.

204 Claim Requirements

204.1 Electronic Claim Preparation and Submittal

LEA services are billed electronically on the 837 Professional (837P) transaction. Information regarding electronic 837P transactions may be found in the Chapter 300, 5010 Companion Guide. All LEA services use the same taxonomy code identified for LEAs in the Taxonomy for 837P chart. Claims may also be submitted via direct data entry within the MEDI system.

For claims requiring attachments providers must use the Attachment Upload Portal. **Providers are strongly advised to upload the attachment before submitting the claim.** Claims are associated to the attachments by the Attachment Control Number (ACN). Providers must submit the ACN in Loop 2300, PWK06 on the X12 electronic claim. By providing the same ACN on the claim and the attachment, the system will associate the two to each other.

Claims and attachments should be submitted on the same day before 7:00 p.m. If the attachment is not found, the claim will process and if the attachment was required for processing, the claim will reject appropriately.

If a problem occurs with electronic billing, the provider should contact the Department. It may be necessary for the provider to contact their software vendor if the Department determines the service rejections are being caused by the submission of incorrect or invalid data.

Providers should take special note that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the remittance advice (voucher). Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims.

204.2 Provider Charges

Charges must be submitted to the Department via an electronic 837P transaction only after the services have been provided. Charges must be the actual costs of providing the services. If services are provided to more than one student, group rates must be used, where available.

204.3 Timely Filing

A claim will be considered for payment only if it is received by the Department no later than 180 days from the date on which the services or items were provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid.

204.4 Billing Provider

Special education cooperatives and joint agreements may file claims on behalf of the LEA they serve, effectively serving as a billing provider. In these situations, the billing provider must utilize the NPI of the LEA that employed the rendering service provider to denote the appropriate LEA as the provider of record.

204.5 Ordering, Referring, Prescribing (ORP) Provider

Claims for services that require an order, referral, or prescription as a component of establishing medical necessity must include the NPI of the ORP provider. LEA services requiring the ORP on claims include occupational therapy, physical therapy, speech/language services, and audiology services.

204.6 Document Control Number (DCN)

Except for those claims received by the Department and immediately returned to the provider as being unacceptable for processing, all claims received are assigned a unique 12-digit Document Control Number (DCN) and are systematically processed. The DCN consists of the date the claim was received by the Department (displayed as a Julian date) plus an individual number to identify the specific claim. The DCN format is YDDDLLSSSSSS:

Y - Last digit of year claim was received
DDD - Julian date claim was received
LL - Document Control Line Number
SSSSSS - Sequential Number

A Julian date calendar is available as a resource in General Appendix 1 of the Chapter 100 General Policy and Procedures Handbook.

204.7 Remittance Advice

Adjudicated claims are identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the provider's payee address on file with the Department. Refer to the All Providers Handbook Supplement for explanations of Remittance Advice detail provided to providers.

Remittance advices for paid claims will be issued to the LEA's designated payee once a month. Remittance advices for rejected claims will be issued to the designated payee weekly.

The remittance advices will provide the detail for each claim submitted by the LEA, such as reimbursement and error codes for each service rejected. The LEA is to review the remittance advices to determine if the reimbursement is correct and

submit an HFS 2292 Adjustment - NIPS form for incorrect reimbursements. If the service has been rejected for other than H37, “Services Not Covered for LEA/DORS,” the claim must be reviewed, corrected, and resubmitted to receive reimbursement. The H37 error code message will be shown for those students for whom federal reimbursement cannot be collected.

205 Covered Services

Covered LEA services are face-to-face, medically necessary health-related services provided to a student or group of students. Services and materials are covered only when provided in accordance with the requirements described within this handbook. Detailed service descriptions for each LEA covered service are provided within this handbook section.

The LEA must use the appropriate Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, identified for each service within this handbook, when submitting claims for reimbursement. While the various procedure codes listed are to be used to designate services provided or procedures performed, such listing does not necessarily assure reimbursement.

205.1 General Limitations and Considerations

Certain services are covered only when provided in accordance with the limitations and requirements described in this section 205. Unless otherwise noted, services are billed in units of 15-minute increments (i.e., 1 unit = 15 minutes) with a maximum billable quantity of 32 units per day. At least 8 minutes of face-to-face service must be provided to claim each unit. A few examples illustrating this rule are below:

- Total service time is 12 minutes = bill 1 unit
- Total service time is 20 minutes = bill 1 unit (1 15-min. unit + 5 mins. remainder)
- Total service time 24 minutes = bill 2 units (1 15-min. unit + 9 mins. remainder)

Individual units of a service may be "rolled up" into one claim if the services have the **same**:

- procedure code.
- date of service.
- place of service.
- staff level of qualification.

