School Health Services Program Guide

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Helping people. It's who we are and what we do.

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Disclaimer: The regulatory information presented in this guide is subject to change and is pending approval through the Public Hearing process. The anticipated effective date is June 1, 2025.

Content

1 School Health Services (SHS) Program Overview

The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), referred to as Nevada Medicaid for the remainder of this guide, covers a variety of services provided to Medicaid-eligible students in school settings. In the past, eligibility was limited to students who had an Individualized Education Plan (IEP), but now these services can be provided to all Medicaid-enrolled students.

Nevada's school-based Medicaid program is known as the School Health Services (SHS) program. Under this program, local education agencies (LEAs) and state education agencies (SEAs) can enroll as Medicaid providers, giving them the ability to access Medicaid reimbursement for health services provided to Medicaid-eligible students in school settings.

This guide is designed to support Local Education Agencies (LEAs) and new School Health Services (SHS) administrators in onboarding and enrolling in the SHS program. Additionally, it aims to assist current SHS providers in enhancing or expanding their participation in the program. **This guide is intended as a helpful reference but is not the sole policy resource for SHS.** Links to other resources are provided throughout the guide, and all SHS providers are bound by applicable state and federal requirements.

For ease of reference, throughout this guide you will find:

- **Callout boxes and graphics** to help explain useful processes
- Highlighted text in **dark orange** for important concepts
- Links to useful reference materials in **blue** so that you can use this guide as a one-stop resource for participation in the SHS program

All SHS program participants should be well-versed in relevant state and federal Medicaid requirements, the Nevada Medicaid State Plan, applicable education requirements, and any other regulations that affect the delivery and Medicaid reimbursement of SHS. For questions about the SHS program, please reach out to the Nevada Medicaid School Health Services team at: schoolhealthservices@dhcfp.nv.gov.

1.1 Delivery System for Medicaid School Health Services

All school health services for Medicaid recipients are covered under the fee-for-service Medicaid program, regardless of whether the recipient is in a managed care organization or not. In other words, school health services are "carved out" of managed care.

1.2 Eligible Providers for Medicaid School Health Services

The following provider types are eligible to enroll as a SHS provider (provider type 60):

- LEA
- SEA
- Charter school (see special circumstances for provider enrollment)

Before a provider (LEA/SEA) can bill for services under the state Medicaid SHS program, the provider must enroll in Medicaid first.

*More information about provider enrollment is detailed in **Section 3** of this guide.*

Special circumstances for provider enrollment:

- If an individual practitioner is not a provider type that is eligible to be enrolled in Medicaid (such as a Registered Nurse), they can only provide services requested for Medicaid reimbursement if they are employed or contracted by an entity that is enrolled in Medicaid (i.e., the school district, LEA) while not being individually enrolled. The **overarching employer (LEA/SEA) or contracting provider organization** must always be enrolled in Medicaid. These Medicaid enrollment requirements are established by the Centers for Medicare and Medicaid Services (CMS).[1]
- **Charter schools** can bill for SHS services under the State Public Charter School Authority (which is a statewide government agency), a school district, or a college that is accredited in Nevada. The State Public Charter School Authority operates as the LEA for the public charter schools it oversees across the state. Charter schools do not operate as independent LEAs; therefore, cannot bill directly for school-based services.

1.3 Covered Populations Eligible for SHS Services

All Medicaid-enrolled students aged 3 years old to 20 years old (under the age of 21) are eligible to receive SHS. Nevada has expanded school health service eligibility to allow all Medicaid-enrolled students to be eligible for covered school health services, regardless of their special education status.

*More information about enrollee eligibility is provided in **Section 4** of this guide.*

1.4 Covered School Health Services

For a service to be covered under the Medicaid SHS Program, it must be:

- Documented in a Plan of Care (POC) for a Medicaid-eligible student that documents the medical necessity of the service to be provided – and/or –
- Preventive services that are coverable under EPSDT. Medicaid coverage of screening and diagnostic services under EPSDT is guided by the Periodicity Schedule recommended by the American Academy of Pediatrics and documented on the Bright Futures website. Guidelines are updated periodically and EPSDT benefits are updated to align with those updates.

*More information about EPSDT can be found in **Section 4** of this guide.*

Nevada Medicaid defines covered school health services as medically necessary diagnostic, evaluative, and direct medical services to detect, correct, or improve any physical or behavioral health diagnoses that meet the medical needs of Medicaid-enrolled students. The services are provided by an LEA/SEA to meet the health needs of a student. The services must be directed at either: 1) early detection of physical or behavioral health impairments, or 2) the reduction of physical or behavioral health impairments and restoration of the child to their best possible functioning level.

[1] Social Security Act, 42 U.S.C. 1396a(78); The Center for Medicare and Medicaid Services. (2023, May 18). Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming. https://www.medicaid.gov/medicaid/financialmanagement/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf [Page 26].

Examples of Nevada SHS covered services include:

- Screening, diagnostic, and treatment services
- Physician services
- Behavioral health and alcohol/substance use services
- Nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Alternative communication devices (ACD), audiological supplies, and disposable medical supplies
- Personal Care Services (PCS)
- Applied Behavioral Analysis (ABA) services
- Dental services
- Optometry services
- Case management services
- Telehealth services
- Community Health Worker services

In addition to in-person services, telehealth may be used to substitute certain in-person services such as consultations, office visits, psychiatry services, and limited medical services. Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice as established by its licensing agency. Refer to MSM Chapter 3400 – Telehealth for additional information.

2 SHS Onboarding Guide

Enrolling in Medicaid and Delivering SHS Services

This onboarding guide offers essential guidance for providers who are just getting started with the SHS program, as well as helpful training for new staff at an LEA or SEA already participating in the SHS program. This section outlines the four initial steps for an LEA or SEA to enroll in the SHS program, addresses common LEA/SEA questions as they initiate SHS services, and provides resources for further information.

2.1 Getting Started as a School Health Services Provider

To bill Medicaid for school health services, an LEA/SEA must first enroll with Medicaid as a **Provider Type (PT) 60** billing provider. Getting enrolled and developing your SHS delivery system begins with the following critical steps:

1. **Obtain a National Provider Identifier (NPI)** at the National Plan & Provider Enumeration System (NPPES), CMS website at NPPES NPI Registry
   - The 10-digit, numeric NPI is administered by the Centers for Medicare and Medicaid Services (CMS).
2. **Create an account within the Nevada** Online Provider Enrollment (OPE) Portal.
   - Submit initial enrollment application through the OPE Portal to enroll as a Nevada Medicaid provider.
   - Provide documentation to verify taxpayer identification numbers (SS-4 or CP575 or W-9)
3. **Engage with or hire a proficient billing agent**.
   - This is not mandatory for SHS providers but can support LEAs/SEAs in navigating the SHS program.
4. **Obtain an Electronic Health Record (EHR) System**.

Individual practitioners may also need to enroll in Nevada Medicaid. Enrollment of individual practitioners is governed by the following rules:

- If an individual practitioner is not a provider type that is eligible to be enrolled in Nevada Medicaid (for example, a Registered Nurse), the LEA/SEA may only bill Nevada Medicaid for their services if they are employed or contracted by an LEA/SEA that is enrolled in Nevada Medicaid.
- If a provider will be ordering, prescribing, or referring, they will need to be enrolled with Nevada Medicaid.

*Learn more about Provider Enrollment in **Section 3**.*

2.2 Frequently Asked Onboarding Questions

2.2.1 How does a school determine if a student is eligible for Medicaid?

LEAs/SEAs enrolled as a Medicaid billing provider can verify a student's eligibility through Nevada Medicaid's Electronic Verification System (EVS): Nevada Medicaid (nv.gov). If a school uses a third-party billing vendor, the vendor can also verify Medicaid eligibility.

It is important to verify eligibility on the day of service prior to billing for services, as enrollee eligibility can change over time. LEAs/SEAs are responsible for having an internal policy and process in place to verify student Medicaid eligibility; this can be completed by the LEA/SEA or authorized billing agent. School health service providers should provide the necessary services to students regardless of Medicaid eligibility.

2.2.2 How Much is Nevada Medicaid Reimbursement for School Health Services?

Currently, Nevada Medicaid reimburses for eligible services at the same **fee-for-service rate** that is used for other providers who bill for these services in a non-school setting. A list of commonly billed SHS services, procedure codes, and rates (current as of the January 2024 fee schedule) have been provided in Appendix B of this guide. Please note, the most current fee schedule is online at the DCHFP Fee Schedule page and should be referenced prior to billing for services.

2.2.3 Does the school or county have to pay a portion of the costs of SHS provided to students?

As of July 1, 2024, the local county or LEA is not required to pay a portion of the costs for SHS that are reimbursable by Nevada Medicaid. This means all local school districts that enroll as a Medicaid billing provider can begin billing Nevada Medicaid directly for covered services when provided by qualified school staff or contractors, reimbursed at the full Nevada Medicaid fee-for-service rate. However, if a school is receiving Medicaid reimbursement for administrative activities, the local county or LEA is still required to pay the state share of the state (local) match.

2.2.4 Who is Qualified under Medicaid to Provide Billable School Health Services?

To be reimbursed by Nevada Medicaid, a provider must be a **"qualified" health care provider** working within their scope of practice under state and federal regulations. Each LEA who bills Nevada Medicaid must ensure all billed services are rendered by the appropriately credentialed providers. This includes maintaining documentation of the provider's license, certifications, registration, or credentials to practice in Nevada.

*More information about qualified providers can be found in **Section 3** of this guide.*

2.2.5 How does a school determine if a Medicaid provider is enrolled with Nevada Medicaid?

It is the responsibility of the LEA/SEA to ensure that its employees or contractors who are a provider type that must enroll in Nevada Medicaid, are enrolled prior to furnishing Medicaid services to Medicaid-enrolled students. LEAs/SEAs can verify provider enrollment using the "Search Provider" function on the Nevada Medicaid website.

2.2.6 What is an Electronic Health Record (EHR), and why is it important?

An EHR is a digital version of a patient's medical chart, maintained by a provider to contain health information about the patient and all services delivered by a provider. It is crucial for schools to have an EHR to manage and share student health records, enhancing the quality of care and communication

with the student's care team.

Having an EHR that supports interoperability (sharing of data among systems) is important for supporting whole-child care. This promotes each student receiving personalized health care by ensuring all providers have a big-picture view of the patient's entire medical chart. EHRs focus on the total health of the student – going beyond standard clinical data collected in the provider's office and inclusive of a broader view on a patient's care. EHRs are designed to extend beyond the health care organization that initially collects patient information. They enable seamless sharing with providers like specialists and laboratories, integrating input from all clinicians involved in a patient's care. This ensures that patient information is portable, moving with the individual across facilities, locations, and even state lines, facilitating coordinated and continuous care.

There is a difference between educational student information systems and an EHR. A Student Information System (also called a SIS; for example, Infinite Campus) records and reports on data (such as attendance, grades, administrative tools); serves as a communication bridge between administration and educators; and creates an efficient system for comprehensive, quality education and record keeping. However, a SIS cannot be used to capture the work of clinical staff that are not educators. For instance, in most SIS, school nurses are not able to document clinical case management notes. That is where an EHR can assist schools. An EHR captures and documents the work that the non-classroom providers do in an efficient way.

An EHR typically provides workspaces where nurses can enter doctor's orders, document administration of medication, and add case management notes about student health conditions. In addition, an EHR can help organize the nurse's day, managing many tasks into a dashboard for ease of documentation. There are several aspects of medication administration that a nurse is legally obligated to document, and an EHR allows for this documentation seamlessly.

By using both a SIS and an EHR, schools can utilize a systems approach that includes efficient workspaces for their staff, help administrators to make data-informed decisions, and collect the information needed for Medicaid billing so that schools can proficiently create another revenue stream to support student health services.

2.2.7 Do schools need to have both an electronic student educational record and EHR for Medicaid reimbursement purposes?

Yes, both electronic student educational records and EHRs are essential for SHS and Medicaid billing. For technical assistance associated with implementing or maintaining an EHR, please feel free to reach out to the Nevada Department of Education's school health team at: schoolhealth@doe.nv.gov; or the Nevada Medicaid School Health Services team at: schoolhealthservices@dhcfp.nv.gov.

2.2.8 How do privacy laws apply to SHS?

Both the **Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA)** regulate the privacy and security of student records and are applicable to the SHS program. While FERPA covers privacy and security for educational records, HIPAA applies to health records. Compliance with both laws is required when handling sensitive student information in SHS. Refer to the Joint Guidance on the Application of FERPA and HIPAA to Student Health Records for more information.

2.3 Additional Resources

In addition to this guide, below are supplemental technical assistance resources to help LEAs/SEAs provide services under the SHS program.

Support Area	Resource
Obtaining a NPI	Directions can be found on the registry site at: NPPES NPI Registry
Enrolling in Medicaid	Online Provider Enrollment User Manual for guidance on how to complete the application. The Manual can be found via the Provider Enrollment webpage
Billing and Claims	View the Nevada Medicaid billing guidelines for SHS OR Contact the DHCFP School Health Services team at: schoolhealthservices@dhcfp.nv.gov
Questions about Electronic Health Records	Contact the Nevada Department of Education (NDE) School Health Services team at: schoolhealth@doe.nv.gov, or the Nevada Medicaid School Health Services team at: schoolhealthservices@dhcfp.nv.gov

3 Provider Enrollment and Qualified Providers

This section details the process for an LEA/SEA to enroll as a Nevada Medicaid provider, the steps for service providers to register with Medicaid, the requirements for maintaining enrollment over time, and the criteria for determining which providers meet the qualifications for SHS and Medicaid enrollment.

3.1 Overview of Medicaid Provider Enrollment Requirements

There are two types of providers in Nevada Medicaid: Providers who can bill for services (called "**billing providers**") and providers who directly provide care to a patient (called "**furnishing/servicing providers**"). All billing providers must enroll in Nevada Medicaid. Some furnishing/servicing providers need to enroll, while others do not, as described below.

Providers must determine if they are a provider type required to enroll in Nevada Medicaid or not, before they provide and bill for Medicaid services, as follows:

- LEAs/SEAs must enroll as a Provider Type (PT) 60.
  - Certain furnishing/servicing providers who may order, prescribe or refer services must enroll in Nevada Medicaid. It is the responsibility of the LEA/SEA to ensure that its employees or contractors who are required to be enrolled, are enrolled prior to billing for Medicaid services, if they are a provider type that is required to enroll. LEAs/SEAs can verify provider enrollment using the "Search Provider" function on the Nevada Medicaid website.

3.1.1 LEA/SEA (Billing Provider) Enrollment Process

To bill Nevada Medicaid for school health services, **LEAs/SEAs must be enrolled with Medicaid as a Provider Type (PT) 60**. LEAs/SEAs must complete the following steps to enroll with Medicaid:

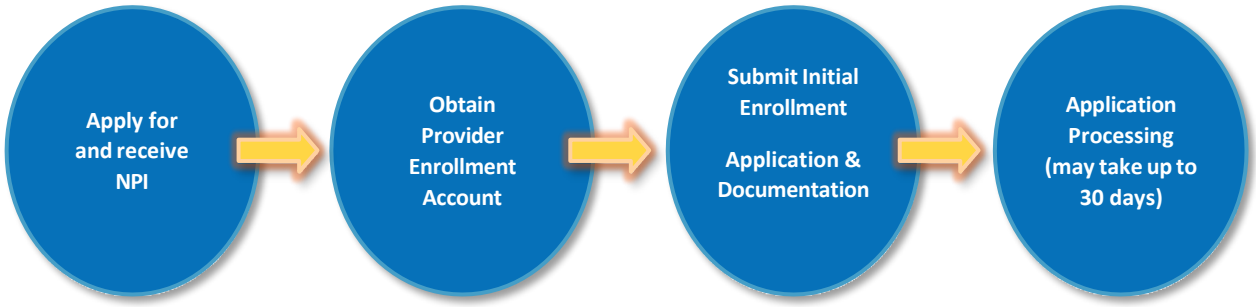
1. **Obtain a National Provider Identifier (NPI) at NPPES NPI Registry on the CMS website.**
   - The 10-digit, numeric NPI is administered by CMS. It does not expire nor change. To get an NPI, apply online at the NPPES website listed above.
   - Note: All furnishing/servicing providers who enroll with Medicaid will need an NPI. Providers may use an existing NPI, if one has already been assigned.
2. **Create an account with Nevada Online Provider Enrollment (OPE) Portal.**
   - Submit an Initial Enrollment Application through the Online Provider Enrollment Web Portal (PWP) to enroll as a Nevada Medicaid provider.
   - Provide documentation to verify taxpayer identification numbers (SS-4 or CP575 or W-9)

Please note: All providers must agree to accept Nevada Medicaid and Nevada Check Up payments via Electronic Funds Transfer (EFT).

3.1.2 Individual Practitioner (Furnishing/Servicing Provider) Enrollment Process

The participation process will vary for individual providers, depending on whether they are a provider type who will enroll in Medicaid. The steps below apply to any provider that is a provider type eligible to enroll in Nevada Medicaid. See Table 3-2 below for a list of providers who can enroll in Nevada Medicaid.

The online provider enrollment manual provides a step-by-step guide for providers to enroll in Medicaid.



Eligible Provider Types

Provider types found in Table 3-1 are **eligible to enroll and bill Nevada Medicaid** for school health services. These provider types can bill under an LEA/SEA.

TABLE 3 - 1: ELIGIBLE PROVIDER TYPES

Medicaid Enrolled Providers: Provider types that provide SHS and can enroll in Medicaid	

• Advanced Practice Registered Nurse (APRN)
• Audiologists
• Applied Behavior Analysis Entity / Agency / Group
  ○ Registered Behavior Technician (RBT)
  ○ Board Certified Behavior Analyst (BCBA)
  ○ Licensed and Board Certified Assistant Behavioral Analyst (BCaBA)
• Clinical Professional Counselor (CPC)
• Community Health Worker (CHW)
• Dentist
• Dental Hygienist
• Licensed Clinical Social Worker (LCSW)
• Licensed Marriage and Family Therapist (LMFT)
	• Licensed Speech-Language Pathologist
	• Occupational Therapist
	• Optometrist
	• Physical Therapist
	• Physician
	• Physician Assistant
	• Psychologist
	• Psychological Assistant
	• Psychological Intern
	• Psychological Trainee
	• Physical Therapist
	• Qualified Behavioral Health Aide (QBA)
	• Qualified Mental Health Associate (QMHA)
	• Qualified Mental Health Professional (QMHP)

Practitioner types not listed in Table 3-1 cannot enroll in Medicaid; they can only be reimbursed for furnishing Medicaid services if they are employed or contracted by an LEA/SEA that is enrolled in Medicaid. In other words, they can be a "furnishing/servicing" provider (directly deliver services) but cannot be a "billing" provider.

Examples of furnishing/servicing provider types that are often employed or contracted by an LEA/SEA, who are not eligible to enroll or bill independently for Medicaid, are found in Table 3-2 below.

TABLE 3 - 2: PROVIDER TYPES THAT ARE NOT ELIGIBLE TO ENROLL INDEPENDENTLY

Not Eligible to enroll in Medicaid Providers: Provider types that provide SHS but cannot directly enroll with Medicaid (not an exhaustive list)	
• CPC Intern • LCSW Intern • LMFT Intern • Licensed Practical Nurse (LPN) • Nursing Assistant • Occupational Therapy Assistant	• Physical Therapy Assistant • Registered Nurse (RN) • School Counselor * • School Social Worker * • School Psychologist * • Speech-Language Pathologist Clinical Fellow

*Indicates provider types that will be eligible to be a furnishing/servicing provider in the SHS program on or after January 1, 2025 (pending CMS approval).

3.2 Nevada Medicaid Provider Qualifications

Beyond being enrolled in Nevada Medicaid, **a furnishing/servicing provider must also meet the qualifications** for the services they wish to deliver to students. To be "qualified," a provider must:

- Meet appropriate licensure and certification requirements, as applicable, including meeting any relevant qualifications in Nevada Revised Statute; and
- Work within their scope of practice, including requirements for supervision.

Further details regarding furnishing/servicing (individual) provider qualifications for different service types, as well as supervision requirements, can be found in Appendix A.

3.3 Revalidation and Updates to Provider Enrollment

As an enrolled Nevada Medicaid provider, LEAs/SEAs must revalidate their enrollment every five (5) years. Nevada Medicaid will mail and email revalidation notices 120, 90, 60 and 30 days prior to the revalidation due date. Providers can start their revalidation process up to a year in advance and are encouraged to revalidate online by logging into the Provider Web Portal. To avoid contract termination and claim denials, your revalidation application must be processed and approved prior to the revalidation due date.

Make sure your organization's Medicaid enrollment contact information is up to date to ensure timely receipt of important notices.

LEAs/SEAs must also report to Nevada Medicaid any changes to enrollment or contact information. The Provider Update Application on the Provider Web Portal can be used by active providers to report contact changes.

For additional information about initial provider enrollment please go to Nevada Medicaid (nv.gov) to find detailed enrollment instructions, videos and training courses on how to enroll. For additional help with enrollment **call 877 638 3472** or reach out to the DHCFP School Health Services team at: **schoolhealthservices@dhcfp.nv.gov**.

3.4 Adding a Billing Agent to Your LEA/SEA Enrollment

LEAs/SEAs may choose to submit their own Medicaid reimbursement claims or contract with a billing agent to submit claims on their behalf. A billing agent is an entity that offers claims submission services for providers. Sometimes, billing agents are also called a "trading partner," which means an entity that is authorized to exchange electronic health data (such as claims) with Medicaid.

Under Medicaid rules, an LEA/SEA can only compensate a Medicaid billing agent using payments that are:

- Related to the actual cost of processing the billing;
- Not related on a percentage or other basis to the amount that is billed or collected; and
- Not dependent on the collection of the payment.[3]

Other billing agent rules:

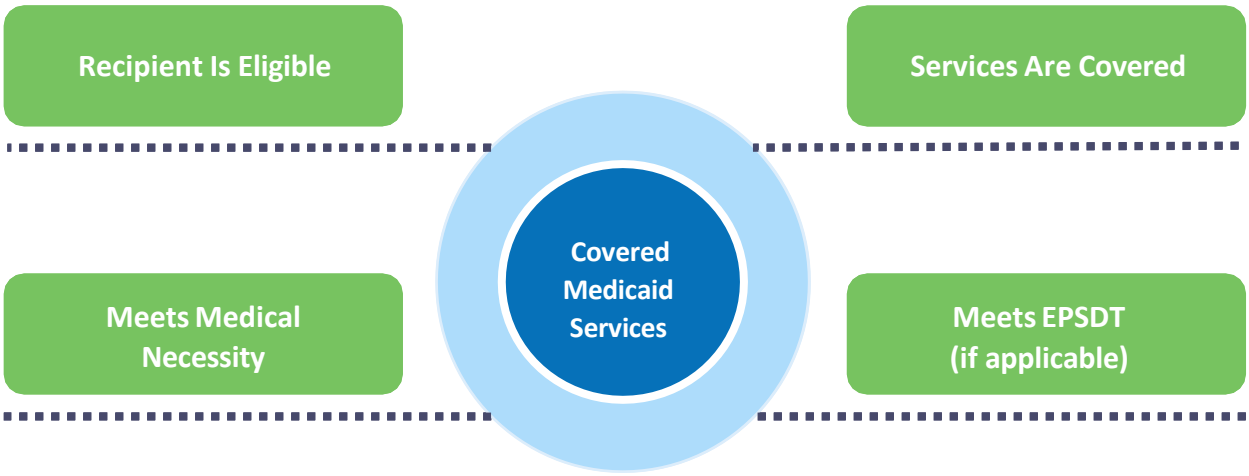
- The billing agent must be enrolled as a trading partner with Nevada Medicaid.
- The billing agent/trading partner and the LEA/SEA must have an appropriate business partner agreement in place.
- The LEA/SEA must list the trading partner information as part of the LEA/SEA's Medicaid provider enrollment process and must certify which transaction types the billing agent/trading partner may perform on behalf of the LEA/SEA. Examples of transaction types that SHS providers often certify a trading partner to perform on their behalf:
    - 270 Eligibility Request/271 Eligibility Response
    - 276 Claim Status Request/277 Claim Status Response
    - 837P Professional (CMS-1500) Claim

The billing agent/trading partner must first apply to become a trading partner under Nevada Medicaid by using the Trading Partner Enrollment Application. Nevada Medicaid has created a Trading Partner User Guide to assist in this enrollment process. Once a trading partner has submitted its enrollment information, it must also be certified through the Nevada Medicaid Trading Partner testing process. Enrollment and certification are both required before a trading partner can submit electronic transactions to Nevada Medicaid.

[3] https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C100/Chapter100/

4 Covered Services: General Information

This section offers comprehensive details about service delivery, including details on eligibility, medical necessity, covered services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and plan of care (POC) requirements.



4.1 Student Eligibility Verification

The first step for determining whether Medicaid services can be billed by an LEA/SEA is to check for Medicaid eligibility on the date of services. SHS are available for students in the Medicaid and Nevada Check Up (NCU) programs who are at least 3 years old and up to 21 years old (referred to as "Medicaid-enrolled" moving forward). The student must be enrolled in Medicaid on the date the services are provided.

Medicaid recipient eligibility is determined by the state on a monthly basis. Therefore, it is important to verify the student's eligibility at least on a monthly basis. Payments can only be made for covered services rendered to eligible students. If the student was not eligible on the date the service was rendered, Medicaid payment to the LEA/SEA will be denied.

Eligibility can be verified by accessing the Automated Response System (ARS), the Electronic Verification System (EVS), or submitting a Health Insurance Portability Accountability Act (HIPAA) compliant electronic transaction. If you work with a billing agent and have certified them to do this task, the billing agent may also check eligibility for you through a HIPAA-compliant electronic transaction. LEAs/SEAs are responsible for having an internal policy and process in place to verify student Medicaid eligibility; this can be completed by the LEA/SEA or authorized billing agent. School health service providers should provide necessary services to students regardless of Medicaid eligibility.

*See **Section 3** for more information about certifying a billing agent to check eligibility.*

4.2 Plan of Care (POC)

For a service to be covered under the SHS program, the Medicaid-enrolled student must have a Plan of Care (POC) that documents either the medical necessity, or preventive nature under EPSDT, of the

service. Medicaid coverage of screening, diagnostic, and treatment services under EPSDT must also be guided by the periodicity schedule recommended by the American Academy of Pediatrics and documented on the Bright Futures/AAP website: http://brightfutures.aap.org.

4.2.1 POC Requirements

A POC is a medical document developed by an LEA/SEA for a student, after an assessment by a qualified health professional acting within their scope of practice. A POC must:

- Identify a health condition/diagnosis that requires treatment.
- Identify the type of treatment to be provided and the frequency it will be provided.
- Identify the short-term objectives of the treatment interventions.
- Include a time frame for evaluation of progress.
- Have a start and end date. Treatment is only authorized during the period as written in the POC.
- Be written for no longer than a year.

POCs must be reviewed at least annually, or more often as medically necessary.

- IEPs and 504 Accommodation Plans may act as a POC; and an additional plan is not required if the IEP or 504 Accommodation Plan meets all requirements of a POC, and documents medical necessity of the services being provided.
- Not all POCs are required to be IEPs, or 504 Accommodation Plans either, since LEAs/SEAs may have the need for shorter and less formal plans for lower acuity health conditions.
- Multiple conditions can be documented in the same POC for a student who has multiple health conditions/diagnoses; however, each service must be documented in a specific service area (e.g., an IEP that authorizes both nursing and speech language therapy services). The POC serves as a medical summary of progress documentation. The POC also serves as a Prior Authorization (PA) for services that would require a PA if they were delivered outside of SHS/PT 60.

Treatment services, meaning those services that correct or improve diagnosed physical and/or behavioral health illness, must be documented appropriately in the POC for the service that is being provided.

*More information about the types of documentation required can be found in **Section 5**.*

4.3 Covered Services

SHS are provided by an LEA/SEA to meet the health needs of a student. The services must be directed at either: 1) early detection of a physical or behavioral health impairment, or 2) the reduction of a physical or behavioral health impairment and restoration of the child to his/her best possible functioning level.

4.3.1 SHS Covered Services

Medicaid covered services under the SHS program include:

- Screening, diagnostic and treatment services

- Physician services
- Behavioral health and alcohol/substance use services
- Nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Assistive communication device (ACD), audiological supplies and disposable medical supplies provided to serve a medical purpose, intervention to maintain or improve the student's health status.
- Personal care services (PCS)
- Applied behavior analysis (ABA) services
- Dental services
- Optometry services
- Case management services
- Telehealth services when clinically appropriate
- Community Health Worker Services

4.3.2 Requirements for Covered Services

For medical services to be payable under the Medicaid or CHIP State plan, **all the following requirements must be met:**

- The medical services must be furnished to a Medicaid- or NCU-enrolled individual;
- The medical services must be a Medicaid- or NCU-covered service and must meet any specific coverage requirements applicable to the service;
- Even if a particular service is not generally covered under the Medicaid State Plan for adults (such as routine preventive dental services), coverage is required under the EPSDT benefit for an EPSDT-eligible beneficiary if the service could be covered under section 1905(a) of the Social Security Act;
- American Academy of Pediatrics (AAP) recommended screenings and diagnostics as part of the EPSDT periodicity schedule;
- Any Medicaid-eligible child requiring SHS services may receive these services from the LEA/SEA provided:
    a. All SHS relate to a medical diagnosis and are medically necessary;
    b. The service performed is within the scope of practice of the healthcare practitioner performing the service;
    c. All services including the scope, amount, frequency and duration of service are documented as part of the child's school record, including the name(s) of the health practitioner(s) actually providing the service(s);

d. The treatment services are a part of the student's written POC, or an assessment, evaluation, or screening for the purpose of early identification of health concerns. This documentation must be kept on file with the LEA/SEA. The plan/documentation may be subject to review by authorized DHCFP personnel; and

e. All applicable federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope of provisions.

4.3.3 Non-Covered Services

The following services are **not covered under Nevada Medicaid**:

- Medical care that does not meet the definition of medical necessity;
- Evaluation and/or covered services performed by unapproved SHS furnishing/servicing providers;
- Information furnished by the provider to the student over the telephone;
- Services which are educational, vocational, or career oriented;
- Speech services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for the child's general good and welfare. Such services do not constitute speech pathology services for Medicaid purposes and are not to be covered since they do not require performance by a licensed qualified health care provider;
- When maximum benefits from any treatment program are reached, the service is no longer covered;
- Any vaccinations, biological products and other products available free of charge from the State Division of Public and Behavioral Health (DPBH), only the administration fee is a billable service;
- Any services that are recreational in nature, including those services provided by an adaptive specialist or assistant;
- Textbooks or other such items that are educational in nature and do not constitute medical necessity;
- Transportation of school aged students to and from school, including specialized transportation for Medicaid-enrolled students on days when they receive Medicaid covered services at school;
- Covered medical service(s) with no POC or that is outside of the effective date range;
- Covered medical or treatment service(s) which require a referral/prescription from a qualified professional working within their scope of practice pursuant to Nevada State law and are being provided without the referral or prescription from a qualified professional;
- Any services considered experimental.

4.4 Medical Necessity

Medical necessity, as defined in the Nevada Medicaid Services Manual, Chapter 100 – Medicaid Program means: "A health care service or product provided for under the Medicaid State Plan that is necessary and consistent with generally accepted professional standards to:

- Diagnose, treat, or prevent illness or disease;

- Regain functional capacity; or
- Reduce or ameliorate effects of an illness, injury, or disability."

The **determination of medical necessity must be made by a qualified provider**, working within the scope of their practice, on the basis of the individual case and takes into account whether:

- The type, frequency, extent, body site, and duration of treatment align with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies;
- The level of service can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available;
- The service is delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the student;
- The service is provided for medical or mental/behavioral health reasons, rather than for the convenience of the student, the student's caregiver, or the health care provider; and
- The service assists the student to remain in a community-based setting, when such a setting is safe.

4.5 EPSDT and Periodicity Schedule

Certain services for children up to age 21 are covered by Nevada Medicaid if they meet criteria under the EPSDT benefit, as follows.