Rolling up units is allowed to facilitate billing for numerous incidents of the same service provision during a day. Bundled minutes, which is not allowed, is gathering less than 1/2 units into a billable unit. Per the American Medical Association (AMA) billing guidelines, if the leftover minutes come from a combination of services, you cannot bill for any of them unless one individual service totals at least 8 minutes.

"Under the direction of" is defined as work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly (at least monthly) reviews the work performed, and who is accountable for the results. The supervisor must co-sign documentation of all services provided by practitioners working under his or her direction.

205.2 Establishing Medical Necessity within a Plan of Care

Medically necessary services that are fully documented in the IEP/IFSP or other medical plan of care are covered, as well as services performed as part of the development of the IEP/IFSP or other medical plan of care.

- Individualized Education Program (IEP) - A written plan for every student receiving special education services that contains information such as the student's special learning needs and the specific special education services required for the student. The document is periodically reviewed and revised.

- Individualized Family Service Plan (IFSP) - A written plan for infants and toddlers with disabilities that describes services to be provided and expected outcomes and is developed in cooperation with the child's parents or guardian.

- Other medical plans of care in which medical necessity has been established – These include 504 plans, individual health plans (IHPs), prescriptions, doctor's orders, etc. This document must be periodically reviewed and revised.

To establish medical necessity, the plan of care (i.e., IEP, IFSP, other medical plan of care) must document the following for each service being provided:

- Start and end date;
- Scope, frequency, and duration for the service; and,
- Rationale or justification for the service.

Plans of care that do not include these elements do not meet the requirement for the establishment of medical necessity and will not support the billing of services.

205.3 Establishing Medical Necessity without a Plan of Care

For medical services to be eligible for Medicaid reimbursement, the determination of medical necessity for that service must be established and documented within an approved plan of care (POC). However, there are two exceptions in which medical necessity may be established without a POC:

- The student's medical or behavioral health needs require the urgent delivery of services. In these instances, if ongoing services are needed and continue to be delivered because of the urgent need, a POC establishing the medical necessity for the services must be developed within 30 calendar days from the first date that services are provided for a specific condition.

- Mandated health related screenings and evaluations are eligible to be billed without an established POC. Those mandated health related evaluations and screenings are covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

205.4 Adaptive Behavior Support (ABS) Services

Service Description: Adaptive Behavior Support (ABS) services are evidence-based interventions provided to help improve social, communicative, and adaptive living skills as well as to address challenging behaviors. ABS services include:

- Behavior assessment and Treatment Planning (BATP), which is a formal process of assessing a student's current maladaptive or disruptive behaviors, functional skills, skill deficits, skill acquisition and maintenance of skills, and developing or updating individualized treatment goals, objectives and service recommendations based upon the assessment findings.
- Behavior analysis intervention (BAI), which are evidence-based interventions identified on the individual's BATP that use behavioral stimuli and consequences to produce socially significant improvement in behavior.
- Parent coaching and training.

Medical Necessity: ABS services are covered when provided to a student under the age of 21 with a diagnosis of autism spectrum disorder (ASD), as indicated by a comprehensive diagnostic evaluation, and requires a documented recommendation by a licensed physician or a licensed clinical psychologist operating within their scope of practice.

Evidence-Based Interventions: BAI services must be delivered consistent with evidence-based practice guidelines for applied behavior analysis (ABA) therapy or any other HFS-recognized developmental intervention. Refer to the Handbook for Providers of ABS Services for additional information on evidence-based intervention requirements.

ABS Staff Qualifications: ABS services are to only be provided by staff operating within the scope of their training and education and in line with evidence-based intervention requirements. Refer to the Handbook for Providers of ABS Services for additional information on the staffing requirements for ABS evidence-based interventions. Qualified ABS staff include:

- Licensed clinical psychologists

- Licensed clinical social workers (LCSW) with advanced training in developmental interventions
- Licensed clinical professional counselors (LCPC) with advanced training in developmental interventions
- Licensed marriage and family therapists (LMFT) with advanced training in developmental interventions
- Licensed occupational therapists with advanced training in developmental interventions
- Licensed speech-language pathologists with advanced training in developmental interventions
- Licensed behavior analysts (LBA)
- Licensed assistant behavior analysts (LABA) delivering services under the supervision of an LCP or LBA
- Registered Behavior Technicians (RBTs) certified by the Behavior Analyst Certification Board (BACB) and who deliver services under the supervision of an LCP, LBA, or LABA. Individuals who have completed 40 hours of RBT training and passed the RBT initial competency assessment may provide ABS services for up to 120 calendar days while concurrently seeking full RBT certification from the BACB.
- Behavior Technicians who deliver services under the supervision of any of the licensed providers listed above. Behavior Technicians must be 18 years or age or older, have a high school diploma or GED, and have received technical training in developmental interventions.