The Healthy Kids Program has established a periodicity schedule for EPSDT-covered screening, vision (ocular), hearing (audiology), and dental services based upon the American Academy of Pediatrics (AAP). The periodicity schedule utilized by the Healthy Kids Program is also utilized by Nevada Medicaid and can be found at the Bright Futures/AAP website: http://brightfutures.aap.org.

LEAs/SEAs are encouraged to provide these screening and diagnostic services for students. **EPSDT services can be covered without being listed in the students' POC so long as they**:

- Follow the periodicity schedule as established in the Healthy Kids Program;
- Are determined to be a medically necessary screening when they fall outside the periodicity schedule (see additional detail below); and
- Are documented in medical records with the assessments and significant positive and negative findings, and referrals made for diagnosis, treatment or other medically necessary health services for any conditions identified.

4.5.1 Services Outside of The Periodicity Schedule:

Some EPSDT services can be covered outside the established periodicity schedule, as follows:

- **Dental services**. Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.
- **Ocular (Vision) services**. Ocular services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.

- **Audiology (Hearing) services**. Audiology services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.
- **Vaccinations**. Nevada Medicaid will reimburse for appropriate immunizations that are due and administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines found on the CDC website. Nevada Medicaid will only reimburse for administration fees if the vaccination is available through the DPBH as part of the Vaccines for Children (VFC) Program.
- **Laboratory Services**. Nevada Medicaid will reimburse for age-appropriate laboratory procedures performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age-appropriate and medically necessary.
- **Interperiodic Screenings**. Screenings are provided to all eligible persons up to 21 years of age, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

4.6 Service (Prior) Authorization and Documentation

Prior authorization (sometimes also called "service authorization") is not required for services provided under the SHS program. However:

- Services must be deemed medically necessary and appropriate, as defined in this section, by a qualified provider working within the scope of their practice.
- The treatment services must also be documented per the instructions in this guide (see **Section 5**) and signed as medically necessary by a qualified provider working within their scope of practice.

Proper **documentation** in the POC is required for all referrals for SHS. Please note that a **referral and signature from a provider are not sufficient to constitute medical necessity**. Medical necessity is determined by the furnishing/servicing provider but also confirmed by Nevada Medicaid through a retroactive process. As a method of protecting the integrity of the SHS program, Nevada Medicaid will perform retroactive reviews on claims to validate medical necessity and that proper documentation and billing procedures were followed.

If a service is reimbursed but a retroactive review later determines that the service was not medically necessary or not properly documented in the POC and not supported by a valid student progress note, as outlined in this section, the provider's reimbursement for that service may be subject to recoupment by Nevada Medicaid.

5 Covered Services by Specific Eligible Providers and Limitations

This section details service delivery requirements and limitations for covered SHS services that are delivered by service providers. Please note that these requirements are specific to each provider type listed below. Providers should review the requirements for their specific provider type before providing services.

5.1 Physician, Physician Assistant & Advanced Nurse Practitioner Services

5.1.1 When Is This Service Type Covered?

Subject to the scope of practice for their profession as defined by Nevada State law, a physician, physician assistant, advanced practice registered nurse (APRN), or other professional permitted under Nevada law to perform services under the personal supervision of a physician, may provide services including, but not limited to:

- Evaluation and consultations with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;
- Record review for diagnostic and prescriptive services;
- Diagnostic and evaluation services to determine a student's medically related condition that results in the student's need for medical services;
- New and established patient visits; and
- Medical Team Conference participation time for the development of medical related services in the POC. Note: Payment is excluded for participation time spent on POC development for educational processes and goals.

5.1.2 Coverage Criteria

Examples of covered services include but are not limited to:

- Primary and preventive health care including medical screenings;
- Treatment for common illnesses and minor injuries;
- Referral and follow-up for serious illnesses and emergencies;
- Care and consultation, as well as referral and follow-up for pregnancy, chronic diseases, disorders, and emotional/behavioral problems;
- Referral, preventive services and care for high-risk behaviors and conditions such as drug and alcohol abuse, violence, injuries and sexually transmitted diseases;
- Sports physicals as part of a comprehensive well child checkup;
- Vaccinations;
- Diagnostic and preventive dental, and referral services; and
- Laboratory testing.

Please also note the following coverage criteria:

- Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of the requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) Unit.
- Some of the procedures or services listed in the Current Procedural Terminology (CPT)

code book are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term “separate procedure”. Do not report a designated “separate procedure” in addition to the code for the total procedure or service of which it is considered an integral component. A designated “separate procedure” can be reported if it is carried out independently or is considered to be unrelated or distinct from other procedures/services provided at the same time.

5.1.3 Service Limitations

All services that are provided must be medically necessary to be covered under the SHS program.

Please also note that new patient procedure codes are not payable for services previously provided by the same provider and same specialty, within the past three years.

Refer to the PT 60 billing guide for a complete list of service limitations.

5.2 Behavioral Health and Alcohol/Substance Use Services

5.2.1 When Is This Service Type Covered?

Nevada Medicaid reimburses LEAs/SEAs for community-based behavioral health services to students under a combination of behavioral health rehabilitation and medical/clinical authority. These services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under Nevada State law for the maximum reduction of a physical or behavior health condition and to restore the individual to the best possible functioning level.

Services are covered within the following parameters:

- **Behavioral health rehabilitation services** are to assist individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.
- **Alcohol and substance use treatment, and services** are aimed to achieve the mental and physical restoration of alcohol and substance users. Medicaid only reimburses LEAs/SEAs for services delivered in an outpatient setting (for instance, at a school), and they must constitute a medical-model service delivery system.
- Also see the behavioral health **supervision and documentation requirements in section 4.3.**

5.2.2 Coverage Criteria

Nevada Medicaid’s philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers, and informal supports when considered appropriate per the student or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the students’ needs.

The following services are covered, when provided in accordance with the provider’s scope of practice and medical necessity:

- Behavioral Health Assessments
- Neuro-Cognitive, Psychological and Mental Status Testing
- Behavioral Health Therapies

- Medication Management
- Medication Training and Support
- Rehabilitative Mental Health Services (Note: In the school based setting these services could include: Basic Skills Training, Psychosocial Rehabilitation, or Crisis Intervention Services).
- Outpatient Alcohol and Substance Use Services
- Medical Team Conference participation time for the development of medical related services in the POC. (Note: Payment is excluded for participation time spent on development for educational processes and goals.)

5.2.3 Service Limitations

Nevada Medicaid does not cover any Behavioral Health or Alcohol/Substance Use Services that are not specifically listed above.

Refer to the limitations listed in MSM Chapter 400 Mental Health Services and/or MSM Chapter 4100 Substance Use Disorder Treatment Services and Coverage for any related services.

5.3 Nursing Services

5.3.1 When Is This Service Type Covered?

All nursing services must be under the order and direction of a physician, physician assistant or APRN. Nursing services may be provided to an individual on a direct, one-to-one basis, on site within the school setting (group services are not reimbursable under the SHS program).

- Skilled nursing services are assessments, judgments, interventions, and evaluation of interventions which require the education, training, and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the student's care and the frequency of skilled nursing interventions. Skilled nursing services are a covered service when provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN in accordance with the POC.
- An LPN may participate in the implementation of the POC for providing care to students under the supervision of a licensed RN, physician, physician assistant or APRN that meet the federal requirements of 42 CFR 440.166.

5.3.2 Coverage Criteria

Nursing services may be provided by a licensed RN, or an LPN under the supervision of an RN, or a CNA under the direction and supervision of an RN. These services may include, but are not limited to:

- Evaluations and assessments (RN only);
- Care and maintenance of tracheotomies;
- Catheterization or catheter care;
- Oral or tracheal suctioning;
- Oxygen administration;
- Prescription medication administration that is part of the POC;
- Tube feedings;
- Ventilator Care; or
- Medical Team Conference participation time for the development of medical related

services in the POC. Payment is excluded for participation time spent on POC development for educational processes and goals (RN only).

5.3.3 Service Limitations

- Nursing service(s) provided without an OPR (order, prescription or referral) from a qualified health professional working within their scope of practice are not eligible for reimbursement.
- Services not listed on the individual's POC (other than services for screening and diagnostics) are not eligible for reimbursement.

5.4 Physical Therapy Services

5.4.1 When Is This Service Type Covered?

Physical Therapy Services are covered when they are prescribed by a physician, PA or APRN and furnished by a licensed physical therapist, physician or other licensed practitioner of the healing arts operating within their scope of practice under Nevada State law and provided to a student by or under the direction of a qualified physical therapist to correct or improve neuromuscular, musculoskeletal and cardiopulmonary disabilities. These services may include:

- Assessing, preventing, or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving treatment;
- Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments affecting areas such as tone, coordination, movement, strength and balance;
- Individual therapy provided to a student in order to correct or improve the effects of motor delays, disabilities and/or physical impairments;
- Group therapy provided to more than one student, but less than seven, simultaneously in order to remediate, correct or improve the effects of motor delays, disabilities, and/or physical impairments;
- Therapeutic exercise, application of heat, cold, water, air, sound, massage, and electricity; and
- Measurements of strength, balance, endurance, range of motion (ROM).

5.4.2 Coverage Criteria

To be considered reasonable and medically necessary, physical therapy services must meet all the following conditions:

- Meet the definition of medical necessity.
- The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's functional deficit/condition.
- The services must be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or qualified assistant under the therapist's supervision.
- There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's realistic rehabilitative/restorative potential in consultation with the qualified therapist.

- The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

5.4.3 Service Limitations

Refer to MSM Chapter 1700 – Therapy for a complete list of service limitations.

5.5 Occupational Therapy Services

5.5.1 When Is This Service Type Covered?

Therapy services are covered when they are prescribed by a physician, PA, or APRN and furnished by an appropriately licensed occupational therapist who evaluates the student's level of functioning and develops a POC. Licensed occupational therapist assistants functioning under the general supervision of the licensed occupational therapist may assist in the delivery of the POC. These services may include:

- Assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation; improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; obtaining and interpreting information; coordinating care and integrating services the student is receiving;
- Evaluation and diagnosis to determine the extent of a student's disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
- Individual therapy provided to a student to remediate and/or adapt skills necessary to promote the student's ability to function independently;
- Group therapy provided to more than one student but less than seven simultaneously to correct or improve and/or adapt skills necessary to promote the students' ability to function independently;
- Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits; and
- Exercise to enhance functional performance.

5.5.2 Coverage Criteria

To be considered reasonable and medically necessary all the following conditions must be met:

- Meet the definition of medical necessity.
- The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s functional deficit/condition.
- The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or qualified assistant under the therapist’s supervision.
- There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient’s realistic rehabilitative/restorative potential in consultation with the qualified therapist
- The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

5.5.3 Service Limitations

Refer to MSM Chapter 1700 – Therapy for a complete list of service limitations.

5.6 Speech Therapy and Audiology Services

5.6.1 When Is This Service Type Covered?

Speech, audiology, and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication, or the condition of the student must be such that the services required can be safely and effectively performed only by a qualified therapist.

5.6.2 Coverage Criteria

The practice of audiology consists of furnishing services for the measurement, testing, appraisal prediction, consultation, counseling, research, or treatment of hearing impairment for the purpose of modifying disorders in communication involving speech, language, and hearing.
Audiology services must be performed by a certified and licensed audiologist. These services may include:

- Speech and language evaluation and diagnosis of delays and/or disabilities including, but not limited to voice, communication, fluency, articulation or language development.
- Audiological evaluation and diagnosis to determine the presence and extent of hearing impairments that affect the student's educational performance. Audiological evaluations include complete hearing and/or hearing aid evaluation, hearing aid fittings or reevaluations, and audiograms.
- Individual therapy provided to a student to correct or improve delays and/or disabilities associated with speech, language, hearing, or communication.
- Group therapy provided to one student, but less than seven, simultaneously to correct or improve delays and/or disabilities associated with speech, language, hearing, or communication.

5.6.3 Service Limitations

Refer to MSM Chapter 1700 – Therapy for a complete list of service limitations.

5.7 Audiological Supplies, Equipment, Medical Supplies, and Other Durable Medical Equipment (DME)

5.7.1 When Is This Service Type Covered?

The LEA/SEA may be reimbursed for medically necessary audiology supplies, equipment, and medical supplies when shown to be appropriate to increase or improve the functional capabilities of individuals with disabilities.

5.7.2 Coverage Criteria

These services may include:

- Disposable medical supplies purchased for use at school or home which are not durable or reusable, such as surgical dressings, disposable syringes, catheters, tracheotomy dressings, urinary tray, etc. SHS PT 60 may dispense audiological supplies, equipment, and medical supplies by their qualified practitioners acting within the scope of their practice under Nevada State law.
- DME is considered items such as Augmentative Communication Devices (ACDs) (e.g. speech generating devices), wheelchairs, canes, standers, walkers, etc. Medicaid DME

providers are qualified to dispense and receive reimbursement for medically necessary DME, prosthetics, orthotics, and supplies.

- DME, ACDs, audiology supplies, equipment, and medical supplies are for the exclusive use of the student that can be used at school, at home and is the property of the **student**.

5.7.3 Service Limitations:

Refer to MSM Chapter 1300 – DME, Disposable Supplies and Supplements for a complete list of covered services for DME, prostheses, and disposable medical supplies.

Refer to MSM Chapter 2000 – Audiology Services for a complete list of covered services on audiological supplies and equipment.

Refer to MSM Chapter 1300 – DME, Disposable Supplies and Supplements and MSM Chapter 2000 – Audiology Services for a complete list of corresponding service limitations.

5.8 Personal Care Services (PCS)

5.8.1 When Is This Service Type Covered?

Personal Care Services (PCS) include a range of human assistance provided to a student with disabilities and/or chronic conditions, which enables the accomplishment of tasks that they would normally do for themselves if they did not have a disability and/or chronic condition. These services are provided where appropriate, medically necessary, and within service limitations.

Assistance may be in the form of direct hands-on assistance or cueing the student to perform the task themselves and related to the performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Personal care services are based on the needs of the student being served, as determined by and documented through a state functional assessment service plan (SFASP) approved by the DHCFP. **LEAs/SEAs may use the POC in lieu of the SFASP as long as the information documented in the POC includes all of the requirements for an SFASP** (see the SFASP Instructions for the required information that must be included within the POC) – this section will reference the POC moving forward.

All services must be performed in accordance with the approved POC. Legally responsible individuals (LRIs) may not be reimbursed for providing PCS.

These services may include:

- Assistance with the following ADLs: (Note: Services must be directed to the individual student and related to their health and welfare):
    - Dressing;
    - Toileting needs including but not limited to routine care of an incontinent student;
    - Transferring and positioning a non-ambulatory student from one stationary position to another, assisting a student out of chair or wheelchair, including adjusting/changing student's position in a chair or wheelchair;
    - Mobility/Ambulation, which is the process of moving between locations, including walking or helping the student to walk with support of a walker, cane or crutches, or assisting a student to stand up or get his/her wheelchair to begin ambulating; or
    - Eating, including cutting up food (Note: Specialized feeding techniques may not be used).
- Assistance with the following IADLs is a covered service (Note: Services must be directed to the individual student and related to their health and welfare):

- Meal preparation, which includes storing, preparing, and serving food.

5.8.2 Coverage Criteria

A POC or SFASP must be completed prior to the service date of any billable PCS. The POC or SFASP must be completed in-person with the student present by a physician, APRN, physician assistant, or trained physical or occupational therapist working within their scope of practice.
When an SFASP is completed, the SFASP should be added as part of the student's POC.

Students receiving PCS must be reassessed at least annually. Annual reassessments must be completed in person with the student present by a physician, APRN, physician assistant, or a trained physical or occupational therapist working within their scope of practice.

Significant change in condition or circumstance may cause a need to reassess a student. All reassessments should be completed in person with the student present by a physician, APRN, physician assistant, or a trained physical or occupational therapist working within their scope of practice.

Flexibility Of Services Delivery

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the student in the school setting, as long as the plan does not alter medical necessity. Any changes that do not increase the total authorized hours can be made, for the students' convenience, within a single week without additional documentation in the POC.

The provider shall have a written backup mechanism to provide a student with his or her service hours in the absence of a regular personal care aid (PCA) due to sickness, vacation or any unscheduled event. The covering individual must be qualified to provide PCS services based on their scope of practice.

Supervision

PCAs providing PCS to students must have a supervisor available to them during their work hours. Each time a PCA providing PCS to students is assigned to a new student, the supervisor must review the student's POC. The supervisor must then clarify the following items with the PCA providing PCS to that student:

- The needs of the student and tasks to be provided;
- Any student-specific procedures including those which may require on-site orientation; and
- Situations in which the PCA should notify the supervisor.

The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA providing the PCS.

Records

The LEA/SEA must maintain all records relating to PCS provided. The LEA/SEA must retain records for a period pursuant to the State record retention policy, which is currently six years from the date of payment for the specified service.

If any litigation, claim or audit is started before the expiration of the retention period, records must be retained until all litigation, claims, or audit findings have been finally determined.

- The LEA/SEA must maintain all required records for each individual employed to provide PCS regardless of the length of employment.
- The LEA/SEA must maintain the required record for each student who has been provided PCS, regardless of the length of the service period.

At a minimum, the LEA/SEA must document the following on all service records:

- Consistent service delivery within program requirements;
- Amount of services provided to students;
- When services were delivered; and
- Documentation attesting to the services provided, and the time spent providing the service signed or initialed by the PCA.

5.8.3 Service Limitations

Assistance with IADLs may only be provided in conjunction with services for ADLs.

5.9 Applied Behavior Analysis (ABA) Therapy

5.9.1 When Is This Service Type Covered?

A behavior intervention is covered if it is medically necessary to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of autism spectrum disorder (ASD), fetal alcohol spectrum disorder (FASD), or other condition for which ABA is recognized as medically necessary. ABA requires form FA-11F to be completed and if the "Other" box is marked, LEAs must also have adequate/proper documentation to justify ABA services for a diagnosis other than ASD or FASD. ABA services must be rendered according to the written orders of the Physician, physician's assistant, or an APRN. The treatment regimen must be designed and signed off on by the qualified ABA provider. More information about ABA services can be found in MSM Chapter 3700 – Applied Behavior Analysis.

These services may include the following, when provided according to an ABA provider's scope of practice:

- Behavioral Screening;
- Comprehensive Diagnostic Evaluation;
- Behavioral Assessment;
- Adaptive Behavioral Treatment Intervention; and
- Adaptive Behavioral Family Treatment.

5.9.2 Coverage Criteria

Coverage of ABA services requires the following criteria to be met:

- The student must be Medicaid-enrolled;
- The student has an established supporting diagnosis of ASD, FASD, or other condition for which ABA is recognized as medically necessary. The diagnosis is to be completed only one time. Repeat testing should not be performed when full criteria were previously met. Diagnosis is to be documented on the FA-11F.
  Tests acceptable as diagnostic tools for ASD include:
  - Autism Diagnostic Observation Schedule, 2nd Ed. (ADOS-2)
  - Childhood Autism Rating Scale, 2nd Ed. (CARS-2)
  - Gilliam Autism Rating Scale, 3rd Ed. (GARS-3)
  - Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Category.

  If Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) criteria alone are

used as the sole basis for diagnosis, the provider must submit documentation of the specific DSM-5 criteria that were met;

- The student exhibits excesses and/or deficits of behavior that impedes access to age- appropriate home or community activities (examples include, but are not limited to aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);
- ABA services are rendered in accordance with the individual's treatment plan with realistic and obtainable treatment goals to address the behavior dysfunction;
- Treatment may vary in intensity and duration based on clinical standards, but approval of fewer hours than recommended/supported in clinical literature requires justification based on objective findings in the medical records;
- A reasonable expectation on the part of the treating healthcare professional that the individual will improve, or maintain to the maximum extent practical, functional gains with behavior intervention services; and
- The treatment plan must be based on evidence-based assessment criteria and the individual's test results.

The following coverage criteria also apply, depending on the types of services delivered:

- Services may be delivered in a treatment session to either one individual or a group of two to eight individuals;
- Services may be delivered in the natural setting (i.e. home, school and community-based settings, including clinics); and
- For Individuals with Disabilities Education Act (IDEA)-related services:
    - Part C, Early Intervention ages zero up to three years old – Services identified on an Individualized Family Services Plan (IFSP) may be billed to DHCFP when the providers are enrolled and meet the provider qualifications as outlined under "provider qualifications" for ABA service.
    - Part B, Special Education and related services ages three up to 21 years old – Services identified on an Individualized Educational Program (IEP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under "provider qualifications" for ABA services.

5.9.3 Service Limitations

ABA services are not covered above these daily and weekly limits:

- Providers are limited to 12 hours of ABA services per day.
- Students are limited to 40 hours of ABA services per week.

5.10 Dental Services

5.10.1 When Is This Service Type Covered?

Through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, students up to the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease, and maintenance of dental health. The EPSDT Program assures children receive the full range of necessary dental services.

5.10.2 Coverage Criteria

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. To be covered by Nevada Medicaid, dentists must provide services in accordance with the rules and regulations of the Nevada Medicaid Dental Program. Dental care provided in the Nevada Medicaid Program must meet prevailing professional standards for the community-at-large. More information about Dental coverage can be found in MSM Chapter 1000 - Dental.

These services may include the following when delivered in the school setting and in accordance with the Nevada Medicaid Dental Program requirements:

- Diagnostic and preventive services
- Restorative dentistry services
- Endodontic services
- Fluoride supplements

5.10.3 Service Limitations

Dental services that are not covered include:

- Dental services not listed above in covered services.
- Service-specific limitations can be found in MSM Chapter 1000 – Dental.

5.11 Optometry Services

5.11.1 When Is This Service Type Covered?

The Nevada Medicaid Ocular Program reimburses medically necessary ocular services to eligible Medicaid-enrolled students.

5.11.2 Coverage Criteria

Optometry services may include any of the following, when delivered in a school setting and as detailed in the Nevada Medicaid Ocular Program:

- Healthy Kids (EPSDT) vision screening
- Glasses
- Refractive examinations
- Ocular examinations

Additionally, glasses may be provided at any interval without prior authorization for EPSDT students, as long as there is a change in refractive status from the most recent exam, or for broken or lost glasses. Physician records must reflect this change, and the records must be available for review for the period when the student's benefits are active, plus a minimum of 3 years thereafter.[4]

5.11.3 Service Limitations

Services that are not covered include:

- Any ocular services not specifically listed above

[4] Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, 42 CFR § 431.17 (2024). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart- A/section-431.17.

Additional limitations:

- Medicaid will only cover routine comprehensive ophthalmological examinations and/or refractive examinations of the eyes and glasses with a prescription for and provision of corrective eyeglasses to eligible Medicaid-enrolled students of all ages once every 12 months.
- Medicaid will only cover refractive examinations performed by an optometrist or ophthalmologist once every 12 months.

5.12 Case Management Services

5.12.1 When Is This Service Type Covered?

The intent of case management services is to assist eligible students in gaining access to needed medical, social, educational, and other support services, including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical, or other direct services. Case management service components include assessment, care planning, referral/linkage, and monitoring/follow-up.

Case management services are covered for the following target groups:

- Children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) as defined by: Children and adolescents, who are Non-SED, excluding dementia and intellectual disabilities, are students with significant life stressors and have:
  - A current International Classification of Diseases (ICD) diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section which does not meet SED criteria.
  - Z-Codes 55-65, R45.850 and R45.851, as listed in the current ICD Manual which does not meet SED criteria.
  - Child and Adolescent Services Intensity Instrument (CASII) Level of 0, 1, 2, or above.
- Adults with a Non-Serious Mental Illness (Non-SMI) as defined by adults, who are Non- SMI, excluding dementia and intellectual disabilities, are students 18 – 21 years of age with significant life stressors and have:
  - A current International Classification of Diseases (ICD) diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section including Z-Codes 55- 65, R45.850 and R45.851, which does not meet SMI criteria.
  - A Level of Care Utilization System (LOCUS) score of Level I or II.
- Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time spent on POC development for educational processes and goals.

5.12.2 Coverage Criteria

Case management services are reimbursable when they meet all the following:

- Are provided to eligible Medicaid-enrolled students, on a one-to-one (telephone or face-to face) basis;
- Are medically necessary;

- Are provided by a qualified provider enrolled to serve the target group in which the student belongs;
- Are not an integral component or administrative service of another covered Medicaid service.

Additionally, case management services may include contact by the case manager with other individuals, when the purpose of the communication is directly related to the management of the eligible student's care.

5.12.3 Service Limitations

The following services are not covered:

- Case management services for a student that is not in a target group not specifically listed above in *5.12.1*.

The maximum hours per target group, per calendar month, per student, allowed for case management services are identified below. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate). All service limits may be exceeded when medically necessary as documented in the POC.

- Children and adolescents who are non-severely emotionally disturbed: 10 hours for initial calendar month, five hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year
- Adults with non-serious mental illness: 10 hours for initial calendar month, five hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year.

Refer to MSM Chapter 2500 - Case Management for a complete list of service limitations.

5.13 Telehealth Services

5.13.1 When Is This Service Type Covered?

Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other medical services. "Telehealth" is defined as the delivery of service from a provider of health care to a patient at a different location using information and telecommunication technology, not including facsimile or electronic mail.

Services provided via telehealth are covered when they are clinically appropriate and within the health care professional's scope of practice as established by its licensing agency.

5.13.2 Coverage Criteria

- The medical examination of the patient must be under the control of the health care professional at the distant site.
- While the distant physician or provider may request a tele-presenter (person who uses telehealth equipment to help remote providers assess patients during physical exams), a tele-presenter is not required as a condition of reimbursement.
- End Stage Renal Disease (ESRD)
    - ESRD visits must include at least one in-person visit to examine the vascular access site by a provider; however, an interactive audio/video telecommunications system may be used for providing additional visits.
    - Medical records must indicate that at least one of the visits was furnished in- person by a provider.

- Audio-only telehealth must be delivered based on medical necessity and clinical appropriateness for the student as documented within the student's medical record.

5.13.3 Service Limitations

Refer to MSM Chapter 3400 – Telehealth Services for a complete list of service limitations.

5.14 Community Health Worker (CHW) Services

5.14.1 When Is This Service Type Covered?

CHWs are trained public health educators improving health care delivery requiring integrated and coordinated services across the continuum of health. CHWs provide students culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options.

5.14.2 Coverage Criteria

To be covered by Nevada Medicaid, CHW services must be related to disease prevention and chronic disease management that follow current national guidelines, recommendations, and standards of care, including but not limited to, the United States Preventive Services Task Force (USPSTF) A and B recommended screenings.

Covered services may include:

- Guidance in attaining health care services;
- Identify student needs and provide education from preventive health services to chronic disease self-management;
- Information on health and community resources, including making referrals to appropriate health care services;
- Connect students to preventive health services or community services to improve health outcomes;
- Provide education, including but not limited to, medication adherence, tobacco cessation, and nutrition; and
- Promote health literacy, including oral health.

5.14.3 Service Limitations

The following services are not covered:

- Any CHW services not specifically listed above.

Other limitations:

- Services provided by a CHW are limited to four units (30 minutes per unit) in a 24- hour period, not to exceed 24 units per calendar month per student. Limits can be exceeded if medically necessary and documented in the POC.
- When providing services in a group setting, the number of participants must be at a minimum of two and a maximum of eight.

Refer to MSM Chapter 600 – Community Health Worker Services for a complete list of service limitations.

5.15 Behavioral Health Supervision and Documentation Requirements

5.15.1 When is this Service Type Covered?

All mental and/or behavioral health services require documentation of oversight by a Clinical Supervisor to

ensure the services provided are medically necessary and clinically appropriate. Clinical Supervision includes the ongoing evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values as set forth by state licensure, certification, and best practice.

5.15.2 Coverage Criteria

As a best practice, **Clinical Supervision should be rendered on-site**. Clinical Supervisors are accountable for all services delivered and must be available to consult with all clinical staff related to delivery of service, at the time the service is delivered. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), and Clinical Professional Counselors (CPC), excluding Interns, operating within the scope of their practice under Nevada State law, may function as Clinical Supervisors.

Clinical Supervisors must have specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, who may include:

- Independent Professionals
- School counselors
- School psychologists
- Individual Rehabilitative Mental Health (RMH) providers

Clinical Supervisors can also supervise other LCSWs, LMFTs, and CPCs. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, and CPCs, excluding Interns, may function as Clinical Supervisors over RMH services. However, Individual RMH providers, including interns, may not function as Clinical Supervisors over Outpatient Mental Health (OMH) services, such as assessments, therapy, testing and medication management.

Clinical Supervisors must ensure all the following:

- An up-to-date case record (current within 30 days) is maintained on the student;
- A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services);
- A comprehensive and progressive treatment plan is developed and approved by the
- Clinical Supervisor and/or a Direct Supervisor, who is a LCSW, LMFT or CPC;
- Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive and age and developmentally appropriate;
- The student and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, the student and their family/legal guardian (in the case of legal minors) sign the treatment plan and the student, and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan(s);
- The student and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing;
- Only qualified providers provide prescribed services within the scope of their practice under state law; and

- Students receive mental and/or behavioral health services in a safe and efficient manner.

5.15.3 Service Referrals and Prescriptions

The Plan of Care (POC) for mental and/or behavioral health services must be renewed at least annually and/or when there are changes to the service's scope, amount, frequency, or duration.

For Medicaid to reimburse for services or medical supplies resulting from a practitioner's order, prescription or referral, the ordering, prescribing or referring (OPR) provider must be enrolled in Medicaid.

If a provider chooses to enroll as an OPR-only provider, they may not submit claims for services individually.

5.15.4 By or Under Direction of

Certain providers must work "by or under the direction" of another provider. "By or under the direction of" means that the qualified provider offering direction is a licensed practitioner of the healing arts, qualified under Nevada State law and federal regulations to diagnose and treat individuals with a disability or functional limitation(s) and is operating within their scope of practice as defined in Nevada State law, and is supervising each student's care. Additional information regarding supervision can be found in Appendix A. The supervision must include, at a minimum:

- Face-to-face contact with the individual provider being supervised initially and periodically as needed, prescribing the services provided and reviewing the need for continued services throughout the course of treatment.
- The qualified supervisor must also assume professional responsibility for the services provided and ensure that the services are medically necessary.
- The qualified supervisor must spend as much time as necessary directly supervising the services to ensure the student(s) are receiving services in a safe and efficient manner and in accordance with accepted standards of practice.
- Documentation must be kept supporting the supervision of services and ongoing involvement in the treatment.

5.16 Documentation Standards

5.16.1 Individualized Treatment Plan

A written individualized treatment plan, referred to as the Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services, to include Rehabilitative Mental Health (RMH) and Outpatient Mental Health (OMH) services. A Treatment Plan is person-centered, rehabilitative and recovery oriented. The treatment plan addresses individualized goals and objectives. The objective is to reduce the duration and intensity of BH services to the least intrusive level possible while sustaining overall health. BH services are designed to improve the student's functional level based on achievable goals and objectives as determined in the Treatment Plan that identifies the amount and duration of services. The Treatment Plan must consist of services designed to achieve the maximum reduction of the BH services required to restore the student to a functional level of independence.

Each prescribed BH service within the Treatment Plan must meet medical necessity criteria, be clinically appropriate, and must utilize evidence-based practices. The prescribed services within the plan must support the students' restoration of functioning consistent with the individualized goals and objectives.

A Treatment Plan must be integrated and coordinated with other components of overall health care.

The person-centered treatment plan must establish strength-based goals and objectives to support

the student's individualized rehabilitative process. The BH services are to accomplish specific, observable changes in skills and behaviors that directly relate to the student's individual diagnosed condition(s). BH services must be rehabilitative and meet medical necessity for all services prescribed.

Treatment Plan Development

The Treatment Plan must be developed jointly with:

- The student or the student's legal representative (in the case of legal minors and when appropriate for an adult);
- The student's parent, family member, guardian or legal representative with given consent from the student if determined necessary by the student;

All BH services requested must ensure that the goal of restoring a student's functional levels is consistent with the therapeutic design of the services to be provided under the Treatment Plan.