Billing Information

Procedure Code	Description	Category of Service
Refer to the Adaptive Behavioral Support Services fee schedule	ABS Services	126

205.5 Audiology Services

Service Description: Covered audiology services include:

- Evaluations, tests, tasks, and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning
- Auditory training and speech reading
- Counseling and guidance regarding hearing loss
- Determining the need for group and individual amplification
- Providing for selection and fitting of hearing aids
- Evaluating the effectiveness of amplification

Medical Necessity: Audiology services require a documented referral by a physician or other licensed practitioner of the healing arts acting within their scope of

practice under state law. The referral must be updated annually and be maintained in the student's health record.

Professional Qualifications:

- Licensed audiologist; or
- Staff with a Master's degree in audiology and Certificate of Clinical Competence in audiology.

Billing Information

Procedure Code	Description	Category of Service
V5299	Audiology	14

205.6 Developmental Assessments

Service Description: Determining a student's level of needed service by utilizing recognized assessment tools necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the IEP/IFSP or other medical plan of care including, but not limited to:

- Vision assessments – students may be assessed once a year at age-appropriate intervals unless additional screenings are determined medically necessary.
- Hearing assessments – students may be assessed at age-appropriate intervals. After the initial screening, all children may be assessed once a year unless additional screenings are determined medically necessary.
- Developmental assessments – students may be assessed at age-appropriate intervals unless additional screenings are determined medically necessary.
- Other assessments covered under EPSDT.

Professional Qualifications: Non-physician personnel administering vision, hearing, or developmental assessments to preschool and school age children must be appropriately trained to provide the assessment. Certification by the Illinois Department of Public Health (DPH) for vision and hearing assessments should be completed. Non-physician personnel working in schools administering hearing screening tests can hold an Illinois Audiology License as issued by the Illinois Department of Financial and Professional Regulation (IDFPR) in lieu of DPH certification.

Billing Information:

Procedure Code	Description	Category of Service
99173	Vision screen	30
92551	Hearing screen	30
96110	Developmental Screening Tools*	30
96112	Developmental test administration and report, first 60 minutes*	30

96113	Developmental test administration and report, additional 30 minutes*	30
Billed with a unit of 1 for each assessment with a maximum billable quantity of 1 unit each for 99173, 92551, and 96112; a maximum billable quantity of 8 units for 96110; and a maximum billable quantity of 6 units for 96113.		
The developmental assessments are reimbursed based on the Practitioner Fee Schedule.		

Developmental screening tools and assessments approved by HFS are listed below:

Procedure Code	Description
96110	Ages & Stages Questionnaires (ASQ)
96110	Ages & Stages Questionnaires Social Emotional (ASQ:SE)
96110	Battelle Developmental Screener
96110	Bayley Infant Neurodevelopment Screener
96110	Brief Infant Toddler Social and Emotional Assessment (BITSEA)
96110	Brigance Early Preschool
96110	Chicago Early Developmental
96110	Screening Inventory
96110	Denver DST/Denver II
96110	Developmental Profile II
96110	Dial-R Developmental Assessment
96110	Dial - 3
96110	Early Language Milestone Scales Screen
96110	Early Screening Inventory
96110	Early Screening Profiles
96110	Infant-Toddler Symptom Checklist
96110	Minneapolis Preschool Screening Instrument
96110	Modified Checklist for Autism in Toddlers M-CHAT
96110	Parents' Evaluation of Developmental Status (PEDS)
96110	Parents' Evaluation of Developmental Status -- Developmental Milestones (PEDS: DM)
96110	Parents' Observations of Infants and Toddlers (POINT)
96110	Project Memphis DST
96110	Revised Developmental Screening Inventory
96110	Revised Parent Developmental Questionnaire
96110	Temperament and Atypical Behavior Scale (TABS) Screener
96112	Battelle Developmental Inventory
96112	Bayley Scales of Infant Development
96112	Child Behavior Checklist 2-3 and Caregiver-Teacher Report Form, Ages 2-5
96112	Child Development Inventory
96112	Conner's Rating Scales
96112	Early Coping Inventory
96112	Erhardt Development Prehension Assessment

96112	Hawaii Early Learning Profile
96112	Infant-Toddler Developmental Assessment
96112	Infant-Toddler Social and Emotional Assessment (ITSEA)
96112	McCarthy Screening Test
96112	Otis-Lenon School Ability Test
96112	Piers-Harris Children's Self Concept Scale
96112	Temperament and Atypical Behavior Scale (TABS) Assessment Tool
96112	Vineland Adaptive Behavior Scales
96112	Vineland Mal Adaptive Skill
96112	Vineland Social-Emotional Early Childhood Scales
96112	Vineland Social Maturity Scale

Developmental screening and assessment tools may be revised to reflect new advances. Revisions to the tools listed above are approved for reimbursement by HFS. However, HFS reserves the right to periodically review revisions to previously approved tools to assure they continue to meet the reimbursement approval criteria. If the revised tool does not meet the criteria, HFS can deny approval for reimbursement. HFS will post the rescission of approval on our website at least 180 days prior to initiation of denials.

205.7 Medical Equipment

Service Description: Medical equipment, as specified in the student's IEP/IFSP or other medical plan of care, are durable items that can withstand repeated use (such as wheelchairs, canes, walkers, etc.), are primarily designed for medical purposes, and are generally not useful in the absence of disability, infirmity, or impairment. Such equipment is for the exclusive use of the student and is the property of the student. Refer to the Handbook for Providers of Medical Equipment and Supplies for an explanation of policy and procedures relating to medical equipment.

Claimable Services: Medically necessary equipment may be claimed up to a total of $1,000 per day. Equipment costing more than $1,000 must be obtained through a durable medical equipment (DME) provider enrolled with the Department. LEA providers are encouraged to contact an enrolled DME provider for equipment needs, as an LEA only receives the FFP on the claim. A DME provider will bill the Department directly and receive the payment for the item.

Billing Information:

Procedure Code	Description	Category of Service
A9900	Equipment (billed with a unit of 1)	41

205.8 Medical Services

Service Description: Medical services necessary for the development of the student's IEP/IFSP, performed for the purpose of identifying or determining the nature and extent of the student's medical or other health-related condition.

Professional Qualifications: Medical services must be delivered by a physician licensed in the State of Illinois.

Billing Information:

Procedure Code	Description	Category of Service
T1018	Medical Services	01

205.9 Medical Supplies

Service Description: Medical supplies, as specified in the student's IEP/IFSP or other medical plan of care, are medical items that have a limited life expectancy purchased for use at school which are not durable or reusable, such as surgical dressings, disposable syringes, catheters, urinary trays, etc. Refer to the Handbook for Providers of Medical Equipment and Supplies for an explanation of policy and procedures relating to medical supplies.

Claimable Services: Medically necessary supplies may be claimed up to a total of $500 per day. Supplies exceeding $500 per day must be procured through a durable medical equipment (DME) provider enrolled with the Department. LEA providers are encouraged to contact an enrolled DME provider for medical supply needs, as an LEA only receives the FFP on the claim. A DME provider will bill the Department directly and receive the payment for the supply.

Billing Information

Procedure Code	Description	Category of Service
Refer to DME Fee Schedule	Medical Supplies (billed with a unit of 1)	48

205.10 Nursing Services

Service Description: Nursing services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the IEP/IFSP or other medical plan of care are professional services relevant to the medical and rehabilitative needs, provided through direct service intervention. Nursing services include, but are not limited to:

- Administering and monitoring medication
- Catheterization
- Evaluations and assessments

- Tube feeding
- Suctioning
- Actively monitoring a student's health condition
- Blood sugar testing or other diabetes related services

Professional Qualifications:

- Licensed registered nurse (RN); or
- School nurse (LSN) with a Professional Educator License with Endorsement for School Nurse; or
- Licensed practical nurse (LPN), working under the direction of a RN or LSN.

Billing Information:

Procedure Code	Description	Category of Service
T1002	RN Services	10
T1003	LPN Services	10
T1502 Modifier KO	Medication Administration*	10
*Billed in units of 5-minute increments with a maximum billable quantity of 3 units. Qualified professionals may use this code when dispensing medication to eligible students.		