All requested BH services must ensure that all involved health professionals incorporate a coherent and cohesively developed treatment plan that best serves the students' needs.

Services should be developed with a goal that promotes collaboration between other health providers of the student, community supports including, but not limited to, community resources, friends, family or other supporters of the student and student-identified stakeholders to ensure the student can receive care coordination and continuity of care.

The services requested are to be specific, measurable and relevant in meeting the goals and objectives identified in the Treatment Plan. The qualified mental health professional must identify within the Treatment Plan the scope of services to be delivered and ensure that the services provided will complement (but do not duplicate) any services being provided by community providers.

Required Information That Must Be Included in the Treatment Plan

Treatment Plans are required to include, but are not limited to, the following information:

- Student's full name;
- Intensity of Needs determination;
- Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination;
- Date of determination for SED or SMI; and
- The name and credentials of the provider who completed the determination.

Goals and Objectives of the Treatment Plan

The individualized treatment plan must demonstrate an improvement of the student's medical, behavioral, social and emotional well-being of the effectiveness of all requested BH services that are recommended in meeting the plan's stated rehabilitative goals and objectives documenting the effectiveness at each reevaluation determined by the QMHP.

Requested Services

The individualized treatment plan must include all the following:

- Services: Identify the specific behavioral health service(s) (i.e., family therapy, individual

therapy, medication management, basic skills training, day treatment, etc.) to be provided;

- Scope of Services and Duration: Identify the daily amount, service duration and therapeutic scope for each service to be provided;
- Providers: Identify the provider or providers who are responsible for implementation of each of the plan's goals, interventions and services;
- Rehabilitative Services: Document that the services have been determined to be rehabilitative services consistent with the regulatory definition;
- Care Coordination: When multiple providers are involved, the plan must identify and designate a primary care coordinator. The primary care coordinator develops the care coordination plan between the identified BH services and integration of other supportive services involved with a student's services;
- Strength-Based Care: Collaboratively develop a treatment plan of care involving the strengths of the student and family (when applicable); and
- Declined Services: If the student declines recommended service(s), this act must be documented within the treatment plan.

Discharge Plan

A discharge plan (explaining when treatment services are expected to be complete and what will happen next) is required to be included in each Treatment Plan. The discharge plan must identify:

- The planned duration of the overall services to be provided under the Treatment Plan;
- Discharge criteria;
- Recommended aftercare services for goals that were both achieved and not achieved during duration of the Treatment Plan; and
- Identification of available agency(ies) and independent provider(s) to provide aftercare services (i.e., community-based services, community organizations, nonprofit agencies, county organization(s) and other institutions) and the purpose of each for the student's identified needs under the Treatment Plan to ensure the student has access to supportive aftercare.

Required Signatures and Identified Credentials

Several signatures, along with the identified credentials for each signer, are required for all treatment plans, as well as any modifications to treatment plans, or reevaluations of treatment plans. Required signatures include:

- The clinical supervisor (with their credentials listed);
- The student, student's family or their legal representative (in the case of legal minors and when appropriate for an adult).

Treatment Plan Reevaluation

A qualified mental health provider must evaluate and reevaluate the Treatment Plan at a minimum of every 90 days, or a shorter period as determined by the qualified mental health provider. Every reevaluated Treatment Plan must include a brief analysis that addresses the recommended services, the

services provided pursuant to the recommendations, a determination of whether the provided services met the developed goals and objectives of those services and whether or not the student would continue to benefit from future services and be signed by the qualified mental health provider.

Requirements upon reevaluation:

- If it is determined that there has been no measurable restoration of functioning, a new student-centered treatment plan must be developed by the qualified mental health provider.
- The updated plan must identify all recommendations and changes to the treatment goals, objectives, strategies, interventions, frequency, or duration; any change of individual providers, or any recommendation to change individual providers; and the expected duration of the medical necessity for the recommended changes.
- The new treatment plan must adhere to the same guidelines outlined above in Treatment Plan Development.

Progress notes for all BH services including Rehabilitative Mental Health (RMH) and Outpatient Mental Health (OMH) services must include the written documentation of treatment services or services coordination provided to the student. For any service that will be billed to Medicaid, the progress note must clearly document the amount, scope and duration of the service(s) provided as well as identify the provider of the service(s).

A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

- The name of the student receiving the service(s). If the services are in a group setting, it must be indicated;
- The place of service;
- The date the service was delivered;
- The actual beginning and ending times the service was delivered;
- The name of the provider who delivered the service;
- The credentials of the person who delivered the service;
- The signature of the provider who delivered the service;
- The goals and objectives that were discussed and provided during the time the services were provided; and
- A statement assessing the student's progress towards attaining the identified treatment goals and objectives.

Alteration of a treatment plan is not required for temporary but clinically necessary services; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

A Discharge Summary must include written documentation of the last service contact with the student, the diagnosis at admission and termination, and a summary statement describing the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives as

documented in the Treatment Plan. The discharge summary documentation must include the reason for discharge, current intensity of needs level and recommendations for further treatment.

- Discharge summaries are to be completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.
- In the case of a student's transfer to another program or school district, a verbal summary must be given by the current health professional at the time of transition and followed with a written summary within seven calendar days of the transfer. This summary will be provided with the consent from the student or the student's legal representative.

Records: The evaluative and diagnostic services (which determine the need for treatment) and the POC (which defines the treatment needs) must both be documented as part of the student's medical record at the school, including the name(s) of the health practitioner(s) providing the service(s). The written POC must be on file with the participating LEA/SEA.

- All medical and financial records which reflect services provided must be maintained by the LEA/SEA and furnished at request to the Department of Health and Human Services (DHHS) or its authorized representative. An LEA/SEA must keep organized and confidential records that detail all student specific information regarding all services rendered for each student receiving services and retain those records for review.
- LEAs/SEAs must maintain appropriate records to document the student's progress in meeting the goals of the treatment. SHS encompasses services from several disciplines, and as such all documentation must be completed as appropriate for the service that is being provided. Nevada Medicaid reserves the right to review the student's records to assure the treatment is restorative and rehabilitative.

5.17 Katie Beckett Recipients

For children to remain eligible under the Katie Beckett eligibility category, DHCFP must assure the Centers for Medicare and Medicaid Services (CMS) that the per capita expenditure under this eligibility category will not exceed the costs of institutional care. There are services and supplies that are not included in the facility rate and are excluded from the children's institutional Level of Car (LOC) overall cost. LEAs may bill Medicaid for children that are enrolled in Medicaid under the Katie Beckett eligibility category.

6 Billing Information

6.1 Overview: Billing Nevada Medicaid

Where to submit claims for payment:
Local Education Agencies (LEAs) and State Education Agencies (SEAs) receive payment for school health services provided to Medicaid recipients in Nevada by submitting a claim directly to Nevada Medicaid, no matter whether students are covered under Fee-For-Service (FFS) or a Managed Care Organization (MCO).

Who can bill:

LEAs and SEAs may either bill the State directly or contract with a billing vendor to submit claims on their behalf. Claims for reimbursement should be submitted at least monthly to adhere to Medicaid's timely filing requirements.

When payments occur:
Nevada Medicaid processes payments on a weekly schedule, with "clean" claims – those that are free from errors and complete with all necessary documentation – submitted by noon on Thursday being paid the following Friday.

6.2 Submitting Claims for School Health Services

To receive payments, claims can be submitted by an enrolled LEA/SEA or by a billing agent. Where claims are submitted depends on whether the LEA/SEA bills directly or via a billing agent.

LEAs/SEAs should use the Nevada Medicaid and Nevada Check up Provider Web Portal (PWP) to submit claims. If you do not already have an account, please click here for instructions on how to register. Through the PWP, LEAs/SEAs may also perform other functions, like:

- **Adjust a claim** – The process of reviewing, modifying, and finalizing Medicaid claims submitted by providers on behalf of students. This process ensures that claims are accurate, compliant, and are reimbursed appropriately.
- **Copy a claim** – The action of duplicating an existing insurance claim to create a new one that is similar or identical, but with some modifications. This process is often used when a healthcare provider needs to resubmit a claim due to errors in the original submission.
- **Verify the status of a claim** – Checking the current state or progress of an insurance claim that has been submitted for reimbursement.

Billing agents/trading partners should use the Electronic Data Interchange (EDI) system to submit claims. Timely filing limits require claims to be submitted within 180 days of the date of service for providers, including LEAs/SEAs.

6.2.1 Submitting claims directly by an LEA/SEA (without a billing vendor):

An overview of the claim submission form for LEAs/SEAs is provided below. For more detailed information on how to submit a claim, please use Chapter Three of the Nevada EVS manual.

EXHIBIT 6 - 1: STEPS FOR CLAIM SUBMISSION USING THE PWP[5]

1. After logging in to the portal, navigate to the **'Claims'** tab in the blue ribbon at the top of the main page.
2. Underneath the blue ribbon is a row to select **'Claim Type'**. There are multiple claim types that can be submitted. Select the applicable claim type to your claim.
3. There will be three subsequent sections of the claim form, listed as steps 1 - 3, that must be completed to submit the claim.

    a. **Step One:** Fill out the fields requesting provider information, patient information, and claim information. The provider section should be automatically populated with Billing Provider ID and ID Type. Please note that fields with an asterisk are required. You will not be able to submit the form if you leave a required field blank. Once you have completed step one, select **'Continue'**.

    b. **Step Two:** This step entails entering information about diagnosis codes and other insurance details. All fields will originally be collapsed but can be expanded using the **'Expand All'** button or the **'+'** buttons on the right of each ribbon.

        i. The first part of step two requires entering diagnosis codes, all of which are searchable. Fill out all required fields marked by the red asterisk.

        ii. The second part of step two is the other insurance details section. The Medicaid policy information for the student should automatically populate. The fields on this page are required only if you are adding other insurance payment information.

        iii. There is also space for condition codes, occurrence codes, value codes, and surgical procedures. If any of these are applicable, click the **'Add'** button to add a code. Once finished, select **'Continue'**.

    c. **Step Three:** Fill out the service details in the required fields. Click the **'Add'** button to add up to 50 service details. The revenue codes are all searchable. If applicable, add attachments in the section after service details.

4. Once steps one through three are completed, click the **'Submit'** button. A page will be displayed to confirm the claim and review details prior to final submission. Review the submission, and if all the details are correct, click **'Confirm'**. A confirmation notification will appear on the page once the claim has been successfully submitted. If the claim needs to be altered, click the **'Adjust'** button. If you wish to view the claim, click the **'View'** button.

[5] https://www.medicaid.nv.gov/Downloads/provider/NV_EVS_User_Manual_Ch3.pdf

Once the claim has been submitted, it will automatically undergo a series of evaluations called "edits and audits" to determine if the claim is to be approved for payment. If it is not approved, the claim will be suspended and put through manual review to be approved or denied. When the claim is determined to be payable it will be processed in the weekly financial cycle, which is Friday - Friday. Through this cycle a remittance advice (RA) notice is uploaded to the providers' EVS Web Portal Account. The RA will contain information on both paid claims and denied claims. The provider can review RAs in the PWP for up to six months.

6.2.2 Submitting claims through a billing vendor

If an LEA/SEA chooses to use a billing vendor rather than submitting claims directly to Nevada Medicaid, it must first ensure that the appropriate trading partner agreements, or contract outlining the terms between the LEA/SEA and the billing vendor, are in place. The LEA/SEA remains responsible for all claims submitted by its billing vendor and must maintain documentation to support services provided and billed through the billing vendor.

To work with a billing vendor, there are steps that the LEA/SEA must take to enroll and authorize the billing vendor to bill. Please see **Section 3** for information about LEAs/SEAs enrolling with a trading partner to complete billing through the PWP and authorizing the trading partner to make transactions on behalf of the LEA/SEA. There are several activities that a billing vendor can carry out as a trading partner, such as:

- **Verifying eligibility** – confirming that a student is Medicaid eligible or covered by an insurance plan and determining the specifics of that coverage before services are rendered.
- **Submitting claims** – sending a bill for services provided by a healthcare provider to Medicaid or payer for reimbursement.
- **Reviewing payment information** – examining the payment details, reconciling payments with the claims submitted, and addressing any discrepancies

A summary of the authorized electronic transaction types used by trading partners is provided in the table below.

TABLE 6 - 2: AUTHORIZED TRANSACTIONS

Electronic Transaction Type	Trading Partner Activity
276 / 277	Healthcare Claim Status Inquiry and Response
270 / 271	Healthcare Eligibility Benefit Inquiry and Information Request
834	Benefit Enrollment and Maintenance
835	Healthcare Claim Payment / Advice

The companion guide for each transaction can be found here with more information on technical data requirements for trading partners when exchanging electronically with Nevada Medicaid.
Trading partners should be familiar with those companion guides, as they outline the technical requirements for each transaction type.

6.2.3 Common Claim Denial Reasons

The following table lists common denial reasons for SHS claims. This table does not contain a complete list of all denials; it is provided as an example of common reasons a claim would be denied. Any entity billing School Health Services should be aware of these denial reasons and take steps to ensure complete and accurate claim submission for less delay in claims processing and payment.

TABLE 6 - 3: COMMON CLAIM DENIALS

Denial Reasons
• Client ineligible on detail level date of service (DL DOS)
• Exact duplicate: practitioner to practitioner
• Place of service not on file
• DOS exceeds timely filing limit
• Student first name is missing or does not match member ID
• Student last name is missing or does not match member ID
• Ordering / Prescribing / Referring (OPR) provider is not currently enrolled in Medicaid
• OPR provider National Provider Identifier (NPI) is required
• Provider submitted void
• 1 unit allowed per 12 rolling months
• 1 unit allowed per day
• National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) conflict pay current – reprocess history
• Modifier restriction for proc billing rule

6.3 Prior Authorization and Third-Party Liability (TPL) Information

6.3.1 Prior Authorization

Prior authorizations are not required for covered SHS provided to a Nevada Medicaid-enrolled student. The Medicaid Service Manual may reference prior authorization requirements, but those do not apply to SHS.

6.3.2 Third Party Liability

In most instances, Medicaid is the "payor of last resort." This means that all other third-party coverage sources must meet their legal obligation to pay for services before the Medicaid program can pay for a service. Exceptions to this rule include IDEA and Children with Special health Care Needs. Currently, services in an IEP and preventive pediatric services covered by the Nevada Medicaid State Plan are exceptions. For example:

- Child has private health insurance and Medicaid – the private health insurance pays first, and Medicaid only pays if there are services that private insurance will not cover.
- Child is eligible for Medicaid and health services through the school district – Medicaid pays for any services covered by Medicaid (up to a set allowable amount), then the school district pays for any remaining service costs.

6.4 Frequently Billed Codes

The most frequently billed Current Procedural Terminology (CPT) codes for Medicaid school health services typically include those related to preventive care, routine health assessments, and common minor treatments. Please note that the specific CPT codes used by an LEA/SEA can vary based on the services provided, the age of the students, and the policies of the healthcare provider or school district. **Practitioners should use the CPT code that is most appropriate to the service provided.**

Below is a table showing ten CPT codes that are commonly used in school health settings. These codes cover a range of services, including initial and periodic preventive medicine evaluations, as well as counseling and risk factor reduction interventions. However, this list is not intended to be a comprehensive list of billable CPT codes for school health services; it is provided only as a reference point. Please see **Appendix B** for a more extensive list of commonly billed codes or visit the fee schedule here to view the complete list for Provider Type 60 School Health Services.

TABLE 6 - 4: EXAMPLE FREQUENTLY BILLED CODES FOR SCHOOL HEALTH SERVICES

Code	Description
99382	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; late childhood (age 5 through 11 years).
99383	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; late childhood (age 5 through 11 years).
99384	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; adolescent (age 12 through 17 years).
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; early childhood (age 1 through 4 years).
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; late childhood (age 5 through 11 years).
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; adolescent (age 12 through 17 years).
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
96110	Developmental screening, with interpretation and report.
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale) with scoring and documentation per standardized instrument.

6.5 Fee Schedule Information

The following table contains the payment rate as of March 2025 for the above-listed sample of ten commonly used CPT codes. The information provided here is intended to be used as an example and is **subject to change**.