205.11 Occupational Therapy

Service Description: Occupational therapy services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the IEP/IFSP or other medical pan of care include, but are not limited to:

- Evaluation of problems which interfere with the student's functional performance.
- Implementation of a therapy program of purposeful activities which are rehabilitative, active, or restorative as prescribed. These activities are designed to:
    - Improve, develop, or restore functions impaired or lost through illness, injury, or deprivation.
    - Improve ability to perform tasks for independent functioning when functioning is impaired or lost.
    - Prevent, through early intervention, initial or further impairment or loss of function.
    - Correct or compensate for a medical problem interfering with age-appropriate functional performance.

Medical Necessity: An order from a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under law is required for occupational therapy services. The Illinois Occupational Therapy Practice Act specifies practitioner types that can order services and includes licensed physician, dentist, podiatric physician, advanced practice registered nurse, physician assistant, or optometrist. The order must be updated annually and be maintained in the

student's health record. Refer to the Handbook for Providers of Therapy Services for additional information on therapy order requirements.

Group services: Occupational therapy services may be provided in either an individual or group setting. The number of customers in the group session should be limited to assure effective delivery of service.

Professional Qualifications:

- Licensed occupational therapist, registered by the American Occupational Therapy Association; or
- Certified occupational therapist assistant, practicing under the direction of a licensed occupational therapist.

Billing Information:

Procedure Code	Description	Category of Service
97535	Individual Occupational Therapy	12
97799	Group Occupational Therapy	12

205.12 Orientation and Mobility Services

Service Description: Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home, and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the IEP/IFSP or other medical plan of care include, but are not limited to:

- Providing assistance in the development of skills and knowledge that enable the child to travel independently to the highest degree possible, based on assessed needs and the IEP.
- Training the child to travel with proficiency, safety, and confidence in familiar and unfamiliar environments.
- Preparing and using equipment and material, such as tactile maps, models, distance low vision aids/devices, and long canes, for the development of orientation and mobility skills.
- Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision.
- Communication skills training (teaching Braille is not a covered benefit).
- Systematic orientation training to allow safe movement within their environments in school, home, and community.
- Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature, and vibration) to establish, maintain, or regain orientation.

- Visual training to understand and use the remaining vision for those with low vision.
- Training necessary to activate visual motor abilities.
- Training to use distance low vision aids/devices.
- Independent living skills training.

Professional Qualifications

- A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Billing Information: Claiming for orientation and mobility services is not yet available. Reimbursement will be maintained through the cost settlement methodology until billing processes are implemented.

205.13 Physical Therapy

Service Description: Physical therapy services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the IEP/IFSP or other medical plan of care include, but are not limited to:

- Evaluations and diagnostic services.
- Therapy services which are rehabilitative, active, or restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
    - Developing, improving, or restoring motor function.
    - Controlling postural deviations.
    - Providing gait training and using assistive devices for physical mobility and dexterity.
    - Maintaining maximal performance within a student's capabilities through the use of therapeutic exercises and procedures.

Medical Necessity: An order from a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under law is required for physical therapy services. The Illinois Physical Therapy Practice Act specifies practitioner types that can order services and includes licensed physician, dentist, advanced practice registered nurse, physician assistant, or podiatric physician. The order must be updated annually and be maintained in the student's health record. Refer to the Handbook for Providers of Therapy Services for additional information on therapy order requirements.

Group Services: Physical therapy services may be provided in either an individual or group setting. The number of customers in the group session should be limited to assure effective delivery of service.

Professional Qualifications

- Licensed physical therapist; or
- Certified physical therapist assistant, practicing under the direction of a licensed physical therapist.

Billing Information

Procedure Code	Description	Category of Service
97110	Individual Physical Therapy	11
97150	Group Physical Therapy	11

205.14 Psychological Services

Service Description: Psychological services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the student's IEP/IFSP or other medical plan of care are diagnostic or active treatments with the intent to reasonably improve the student's physical or mental condition and are provided to the student whose condition or functioning can be expected to improve with interventions. These services include, but are not limited to:

- Testing and evaluation that appraise cognitive, emotional, and social functioning, and self-concept.
- Interviews and behavioral evaluations including interpretations of information about the student's behavior and conditions relating to functioning.
- Therapy including providing a program of psychological services for the student with diagnosed psychological problems.
- Unscheduled activities for the purpose of resolving an immediate crisis.

Group services: Psychological services may be provided in an individual, group, or family setting. The number of customers in the group should be limited to assure effective delivery of service.