The complete and current fee schedule is available online here. Please use the link provided on the webpage for **Provider Type 60 School Health Services to access current rates**.

TABLE 6 - 5: EXAMPLE FEE SCHEDULE

Code	Description	Rate
99382	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; late childhood (age 5 through 11 years).	$113.18
99383	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; late childhood (age 5 through 11 years).	$118.04
99384	Initial comprehensive preventive medicine evaluation and management of an individual, new patient; adolescent (age 12 through 17 years).	$133.32
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; early childhood (age 1 through 4 years).	$104.41
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; late childhood (age 5 through 11 years).	$104.05
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual, established patient; adolescent (age 12 through 17 years).	$113.73
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.	$35.08
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.	$60.00
96110	Developmental screening, with interpretation and report.	$7.40
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale) with scoring and documentation per standardized instrument.	$4.82

7 Practical Guidance for Successful SHS Program Operations

7.1 Obtaining Signed Release of Information (Family Educational Rights and Privacy Act (FERPA)) Required Consent Forms

Obtaining parents' release of information for the LEA/SEA to bill Medicaid has been noted as a common barrier to obtaining Medicaid reimbursement for services. Parents may not understand the requirements for signed forms, may think that the form does not apply to their student, or they may lack the access to the needed technology to print and sign a form.

A variety of barriers may impact whether parents give consent:

- Lack of technical skills
- Lack of printing capacity
- Language barriers
- Lack of understanding for the purpose of the form
- Lack of opportunity for parents to sign the form

Solutions for gaining more signed forms should be designed to address the root cause of the specific barriers. Some potential actions could include:

- Create a single form that is signed up front by all parents as part of the school enrollment process (versus waiting for service delivery).
- Add the form for all students in start-of-school-year packets and at all health fair meetings.
- Provide the form to all parents with all free and reduced lunch applications.
- Offer multiple methods for submitting the forms (hard copy, scanned copy, email submission, on-line signature process).
- Develop an educational cover sheet for the form in multiple languages (based on your student population) and/or offer translation assistance to parents to complete the form.

7.2 Administrative Oversight and Management with a Billing Vendor

LEA/SEA staff that work with a billing vendor should familiarize themselves with their vendor's contractual obligations, since the LEA/SEA is liable for those claims submitted by the billing vendor. This section provides an overview of the suggested administrative activities that an LEA/SEA should consider implementing to administer and manage the SHS.

Each LEA/SEA should designate a SHS administrator as a primary point of contact. The SHS administrator should not only be a point of contact for SHS practitioners but also have a chain of communication up to LEA/SEA leadership (and the Nevada Medicaid SHS team) for support with implementing best practices.

The SHS Administrator Timeline should also assure that the following key SHS administrative activities are completed, according to the timeframes listed below:

- **Weekly**
  - Ensure that claims are submitted (provided by billing vendor)
  - Review Remittance Advice
  - Review denial reports and follow-up with denials that can be resubmitted (provided by billing vendor)
  - Follow-up on claim denials (LEA works with billing vendor)
  - Review SHS documentation in EHR (completed by LEA)
- **Monthly**
  - Medicaid eligibility checks and review results (provided by billing vendor)
  - Follow-up on Medicaid eligibility check results that can be adjusted (LEA works with billing vendor)
  - Release of information response review and follow-up when the release of information has not been offered to a parent/guardian (completed by LEA)
- **Quarterly**
  - Review services delivered compared to authorized (completed by LEA)
  - SHS newsletter announcing funding investments, program requirement changes, and other supportive updates (completed by LEA)
  - Check for a plan of care on file that demonstrates medical necessity (completed by LEA)
- **Annually**
  - Practitioner training for new staff and staff that provide documented services (completed by LEA)
  - Compliance review of documentation (completed by LEA)
  - Ensure that service referrals or treatment orders are updated (completed by LEA)

7.3 Documentation Standards

LEAs/SEAs are responsible for ensuring that documentation in the student's POC and treatment/progress notes will **clearly support medical necessity of services, and the level of services delivered**.

While different services may have different specific documentation requirements, some general best practices for maintaining documentation include:

- All documentation should be completed as soon as possible after the service is delivered.
- All instances of documentation include the date and time entered.
- Initials or other methods of identification should be used to identify who completed the documentation.
- Electronic Health Records (EHR) systems can assist in medical documentation and lead to documentation that is consistent and easier to maintain. There are a few key things to consider when you use an EHR. However, make sure that auto-fill features do not lead to identical notes for different services or visits for an individual.

CMS suggests that providers regularly self-audit their documentation to prevent large scale problems. You can learn more about CMS guidance on documentation through the Documentation Matters Toolkit.

Appendix A: Eligible Provider Qualifications and Supervision Requirements

Information is provided below regarding which provider types can act as a supervisor, versus who must act as a supervisee that bills "Under the Direction Of" a supervisor.

Qualified Nevada Medicaid Providers	Supervisor	Supervisee that bills 'Under the Direction of a Supervisor'
PHYSICIAN & NURSING SERVICES		
Physician licensed by the Nevada State Board of Medical Examiners or the Nevada State Board of Osteopathic Medical Examiners acting within their scope of practice and meeting the qualifications of NRS Chapter 630 or NRS Chapter 633.	✓	
Physician Assistant licensed by the Nevada State Board of Medical Examiners or certification by the Nevada State Board of Osteopathic Medicine to perform medical services supervised by a licensed physician in accordance with professional standards and meeting the qualifications of NRS Chapter 630.		
Advanced Practice Registered Nurse (APRN) licensed by the Nevada State Board of Nursing acting within their scope of practice and meeting the qualifications of NRS Chapter 632.	✓	
A Registered Nurse (RN) licensed by the Nevada State Board of Nursing acting within their scope of practice and meeting the qualifications of NRS Chapter 632.	LPNs/CNAs Only	M.D., D.O., or APRN
A licensed Practical Nurse licensed by the Nevada State Board of Nursing. Supervised by a licensed APRN or RN in accordance with professional standards.		✓
A Nursing Assistant certified by the Nevada State Board of Nursing. Supervised by a licensed APRN or RN in accordance with professional standards.		
Community Health Workers certified by Nevada Certification Board.		✓
BEHAVIORAL HEALTH & ALCOHOL / SUBSTANCE USE SERVICES		
A Doctorate Degree in Psychology and licensed by the State of Nevada Board of Psychological Examiners acting within their scope of practice.	✓	
Psychological Assistants registered with the State of Nevada Board of Psychological Examiners and supervised by a Licensed Board of Examiners Psychologist in accordance with professional standards.		
Psychological Interns registered with the State of Nevada Board of Psychological Examiners and supervised		✓

by a Licensed Board of Examiners Psychologist in accordance with professional standards.		✓
Psychological Trainees registered with the State of Nevada Board of Psychological Examiners and supervised by a Licensed Board of Examiners Psychologist in accordance with professional standards.		
Licensed Clinical Social Workers (LCSW) licensed by the Nevada Board of Examiners for Social Workers acting within their scope of practice.	✓	
Licensed Marriage and Family Therapists (LMFT) licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors acting within their scope of practice.	✓	
Clinical Professional Counselors (CPC) licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors acting within their scope of practice.	✓	
LCSW interns licensed by the Nevada Board of Examiners for Social Workers and supervised by a LCSW, LMFT, or CPC acting within their scope of practice.		
LMFT interns licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors and supervised by a LCSW, LMFT, or CPC acting within their scope of practice.		✓
CPC intern licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors and supervised by a LCSW, LMFT, or CPC acting within their scope of practice.		
Board Certified Behavior Analyst or Board Certified Assistant Behavior Analyst (BCBA/BCaBA) certified by the Nevada Board of Applied Behavior Analysis acting within their scope of practice and meeting the requirements of NRS Chapter 641D.	✓	
Registered Behavior Technician (RBT) certified by the Nevada Board of Applied Behavior Analysis acting within their scope of practice and meeting the requirements of NRS Chapter 641D.		
OCCUPATIONAL THERAPY SERVICES		
An Occupational Therapist licensed by the State of Nevada Board of Occupational Therapy acting within their scope of practice and meeting the qualifications of NRS Chapter 640A.		

An Occupational Therapy Assistant certified by the State of Nevada Board of Occupational Board of Therapy. Supervised by a Licensed Occupational Therapist in accordance with professional standards and meeting the qualifications of NRS Chapter 640A.		✓
PHYSICAL THERAPY SERVICES		
A Physical Therapist licensed by the State of Nevada Physical Therapy Examiners Board and meeting the qualifications of NRS Chapter 640.	✓	
A Physical Therapist Assistant licensed by the State of Nevada Physical Therapy Examiners Board. Supervised by a licensed Physical Therapist in accordance with professional standards and meeting the qualifications of NRS Chapter 640.		
SPEECH PATHOLOGY SERVICES		
Licensed Speech-Language Pathologist by the Nevada Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board and has Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA) and meeting the qualifications of NRS Chapter 637B.		
Licensed Speech-Language Pathologist by the Nevada Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board with no CCC but holds a master's or doctoral degree from an accredited institution and meeting the qualifications of NRS Chapter 637B.	✓	
Speech-Language Pathologist clinical fellow with a provisional license from the Nevada Speech- Language Pathology, Audiology, and Hearing Aid Dispensing Board and supervised by a licensed Speech-Language Pathologist in accordance with professional standards and meeting the qualifications of NRS Chapter 637B.		
Qualified Speech-Language endorsed by the Department of Education as detailed in NAC 391.370 2(a), (c), (d), (e) and supervised by a licensed Speech-Language Pathologist in accordance with professional standards and meeting the qualifications of NRS Chapter 637B.		✓

Appendix B: Billing Codes and Limitations

This list is **not an exhaustive list of billable CPT codes** for school health services, it is a listing of *commonly billed codes* by Nevada SHS programs.

Code	Description	Limitations
	SCREENING & DIAGNOSTIC SERVICES	
99382 Modifier EP or TS	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION (1- 4 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99383 Modifier EP or TS	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION (5- 11 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99384 Modifier EP or TS	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION (12-17 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99385 Modifier EP or TS	INITIAL NEW PATIENT PREVENTIVE MEDICINE EVALUATION (18-39 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99392 Modifier EP or TS	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION (1-4 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99393 Modifier EP or TS	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION (5-11 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99394 Modifier EP or TS	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION (12-17 YEARS)	Encounter = 1 unit Limit of 1 unit per day
99395 Modifier EP or TS	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION (18-39 YEARS)	Encounter = 1 unit Limit of 1 unit per day
90460	ADMINISTRATION OF FIRST VACCINE OR TOXOID COMPONENT WITH COUNSELING (18 YEARS OR YOUNGER)	Vaccine = 1 unit Limit of 9 units per day
90461	ADMINISTRATION OF VACCINE OR TOXOID COMPONENT WITH COUNSELING (18 YEARS OR YOUNGER), EACH ADDITIONAL VACCINE OR TOXOID COMPONENT	Vaccine = 1 unit Limit 8 units per day
90471	ADMINISTRATION OF VACCINE	Vaccine = 1 unit Limit of 1 unit per day
90472	ADMINISTRATION OF VACCINE, EACH ADDITIONAL VACCINE	Vaccine = 1 unit Limit of 8 units per day
90473	ADMINISTRATION OF NASAL OR ORAL VACCINE, 1 VACCINE	Vaccine = 1 unit Limit of 1 unit per day
90474	ADMINISTRATION OF NASAL OR ORAL VACCINE, EACH ADDITIONAL VACCINE	Vaccine = 1 unit Limit of 1 unit per day
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	Encounter = 1 unit Limit 1 unit per day

90785	PSYCHIATRIC SERVICES COMPLICATED BY COMMUNICATION FACTOR	Encounter = 1 unit Limit 3 units per day
92521	EVALUATION OF SPEECH CONTINUITY, SMOOTHNESS, RATE, AND EFFORT	Encounter = 1 unit Limit 1 unit per day
92522	EVALUATION OF SPEECH SOUND PRODUCTION	Encounter = 1 unit Limit 1 unit per day
92523	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION	Encounter = 1 unit Limit 1 unit per day
92551	TEST FOR SCREENING HEARING	Encounter = 1 unit Limit 1 unit per day
92620	EVALUATION OF HEARING FUNCTION BRAIN RESPONSES, FIRST HOUR	60 minutes = 1 unit Limit 1 unit per day
92621	EVALUATION OF HEARING FUNCTION BRAIN RESPONSES, EACH ADDITIONAL 15 MINUTES	15 minutes = 1 unit Limit 4 units per day
96110	DEVELOPMENTAL SCREENING	1 instrument = 1 unit Limit of 3 units per day
96112	ADMINISTRATION OF DEVELOPMENTAL TEST, FIRST HOUR	1 hour = 1 unit Limit of 1 unit per day
96113	ADMINISTRATION OF DEVELOPMENTAL TEST, EACH ADDITIONAL 30 MINUTES	Limit of 6 units per day
96116	EXAM OF NEUROBEHAVIORAL STATUS, FIRST HOUR	60 minutes = 1 unit Limit 1 unit per day
96121	EXAM OF NEUROBEHAVIORAL STATUS, EACH ADDITIONAL HOUR	60 minutes = 1 unit Limit of 3 units per day
96156	ASSESSMENT OF HEALTH BEHAVIOR	Encounter = 1 unit Limit of 1 unit per day
96158	TREATMENT OF BEHAVIOR IMPACTING HEALTH, INITIAL 30 MINUTES	30 minutes = 1 unit Limit 1 unit per day
96159	TREATMENT OF BEHAVIOR IMPACTING HEALTH, EACH ADDITIONAL 15 MINUTES	15 minutes = 1 unit Limit of 4 units per day
96160	ADMINISTRATION AND INTERPRETATION OF PATIENT- FOCUSED HEALTH RISK ASSESSMENT	Assessment = 1 unit Limit of 3 units per day
96164	TREATMENT OF BEHAVIOR IMPACTING HEALTH IN GROUP SETTING, INITIAL 30 MINUTES	Initial 30 minutes
96165	TREATMENT OF BEHAVIOR IMPACTING HEALTH IN GROUP SETTING, EACH ADDITIONAL 30 MINUTES	Each additional 15 minutes
96167	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY AND PATIENT, INITIAL 30 MINUTES	30 minutes = 1 unit Limit of 1 unit per day
96168	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY AND PATIENT, EACH ADDITIONAL 30 MINUTES	15 minutes = 1 unit Limit of 6 units per day
96170	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY, INITIAL 30 MINUTES	30 minutes = 1 unit Limit of 1 unit per day
96171	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY, EACH ADDITIONAL 30 MINUTES	15 minutes = 1 unit Limit of 2 units per day
96127	ASSESSMENT OF EMOTIONAL OR BEHAVIORAL PROBLEMS	Assessment = 1 unit Limit 2 units per day

97161	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 20 MINUTES	20 minutes = 1 unit Limit 1 unit per day
97162	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 30 MINUTES	30 minutes = 1 unit Limit 1 unit per day
97163	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 45 MINUTES	45 minutes = 1 unit Limit 1 unit per day
97165	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 30 MINUTES	30 minutes = 1 unit Limit 1 unit per day
97166	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 45 MINUTES	45 minutes = 1 unit, Limit 1 unit per day
97167	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 1 HOUR	60 minutes = 1 unit Limit 1 unit per day
99174	SCREENING OF EYE WITH SPECIAL INSTRUMENT WITH REMOTE ANALYSIS	Encounter = 1 unit Limit of 1 per day
99188	APPLICATION OF TOPICAL FLUORIDE	Encounter = 1 unit Limit 1 unit per day
G0312	IMMUNIZATION COUNSELING BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHEN THE VACCINE(S) IS NOT ADMINISTERED ON THE SAME DATE OF SERVICE FOR AGES UNDER 21, 5 TO 15 MINS TIME (THIS CODE IS USED FOR MEDICAID BILLING PURPOSES)	Limit 1 unit per day
G0313	IMMUNIZATION COUNSELING BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHEN THE VACCINE(S) IS NOT ADMINISTERED ON THE SAME DATE OF SERVICE FOR AGES UNDER 21, 16-30 MINS TIME (THIS CODE IS USED FOR MEDICAID BILLING PURPOSES)	Limit 1 unit per day
G0314	IMMUNIZATION COUNSELING BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL FOR COVID-19, AGES UNDER 21, 16-30 MINS TIME (THIS CODE IS USED FOR THE MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT BENEFIT (EPSDT)	Limit 1 unit per day
G0315	IMMUNIZATION COUNSELING BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL FOR COVID-19, AGES UNDER 21, 5-15 MINS TIME (THIS CODE IS USED FOR THE MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT BENEFIT (EPSDT)	Limit 1 unit per day
EPSDT SERVICES THAT <u>CANNOT</u> BE BILLED WITH HEALTHY KIDS' SCREENINGS		
99078	PHYSICIAN EDUCATIONAL SERVICES RENDERED TO PATIENTS IN A GROUP SETTING	Group = 1 unit Limit 3 units per day
99401	PREVENTIVE MEDICINE COUNSELING, TYPICALLY 15 MINUTES	Encounter = 1 unit Limit 1 unit per day
99402	PREVENTIVE MEDICINE COUNSELING, TYPICALLY 30 MINUTES	Encounter = 1 unit Limit 1 unit per day
99403	PREVENTIVE MEDICINE COUNSELING, TYPICALLY 45 MINUTES	Encounter = 1 unit Limit 1 unit per day
99404	PREVENTIVE MEDICINE COUNSELING, TYPICALLY 1 HOUR	Encounter = 1 unit Limit 1 unit per day
99406	SMOKING AND TOBACCO USE INTENSIVE COUNSELING, 4-10 MINUTES	Encounter = 1 unit Limit 1 unit per day
99407	SMOKING AND TOBACCO USE INTENSIVE COUNSELING, MORE THAN 10 MINUTES	Encounter = 1 unit Limit 1 unit per day

99408	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND INTERVENTION, 15-30 MINUTES	Encounter = 1 unit Limit 1 unit per day
99409	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND INTERVENTION, MORE THAN 30 MINUTES	Encounter = 1 unit Limit 1 unit per day
99411	GROUP PREVENTIVE MEDICINE COUNSELING, TYPICALLY 30 MINUTES	Encounter = 1 unit Limit 1 unit per day
99412	GROUP PREVENTIVE MEDICINE COUNSELING, TYPICALLY 1 HOUR	Encounter = 1 unit Limit 1 unit per day
99202	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFORWARD MEDICAL DECISION MAKING, IF USING TIME, 15 MINUTES OR MORE	Encounter = 1 unit Limit 1 unit per day
PHYSICIAN SERVICES		
99203	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH LOW LEVEL OF MEDICAL DECISION MAKING, IF USING TIME, 30 MINUTES OR MORE	Encounter = 1 unit Limit 1 unit per day
99204	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH MODERATE LEVEL OF MEDICAL DECISION MAKING, IF USING TIME, 45 MINUTES OR MORE	Encounter = 1 unit Limit 1 unit per day
99205	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH A HIGH LEVEL OF MEDICAL DECISION MAKING, IF USING TIME, 60 MINUTES OR MORE	Encounter = 1 unit Limit 1 unit per day
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF ESTABLISHED PATIENT THAT MAY NOT REQUIRE PRESENCE OF HEALTHCARE PROFESSIONAL	Encounter = 1 unit Limit 1 unit per day
99212	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH STRAIGHTFORWARD MEDICAL DECISION MAKING, IF USING TIME, 10 MINUTES OR MORE	Encounter = 1 unit Limit 2 units per day
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH LOW LEVEL OF DECISION MAKING, IF USING TIME, 20 MINUTES OR MORE	Encounter = 1 unit Limit 2 units per day
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH MODERATE LEVEL OF DECISION MAKING, IF USING TIME, 30 MINUTES OR MORE	Encounter = 1 unit Limit 2 units per day
99215	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH HIGH LEVEL OF MEDICAL DECISION MAKING, IF USING TIME, 40 MINUTES OR MORE	Limit 2 units per 12 rolling months
99367	MEDICAL TEAM CONFERENCE WITH PHYSICIAN, 30 MINUTES OR MORE	Encounter = 1 unit Limit 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
BEHAVIORAL HEALTH & ALCOHOL / SUBSTANCE ABUSE SERVICES		
H0031	MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN	Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid
H0002	BEHAVIORAL HEALTH SCREENING TO DETERMINE ELIGIBILITY FOR ADMISSION TO TREATMENT PROGRAM	Encounter = 1 unit Limit of 1 unit per day Limit 1 time every 90 days; Bill 1 unit for each screening
96127	ASSESSMENT OF EMOTIONAL OR BEHAVIORAL PROBLEMS	Assessment = 1 unit Bill 1 unit for each screening Limit 2 units per day
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid

H0034 Modifier TD	MEDICATION TRAINING AND SUPPORT, PER 15 MINUTES	15 minutes = 1 unit Limit of 2 units per calendar month per student
96138	ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, FIRST 30 MINUTES	First 30 minutes
+96139	ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, EACH ADDITIONAL 30 MINUTES	Each additional 30 minutes
96156	ASSESSMENT OF HEALTH BEHAVIOR	Initial assessment, face- to-face with patient 4 units allowed per calendar year
96158	TREATMENT OF BEHAVIOR IMPACTING HEALTH, INITIAL 30 MINUTES	Individual, face-to- face initial 30 minutes
96159	TREATMENT OF BEHAVIOR IMPACTING HEALTH, EACH ADDITIONAL 15 MINUTES	Each additional 15 minutes
96164	TREATMENT OF BEHAVIOR IMPACTING HEALTH IN GROUP SETTING, INITIAL 30 MINUTES	Initial 30 minutes
96165	TREATMENT OF BEHAVIOR IMPACTING HEALTH IN GROUP SETTING, EACH ADDITIONAL 30 MINUTES	Each additional 15 minutes
96167	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY AND PATIENT, INITIAL 30 MINUTES	Initial 30 minutes face- to-face
96168	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY AND PATIENT, EACH ADDITIONAL 30 MINUTES	Each additional 15 minutes, face-to- face
96170	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY, INITIAL 30 MINUTES	Initial 30 minutes, face- to-face
96171	TREATMENT OF BEHAVIOR IMPACTING HEALTH WITH FAMILY, EACH ADDITIONAL 30 MINUTES	Each additional 15 minutes, face-to- face Limit of 2 units per day
+90785	PSYCHIATRIC SERVICES COMPLICATED BY COMMUNICATION FACTOR	Encounter = 1 unit Limit 3 units per day
90832	PSYCHOTHERAPY, 30 MINUTES	30 minutes; bill 1 unit per day The patient must be present for all or most of the session
90833	PSYCHOTHERAPY WITH EVALUATION AND MANAGEMENT VISIT, 30 MINUTES	30 minutes with patient; Bill 1 unit per day
90834	PSYCHOTHERAPY, 45 MINUTES	45 minutes; Bill 1 unit per day The patient must be present for all or most of the session
90836	PSYCHOTHERAPY WITH EVALUATION AND MANAGEMENT VISIT, 45 MINUTES	45 minutes with patient; Bill 1 unit per day
90837	PSYCHOTHERAPY, 1 HOUR	60 minutes; Bill 1 unit per day The patient must be present for all or most of the session
90838	PSYCHOTHERAPY WITH EVALUATION AND MANAGEMENT VISIT, 1 HOUR	60 minutes with patient Bill 1 unit per day
90839	PSYCHOTHERAPY FOR CRISIS, FIRST HOUR	First 60 minutes, face- to-face Bill 1 unit per day

90840	PSYCHOTHERAPY FOR CRISIS, EACH ADDITIONAL 30 MINUTES	Each additional 30 minutes Bill 1 unit per day
90845	PSYCHOANALYSIS	Bill 1 unit per day The patient must be present for all or most of the session
90846	FAMILY PSYCHOTHERAPY WITHOUT PATIENT, 50 MINUTES	50 minutes Bill 1 unit per day
90847	FAMILY PSYCHOTHERAPY WITH PATIENT, 50 MINUTES	50 minutes Bill 1 unit per day
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY	Bill 1 unit per day; maximum of two (2) hours per session
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE- FAMILY GROUP). (USE IN CONJUNCTION WITH 90785 FOR THE SPECIFIED PATIENT WHEN GROUP PSYCHOTHERAPY INCLUDES INTERACTIVE COMPLEXITY.)	Bill 1 unit per day; maximum 2 hours per session
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	Unit = 15 minutes
H2011 Modifier GT	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	Unit = 15 minutes
H2011 Modifier HT	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	Unit = 15 minutes
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	Unit = 15 minutes
H0038	SELF-HELP/PEER SERVICES, PER 15 MINUTES	Per 15 minutes
H2014	SKILLS TRAINING AND DEVELOPMENT, PER 15 MINUTES	Per 15 minutes; maximum of 2 hours per day (H2014 and H2014 HQ combined)
H2017	PSYCHOSOCIAL REHABILITATION SERVICES, PER 15 MINUTES	Per 15 minutes
H2017 Modifier HQ	PSYCHOSOCIAL REHABILITATION SERVICES, PER 15 MINUTES	Per 15 minutes; maximum of 2 hours per day (H2017 and H2017 HQ combined)
99366 Modifier HE or HF	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day
99367 Modifier HE or HF	MEDICAL TEAM CONFERENCE WITH PHYSICIAN, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day
99368 Modifier HE or HF	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day
NURSING SERVICES		
T1001	NURSING ASSESSMENT / EVALUATION	Encounter = 1 unit Limited to 2 units per day

T1002	RN SERVICES, UP TO 15 MINUTES	15 min = 1 unit
T1003	LPN/LVN SERVICES, UP TO 15 MINUTES	15 min = 1 unit
T1004	SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES	15 min = 1 unit
99366 Modifier TD or SA	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99368 Modifier TD or SA	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
PHYSICAL THERAPY SERVICES		
97010 Modifier GP or GP/CQ	APPLICATION OF HOT OR COLD PACKS	Encounter = 1 unit Limited to 1 unit per day
97012 Modifier GP or GP/CQ	APPLICATION OF MECHANICAL TRACTION	Encounter = 1 unit Limited to 1 unit per day
97014 Modifier GP or GP/CQ	APPLICATION OF ELECTRICAL STIMULATION	Encounter = 1 unit Limited to 1 unit per day
97016 Modifier GP or GP/CQ	APPLICATION OF BLOOD VESSEL COMPRESSION DEVICE	Encounter = 1 unit Limited to 1 unit per day
97018 Modifier GP or GP/CQ	APPLICATION OF HOT WAX BATH	Encounter = 1 unit Limited to 1 unit per day
97022 Modifier GP or GP/CQ	APPLICATION OF WHIRLPOOL THERAPY	Encounter = 1 unit Limited to 1 unit per day
97024 Modifier GP or GP/CQ	APPLICATION OF HEAT WAVE THERAPY	Encounter = 1 unit Limited to 1 unit per day
97026 Modifier GP or GP/CQ	APPLICATION OF LOW ENERGY HEAT	Encounter = 1 unit Limited to 1 unit per day
97028 Modifier GP or GP/CQ	APPLICATION OF ULTRAVIOLET LIGHT	Encounter = 1 unit Limited to 1 unit per day
97032 Modifier GP or GP/CQ	APPLICATION OF ELECTRICAL STIMULATION WITH THERAPIST PRESENT, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day
97033 Modifier GP or GP/CQ	APPLICATION OF MEDICATION USING ELECTRICAL CURRENT, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day
97034 Modifier GP or GP/CQ	APPLICATION OF HOT AND COLD BATHS, EACH 15 MINUTES	15 minutes = 1 unit Limited to 2 units per day
97035 Modifier GP or GP/CQ	APPLICATION OF ULTRASOUND, EACH 15 MINUTES	15 minutes = 1 unit Limited to 2 units per day
97036 Modifier	APPLICATION OF WATER THERAPY USING A SPECIAL TANK, EACH 15 MINUTES	15 minutes = 1 unit Limited to 3 units per day

GP or GP/CQ		
97110 Modifier GP or GP/CQ	THERAPY PROCEDURE USING EXERCISE TO DEVELOP STRENGTH, ENDURANCE, RANGE OF MOTION, AND FLEXIBILITY, EACH 15 MINUTES	15 minutes = 1 unit Limited to 6 units per day
97112 Modifier GP or GP/CQ	THERAPY PROCEDURE TO RE-EDUCATE BRAIN-TO-NERVE- TO-MUSCLE FUNCTION, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day
97113 Modifier GP or GP/CQ	THERAPY PROCEDURE USING WATER POOL TO EXERCISES, EACH 15 MINUTES	15 minutes = 1 unit Limited to 6 units per day
97116 Modifier GP or GP/CQ	THERAPY PROCEDURE FOR WALKING TRAINING, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day
97124 Modifier GP or GP/CQ	THERAPY PROCEDURE USING MASSAGE, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day
97140 Modifier GP or GP/CQ	THERAPY PROCEDURE USING MANUAL TECHNIQUE, EACH 15 MINUTES	15 minutes = 1 unit Limited to 6 units per day Or 6 combined units of codes 97140, 97110 and/or 97535
97150 Modifier GP or GP/CQ	THERAPY PROCEDURE IN A GROUP SETTING	1 encounter = 1 unit Limited to 1 unit per day
97161 Modifier GP or GP/CQ	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 20 MINUTES	20 minutes = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year.
97162 Modifier GP or GP/CQ	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 30 MINUTES	30 minutes = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year.
97163 Modifier GP or GP/CQ	EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 45 MINUTES	45 minutes = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year.
97164 Modifier GP or GP/CQ	RE-EVALUATION FOR PHYSICAL THERAPY, TYPICALLY 20 MINUTES	20 minutes = 1 unit Limited to 1 unit per day
97530 Modifier GP or GP/CQ	THERAPY PROCEDURE USING FUNCTIONAL ACTIVITIES	15 minutes = 1 unit Limited to 6 units per day
97129 Modifier GP or GP/CQ	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, INITIAL 15 MINUTES	15 minutes = 1 unit Limit 1 unit per day
97130 Modifier GP or GP/CQ	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, EACH ADDITIONAL 15 MINUTES	15 minutes = 1 unit Limit 7 units per day
97533 Modifier GP or GP/CQ	THERAPY PROCEDURE USING SENSORY EXPERIENCES	15 minutes = 1 unit Limit of 4 units per day
97535 Modifier GP or GP/CQ	TRAINING FOR SELF-CARE OR HOME MANAGEMENT, EACH 15 MINUTES	15 minutes = 1 unit Limit of 8 units per day
97542 Modifier GP or GP/CQ	EVALUATION FOR WHEELCHAIR, EACH 15 MINUTES	15 minutes = 1 unit Limit of 8 units per day

97760 Modifier GP or GP/CQ	TRAINING IN THE USE OF ORTHOPEDIC DEVICE FOR ARM, LEG AND/OR TRUNK, EACH 15 MINUTES	15 minutes = 1 unit Limit of 6 units per day
97761 Modifier GP or GP/CQ	TRAINING IN THE USE OF ARTIFICIAL ARM AND/OR LEG, EACH 15 MINUTES	15 minutes = 1 unit Limit of 6 units per day
99366 Modifier GP	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99368 Modifier GP	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
OCCUPATIONAL THERAPY SERVICES		
97010 Modifier GO or GO/CO	APPLICATION OF HOT OR COLD PACKS	Encounter = 1 unit Limit of 1 unit per day
97014 Modifier GO or GO/CO	APPLICATION OF ELECTRICAL STIMULATION	Encounter = 1 unit Limit of 1 unit per day
97016 Modifier GO or GO/CO	APPLICATION OF BLOOD VESSEL COMPRESSION DEVICE	Encounter = 1 unit Limit of 1 unit per day
97018 Modifier GO or GO/CO	APPLICATION OF HOT WAX BATH	Encounter = 1 unit Limit of 1 unit per day
97022 Modifier GO or GO/CO	APPLICATION OF WHIRLPOOL THERAPY	Encounter = 1 unit Limit of 1 unit per day
97032 Modifier GO or GO/CO	APPLICATION OF ELECTRICAL STIMULATION WITH THERAPIST PRESENT, EACH 15 MINUTES	15 minutes = 1 unit Limit of 4 units per day
97033 Modifier GO or GO/CO	APPLICATION OF MEDICATION USING ELECTRICAL CURRENT, EACH 15 MINUTES	15 minutes = 1 unit Limit of 4 units per day
97034 Modifier GO or GO/CO	APPLICATION OF HOT AND COLD BATHS, EACH 15 MINUTES	15 minutes = 1 unit Limit of 2 units per day
97035 Modifier GO or GO/CO	APPLICATION OF ULTRASOUND, EACH 15 MINUTES	15 minutes = 1 unit Limit of 2 units per day
97036 Modifier GO or GO/CO	APPLICATION OF WATER THERAPY USING A SPECIAL TANK, EACH 15 MINUTES	15 minutes = 1 unit Limit of 3 units per day
97110 Modifier GO or GO/CO	THERAPY PROCEDURE USING EXERCISE TO DEVELOP STRENGTH, ENDURANCE, RANGE OF MOTION, AND FLEXIBILITY, EACH 15 MINUTES	15 minutes = 1 unit Limit of 6 units per day
97112 Modifier GO or GO/CO	THERAPY PROCEDURE TO RE-EDUCATE BRAIN-TO-NERVE- TO-MUSCLE FUNCTION, EACH 15 MINUTES	15 minutes = 1 unit Limit of 4 units per day
97116 Modifier GO or GO/CO	THERAPY PROCEDURE FOR WALKING TRAINING, EACH 15 MINUTES	15 minutes = 1 unit Limited to 4 units per day