Crisis Intervention: Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral, and direct therapy. Since these services are unscheduled activities, they are not listed in the student's plan of care. Crisis intervention services can be provided for up to 30 days from the event without a medical plan of care. If services are to extend beyond 30 days, a formal medical plan of care must be established meeting all the requirements necessary to document medical necessity for those services to be billed.

Professional Qualifications

- Psychologists with a Professional Educator License with Endorsement for School Psychologist; or
- Licensed clinical psychologists; or

- Psychologist intern with Illinois State Board of Education (ISBE) approval, who provides services under the direction of a qualified school psychologist.

Billing Information

Procedure Code	Description	Category of Service
90832 Modifier AH	Individual Psychological Service	59
90853 Modifier AH	Group Psychological Service	59

205.15 School Health Aide Services

Service Description: School health aide services, documented in the student's IEP/IFSP or other medical plan of care, provide assistance with activities of daily living and are necessitated by the student's medical condition. These services include, but are not limited to:

- Transferring and ambulating.
- Assistance with food, nutrition, and diet activities.
- Bowel and bladder care.
- Active redirection and active intervention for medically-related behavior (non-discipline related) with the medical need outlined specifically in the plan of care.

These services are generally the responsibility of family members when the student is at home. Services provided to the student by family members are not claimable.

Exception: In the instance of a student who receives services through a home and community-based services (HCBS) waiver and continuity of care is determined to be in the best interest of the student, the student's provider under the waiver program may continue to provide the personal care services in the school setting.)

Professional Qualifications: Staff who have been trained and remain under the direction of skilled professional medical personnel or a qualified professional. Skilled professional medical personnel have completed a two-year or longer professional educational program leading to an academic degree or certification in a medical or medically-related profession, have skilled professional medical activities included in their job descriptions, and use their professional medical knowledge in performing work-related activities.

Billing Information:

Procedure Code	Description	Category of Service
T1021	School Health Aide	93

205.16 Social Work/Counseling Services

Service Description: Social work/counseling services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the student's IEP/IFSP or other medical plan of care are diagnostic or active treatments provided with the intent to reasonably improve the student's physical or mental condition or functioning. Social work/counseling services include those services provided to assist the student or family members in understanding the nature of the disability, the special needs of the student, and the student's development. These services include, but are not limited to:

- Screenings, assessments, and evaluations.
- Social development studies.
- Counseling and therapy.
- Unscheduled activities for the purpose of resolving an immediate crisis situation.

Group Services: Social work/counseling services may be provided in an individual, group, or family setting. The number of customers in the group session should be limited to assure effective delivery of service.

Crisis Intervention: Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral, and direct therapy. Since these services are unscheduled activities, they are not listed in the student's plan of care. Crisis intervention services can be provided for up to 30 days from the event without a medical plan of care. If services are to extend beyond 30 days, a formal medical plan of care must be established meeting all the requirements necessary to document medical necessity for those services to be billed.

Professional Qualifications:

- Social worker with a Professional Educator License with Endorsement for School Social Worker; or
- Social work intern with ISBE approval who provides counseling and evaluation services under the direction of a qualified social worker; or
- Licensed clinical social worker (LCSW); or
- Licensed clinical professional counselor (LCPC); or
- School Counselor with a Professional Educator License with Endorsement for School Counselor; or
- Licensed marriage and family therapist (LMFT).

Billing Information

Procedure Code	Description	Category of Service
96158 Modifier AJ	Individual Social Work, initial 30 minutes (billed with a unit of 1)	58

96159 Modifier AJ	Individual Social Work, each additional 15 minutes (4 unit maximum)	58
96164 Modifier AJ	Group Social Work, initial 30 minutes (billed with a unit of 1)	58
96165 Modifier AJ	Group Social Work, each additional 15 minutes (6 unit maximum)	58
96158 Modifier HO	Individual Counseling, initial 30 minutes (billed with a unit of 1)	88
96159 Modifier HO	Individual Counseling, each additional 15 minutes (4 unit maximum)	88
96164 Modifier HO	Group Counseling, initial 30 minutes (billed with a unit of 1)	88
96165 Modifier HO	Group Counseling, each additional 15 minutes (6 unit maximum)	88

205.17 Speech/Language Services

Service Description: Speech/language therapy services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the student's IEP/IFSP or other speech/language therapy services necessary for the development of the student's IEP/IFSP or other medical plan of care or documented in the student's IEP/IFSP or other medical plan of care include, but are not limited to:

- Diagnostic services
- Screening and assessment
- Preventative services
- Corrective services

Medical Necessity: A referral by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law is required for speech/language services. The referral must be updated annually and be maintained in the student's health record.

Group Services: Speech/language services may be provided in either an individual or group setting. The number of customers in the group session should be limited to assure effective delivery of services, reflecting current best practices and the clinical judgment of the provider.

Professional Qualifications:

- Licensed speech language pathologist; or
- Professional Educator License with Endorsement for Speech Language Pathologist (teaching/non-teaching) and a Certificate of Clinical Competence; or
- Professional Educator License with Endorsement for Speech Language Pathologist (teaching/non-teaching) with the equivalent educational

requirements and work experience necessary for the Certificate of Clinical Competence; or

- Professional Educator License with Endorsement for Speech Language Pathologist (teaching/non-teaching) with completed academic requirements, in the process of acquiring supervised work experience to qualify for licensure in accordance with the Illinois Speech/Language Pathology and Audiology Practice Act; or
- Speech/Language pathology assistant practicing under the supervision of a qualified speech/language pathologist.

Billing Information:

Procedure Code	Description	Category of Service
92507	Individual Speech Therapy	13
92508	Group Speech Therapy	13

205.18 Transportation Services

Medicaid funding is reserved for transportation services to and from school for children on days when they receive a medical service in school and specialized transportation needs are specifically identified in their IEP/IFSP. Specialized transportation from the school to a medical provider in the community is also a claimable service. Transportation **must** be provided on specialized (physically modified) vehicles such as adapted buses, lift vehicles, vans. Transportation on a non-specially modified bus is not eligible for reimbursement.

The transportation costs for a child with special education needs, as identified in the Individuals with Disabilities Education Act (IDEA), who rides the regular school bus to his or her neighborhood school with non-disabled children may not be billed to Medicaid. Transportation for general education students may not be billed to Medicaid. The inclusion of an aide on the bus, even if the bus only has riders that have an IEP/IFSP, does not meet the criteria of specialized transportation and may not be billed to Medicaid.

Refer to Topic 207.3 for transportation services documentation requirements.

Service Description: As documented in the student's IEP/IFSP, other transportation services are those services provided to transport the student to and from the student's place of residence and the location where health-related services are provided, as well as from school to the site of medical or therapy services and back. The student's specific needs must require special physical accommodation/modifications to the vehicle for transport to receive the LEA health-related services, and the physical accommodations/modifications to the bus must be outlined in the student's IEP/IFSP. Transportation services may include, but are not

limited to, transport in specialized vehicles such as adapted buses, lift vehicles, and vans.

Provider Qualifications: Entities licensed by the Illinois Secretary of State and, where appropriate, by local regulation agencies.

Claimable Services: One or more round trips to a source of medical care on a day the student receives another covered service.

Billing Information

Procedure Code	Description	Category of Service
T2003	Other Transportation (billed with a unit of 1)	56

206 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

Services listed below are not covered for LEAs and will not be approved for reimbursement.

- Medical care not related to the IEP/IFSP or other medical plans of care or the development of the IEP/IFSP or other medical plans of care, such as illness and injury care, health education classes, first aid classes, and chemical abuse classes.
- Art, music, or recreation therapy including adaptive physical education, unless these activities are part of physical therapy services and provided by a qualified practitioner as outlined in this handbook.
- Treatment related to recreational/sports/leisure goals that does not demonstrate medical necessity.
- Services provided by parents, foster parents, or adult siblings.
- Transportation of students who do not require a special adaptation.
- Transportation of students on days when another covered medical service is not provided.
- Transportation for general education students.
- Classroom instruction or educational services.
- Services provided by terminated, suspended, or barred practitioners.
- Services not listed in section 205 of this handbook.
- Time spent in IEP meetings or other meetings in which the medical plan of care is established, reviewed, or revised.

207 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. In the absence of proper and complete medical records, payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the Office of the Inspector General or the appropriate law enforcement agency for further action. The retention requirements are not intended to replace professional judgment, nor do they supersede record retention requirements under law or regulations of other agencies. The LEA may choose to retain records beyond the Department's required period.

LEAs must maintain records which fully document the basis upon which all claims for reimbursement payments are made. A complete set of records includes the student's medical record, case documentation, general billing documentation, and practitioner credentials. All documentation must be available, if requested, for state and federal audits. Chapter 100, Handbook for Providers of Medical Services, contains information regarding the Department's audit process.

In addition, LEAs must retain all records and supporting documents relating to the delivery of service for a period of six (6) years after payment of federal funds. If an audit has commenced or any litigation, claim, or other action involving the records has been initiated prior to the expiration of the six (6) year period, the records must be retained until completion of the action and resolution of all issues arising from it.

207.1 Student Eligibility Verification

To be eligible for covered services, students must:

- Be under 21 years of age on the date of service; and
- Require services necessary for the development of an IEP/IFSP or other medical plan of care or have an IEP/IFSP or other medical plan of care in place that includes the covered services; and
- Be enrolled in a federally funded Medicaid program on the date services are provided; and
- Receive a covered service on the date(s) claimed for reimbursement.

Providers should verify a student's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

207.2 Student Medical Record

A student's medical record must include:

- Results of tests or evaluations performed for the development of an IEP/IFSP or other medical plan of care, if an IEP/IFSP or other medical plan of care is not already developed.
- A complete copy of the IEP/IFSP or other medical plan of care that includes frequency, duration, and scope of services provided.
- Copies of any amendments to the IEP/IFSP or other medical plan of care.
- Medical diagnosis and/or condition.
    - The primary diagnosis that describes the condition primarily responsible for the patient's treatment. The Department requires International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes.
- Case documentation including a complete description of the specific service provided including: date, service type, length of time, a brief description of the services provided, and the name, title, and written or electronic signature of the rendering practitioner.

All entries to the student's medical record must be dated, legible, and written in English. Records that cannot be audited because of illegibility are not proper records.

207.3 Case Documentation

LEAs must document all services for which Medicaid reimbursement is claimed. This documentation must be maintained by the LEA for each student. Each occurrence of service delivery must be documented and the documentation must be kept in the student's medical record. The IEP/IFSP or other medical plan of care is not sufficient documentation of actual services provided for reimbursement claiming.

LEAs may use any documentation format or combination of formats (such as case notes and service logs) that includes all the information listed below:

- Student's name
- Student's date of birth
- School/Place of Service
- Service date
- Service description
- Duration of face-to-face service (time spent).
- Service type (OT, PT, SLP, etc.).
- Medical diagnosis or prescription as required by service type (see section 205).
- Service practitioner's name, title, and written or electronic signature.
- Signature of service practitioner's supervisor, if required.
- Progress notes (see detail below).

In addition to the service-specific documentation requirements listed above, LEAs must maintain documentation of the student's response and progress resulting from the claimed service. This documentation must be updated no less than quarterly.

LEAs must maintain records which fully document the basis upon which all claims for reimbursement payments are made, including claims for transportation services. Documentation for transportation claims must include all the information listed below:

- Student's name
- Student's recipient identification number (RIN)
- School name
- Service date
- Procedure code (see section 205).
- Vehicle identifier (license plate number or bus number)
- Name of attendant/aide, if applicable
- Verification that an eligible student utilized the transportation service for each trip claimed for reimbursement (trip logs).
- Documentation that indicates the student received another covered service on the date(s) special transportation services are billed.

207.4 General Billing Documentation

Documentation must also include:

- The Provider Information Sheet (see Topic 202.3 and Handbook Supplement.
- An original signed billing certification form for every voucher paid.
- Cost information including: salaries, benefits, and employment hours.

207.5 Practitioner Credential Records

The LEA must verify that no practitioner providing service has been terminated, suspended, or barred from the Medicaid or the Medicare program. The lists of terminated, suspended, and barred practitioners can be found on the HFS Office of the Inspector General Provider Sanctions website or the U.S. Department of Health and Human Services Office of the Inspector General Searchable Exclusions Database website. Both lists must be queried to obtain a complete list of terminated, suspended, or barred providers.

A completed copy of the Verification Statement (see example below) should be retained in the practitioner credential record as verification that the practitioner is not terminated, suspended, or barred from the Medicaid or Medicare program. The verification statement should be updated annually.

Verification Statement

(Name): _____,

Practitioner at (Name of LEA):
_____,

has been verified as not being terminated, suspended, or barred from the Medicaid or Medicare program. Electronic look-ups can be obtained at the OIG Sanction List and at HHS Sanction list.

This verification was performed by (Name):
_____

Date of verification: _____

The LEA is responsible for maintaining credential records in line with staff qualifications outlined in Section 205 of the LEA Handbook and applicable law. Practitioner credential records must:

- Be retained in hardcopy or electronic format by the LEA.
- Be current.
- Include copies of all applicable licenses and certificates.
- Include a list of current practitioners and associated license numbers.