97140 Modifier GO or GO/CO	THERAPY PROCEDURE USING MANUAL TECHNIQUE, EACH 15 MINUTES	15 minutes = 1 unit Limited to 6 units of code 97140 OR 6 combined units of codes 97140, 97110 and/or 97533
97150 Modifier GO or GO/CO	THERAPY PROCEDURE IN A GROUP SETTING	1 Encounter = 1 unit Limited to 1 unit per day Bill 1 unit for each student per session
97165 Modifier GO or GO/CO	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 30 MINUTES	1 encounter = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year
97166 Modifier GO or GO/CO	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 45 MINUTES	1 encounter = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year
97167 Modifier GO or GO/CO	EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 1 HOUR	1 encounter = 1 unit Limited to 1 evaluation per provider, per condition, per calendar year
97168 Modifier GO or GO/CO	RE-EVALUATION FOR OCCUPATIONAL THERAPY, TYPICALLY 30 MINUTES	1 encounter = 1 unit Limited to 1 unit per day
97530 Modifier GO or GO/CO	THERAPY PROCEDURE USING FUNCTIONAL ACTIVITIES	15 minutes = 1 unit Limit of 6 units per day
97129 Modifier GO or GO/CO	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, INITIAL 15 MINUTES	15 minutes = 1 unit Limit of 1 unit per day
97130 Modifier GO or GO/CO	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, EACH ADDITIONAL 15 MINUTES	15 minutes = 1 unit Limit of 7 units per day
97533 Modifier GO or GO/CO	THERAPY PROCEDURE USING SENSORY EXPERIENCES	15 minutes = 1 unit Limit of 4 units per day
97535 Modifier GO or GO/CO	TRAINING FOR SELF-CARE OR HOME MANAGEMENT, EACH 15 MINUTES	15 minutes = 1 unit Limit of 8 units per day
97542 Modifier GO or GO/CO	EVALUATION FOR WHEELCHAIR, EACH 15 MINUTES	15 minutes = 1 unit Limit of 8 units per day
97760 Modifier GO or GO/CO	TRAINING IN THE USE OF ORTHOPEDIC DEVICE FOR ARM, LEG AND/OR TRUNK, EACH 15 MINUTES	15 minutes = 1 unit Limit of 6 units per day
97761 Modifier GO or GO/CO	TRAINING IN THE USE OF ARTIFICIAL ARM AND/OR LEG, EACH 15 MINUTES	15 minutes = 1 unit Limit of 6 units per day
99366 Modifier GO	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year

99368 Modifier GO	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
SPEECH THERAPY SERVICES		
92507 Modifier GN	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER	Encounter = 1 unit
92508 Modifier GN	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER IN A GROUP SETTING	Encounter = 1 unit
92521 Modifier GN	EVALUATION OF SPEECH CONTINUITY, SMOOTHNESS, RATE, AND EFFORT	Encounter = 1 unit Limit of 1 unit per day
92522 Modifier GN	EVALUATION OF SPEECH SOUND PRODUCTION	Encounter = 1 unit Limit of 1 unit per day
92523 Modifier GN	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION	Encounter = 1 unit Limit of 1 unit per day
92526 Modifier GN	TREATMENT OF SWALLOWING AND FEEDING DISORDER	Encounter = 1 unit
92605 Modifier GN	EVALUATION AND PRESCRIPTION OF NONSPEECH- GENERATING AND ALTERNATIVE COMMUNICATION DEVICE, FIRST HOUR	Encounter = 1 unit Limit of 1 unit per day
92606 Modifier GN	THERAPY SERVICE FOR USE OF NONSPEECH-GENERATING DEVICE WITH PROGRAMMING	Encounter = 1 unit Limit of 1 unit per day
92607 Modifier GN	EVALUATION WITH PRESCRIPTION OF SPEECH-GENERATING AND ALTERNATIVE COMMUNICATION DEVICE, FIRST HOUR	Encounter = 1 unit Limit of 1 unit per day
92608 Modifier GN	EVALUATION WITH PRESCRIPTION OF SPEECH-GENERATING AND ALTERNATIVE COMMUNICATION DEVICE, EACH ADDITIONAL 30 MINUTES	30 minutes = 1 unit Limit of 4 units per day
92609 Modifier GN	THERAPY SERVICE FOR USE OF SPEECH-GENERATING DEVICE WITH PROGRAMMING	Encounter = 1 unit Limit of 1 unit per day
97129 Modifier GN	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, INITIAL 15 MINUTES	Encounter = 1 unit Limit of 1 unit per day
97130 Modifier GN	THERAPY PROCEDURE FOR A RANGE OF MENTAL PROCESSES, EACH ADDITIONAL 15 MINUTES	15 minutes = 1 unit Limit of 7 units per day
99366 Modifier GN	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99368 Modifier GN	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
PERSONAL CARE SERVICES		

T1019	PERSONAL CARE SERVICES, PER 15 MINUTES, NOT FOR AN INPATIENT OR RESIDENT OF A HOSPITAL, NURSING FACILITY, ICF/MR OR IMD, PART OF THE INDIVIDUALIZED PLAN OF TREATMENT (CODE MAY NOT BE USED TO IDENTIFY SERVICES PROVIDED BY HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT)	15 minutes = 1 unit Limited to units from School Functional Assessment for Service Plan (SFASP) or POC
APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES		
97151	BEHAVIOR IDENTIFICATION ASSESSMENT BY PROFESSIONAL, EACH 15 MINUTES	15 minutes = 1 unit 1 session of 16 units per 180 days
97152	BEHAVIOR IDENTIFICATION ASSESSMENT BY TECHNICIAN, EACH 15 MINUTES	15 minutes = 1 unit 1 session of 4 units per 180 days
0362T	BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT FOR PATIENT EXHIBITING DESTRUCTIVE BEHAVIOR, EACH 15 MINUTES OF TECHNICIANS' FACE-TO-FACE TIME	15 minutes = 1 unit 1 session of 4 units per 180 days
97153	ADAPTIVE BEHAVIOR TREATMENT BY TECHNICIAN USING AN ESTABLISHED PLAN, EACH 15 MINUTES	15 minutes = 1 unit
97155	ADAPTIVE BEHAVIOR TREATMENT BY PROFESSIONAL USING AN ESTABLISHED PLAN, EACH 15 MINUTES	15 minutes = 1 unit The maximum number of units that can be used for supervision is 20% of the total number of hours
0373T	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION FOR PATIENT EXHIBITING DESTRUCTIVE BEHAVIOR, EACH 15 MINUTES OF TECHNICIANS' FACE-TO-FACE TIME	15 minutes = 1 unit
97154	ADAPTIVE BEHAVIOR TREATMENT BY TECHNICIAN WITH MULTIPLE PATIENTS USING AN ESTABLISHED PLAN, EACH 15 MINUTES	15 minutes = 1 unit
97158	ADAPTIVE BEHAVIOR TREATMENT BY PROFESSIONAL WITH GROUP USING AN ESTABLISHED PLAN, EACH 15 MINUTES	15 minutes = 1 unit
97156	ADAPTIVE BEHAVIOR TREATMENT BY PROFESSIONAL WITH FAMILY USING AN ESTABLISHED PLAN, EACH 15 MINUTES	15 minutes = 1 unit 1 session of 4 units per week
97157	ADAPTIVE BEHAVIOR TREATMENT BY PROFESSIONAL WITH MULTIPLE FAMILY GROUP MEMBERS USING AN ESTABLISHED PLAN, EACH 15 MINUTES	1 session of 4 units per calendar month
99366	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99368	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
DENTAL SERVICES		
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	Limit of 1 service unit per 6 rolling months
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	Limit of 2 service units per 6 rolling months
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	Limit of 1 service unit per 12 rolling months
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	Limit of 1 service unit per 6 rolling months
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	Limit of 1 service unit per 6 rolling months

D0190	SCREENING OF A PATIENT	Limit of 1 service unit per 6 rolling months
D0191	ASSESSMENT OF A PATIENT	Limit of 1 service unit per 6 rolling months
D0210	INTRAORAL - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	Limit of 1 service unit (one complete series) per 36 rolling months. D0210 may not be billed on the same date of service as D0220 and/or D0230. Use code D0210 when providing 14 or more intraoral exams on the same date of service.
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	Limit of 1 service unit per 12 rolling months. D0220 may not be billed on the same date of service as D0210.
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	Limit of 12 units per rolling year. D0230 may not be billed on the same date of service as D0210. No more than 13 units of any combinations of D0220 and/or D0230 may be billed within any rolling year.
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	Limit of 2 units per 12 rolling months
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	Limit of 1 unit per 6 months
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	Limit of 1 unit per 6 months
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	Limit of 1 unit per 6 months
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	Limit of 1 unit per 6 months
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	Limit of 1 unit per 6 months
D0322	TOMOGRAPHIC SURVEY	Limit of 1 unit per 6 months
D0330	PANORAMIC RADIOGRAPHIC IMAGE	Limit of 1 unit per 36 months
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	Limit of 1 unit per 36 months
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW	Limit of 1 unit per 6 months
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MANDIBLE	Limit of 1 unit per 6 months
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MAXILLA, WITH OR WITHOUT CRANIUM	Limit of 1 unit per 6 months
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM	Limit of 1 unit per 6 months
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	Limit of 1 service unit per 6 months
D0415	COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY	Limit of 1 unit per 6 months
D0416	VIRAL CULTURE	Limit of 1 unit per 6 months
D0460	PULP VITALITY TESTS	Limit of 1 service unit per patient, per day, same provider
D0470	DIAGNOSTIC CASTS	Limit of 1 unit per 12 rolling months
D0502	OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT	Limit of 1 unit per 12 months

D0600	NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN, AND CEMENTUM	Limit of 1 unit per 6 months
D1110	PROPHYLAXIS – ADULT	Limit of 1 unit per 6 months
D1120	PROPHYLAXIS – CHILD	Limit of 1 unit per 6 months
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	Limit of 1 unit per 6 months
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	Limit of 1 unit per 6 months
D1351	SEALANT-PER TOOTH	Limit of 1 unit per 60 months,
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT - PERMANENT TOOTH	Once in a lifetime per tooth
D1353	SEALANT REPAIR - PER TOOTH	Limit of 1 unit per 36 months
D1354	APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH	Limit of 1 unit per 6 months per tooth
D1510	SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	Limit of 4 units any provider and 2 units per 12 months
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	Limit of 2 units any provider and 1 unit per 12 months
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	Limit of 2 units any provider and 1 unit per 12 months
D1520	SPACE MAINTAINER - REMOVABLE, UNILATERAL - PER QUADRANT	Limit of 4 units any provider and 2 units per 12 months
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	Limit of 2 units any provider and 1 unit per 12 months
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	Limit of 2 units any provider and 1 unit per 12 months
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	Limit of 2 units per lifetime
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	Limit of 2 units per lifetime
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	Limit of 2 units per lifetime
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT	Limit of 1 unit per lifetime
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY	Limit of 1 unit per lifetime
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR	Limit of 1 unit per lifetime
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	Limit of 4 units any provider and 2 units per 12 months
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	Limit of 1 unit per 36 months per tooth
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	Limit of 1 unit per 36 months per tooth
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	Limit of 1 unit per 36 months per tooth
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	Limit of 1 unit per 36 months per tooth
D2330	RESIN-ONE SURFACE, ANTERIOR	Limit of 1 unit per 36 months per tooth
D2331	RESIN-TWO SURFACES, ANTERIOR	Limit of 1 unit per 36 months per tooth
D2332	RESIN-THREE SURFACES, ANTERIOR	Limit of 1 unit per 36 months per tooth
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES (ANTERIOR)	Limit of 1 unit per 36 months per tooth
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	Limit of 1 unit per 36 months per tooth
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	Limit of 1 unit per 36 months per tooth
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	Limit of 1 unit per 36 months per tooth

D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	Limit of 1 unit per 36 months per tooth
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	Limit of 1 unit per 36 months per tooth
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT)	Once in a lifetime per tooth
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	Once in a lifetime per tooth
D2740	CROWN - PORCELAIN/CERAMIC	Once in a lifetime per tooth
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Once in a lifetime per tooth
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	Once in a lifetime per tooth
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	Once in a lifetime per tooth
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	Limit of 1 unit per 12 months per tooth
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	Once in a lifetime per tooth
D2920	RE-CEMENT OR RE-BOND CROWN	Limit of 1 unit per 12 months per tooth
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH	Once in a lifetime per tooth
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	Limit of 1 unit per 36 months per tooth
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	Once in a lifetime per tooth
D2932	PREFABRICATED RESIN CROWN	Limit of 1 unit per 36 months per tooth
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	Limit of 1 unit per 36 months per tooth
D2940	PROTECTIVE RESTORATION	Limit of 2 units per 6 months per tooth
D2950	CORE BUILD-UP, INCLUDING ANY PINS WHEN REQUIRED	Limit of 1 unit per 36 months per tooth
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	Limit of 2 units per 36 months per tooth
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	Once in a lifetime per tooth
D2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	Once in a lifetime per tooth
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	Once in a lifetime per tooth
D2955	POST REMOVAL	Once in a lifetime per tooth
D2957	EACH ADDITIONAL PRE-FABRICATED POST - SAME TOOTH	Once in a lifetime per tooth
D2960	LABIAL VENEER (RESIN LAMINATE) - DIRECT	Once in a lifetime per tooth
D2961	LABIAL VENEER (RESIN LAMINATE) - INDIRECT	Once in a lifetime per tooth
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT	Once in a lifetime per tooth
D2975	COPING	Once in a lifetime per tooth
D2980	CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE	Once in a lifetime per tooth
D3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)	Limit of 1 unit per 36 months per tooth
D3120	PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)	Limit of 1 unit per 36 months per tooth
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	Limit of 1 unit per 36 months per tooth
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT	Once in a lifetime per tooth
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	Once in a lifetime per tooth
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	Once in a lifetime per tooth
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	Once in a lifetime per tooth

D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	Once in a lifetime per tooth
D3330	ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)	Once in a lifetime per tooth
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)	Once in a lifetime per tooth
D3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)	Once in a lifetime per tooth
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)	Once in a lifetime per tooth
D3410	APICOECTOMY - ANTERIOR	Once in a lifetime per tooth
D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	Once in a lifetime per tooth
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	Once in a lifetime per tooth
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	Once in a lifetime per tooth
D3430	RETROGRADE FILLING-PER ROOT	Once in a lifetime per tooth-multiple roots may be claimed; you must attach documentation to claim if multiple roots are involved on the same tooth
D3450	ROOT AMPUTATION-PER ROOT	Once in a lifetime per tooth
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	Once in a lifetime per tooth
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	Once in a lifetime per tooth
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	Once in a lifetime per tooth
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	Limit of 4 units per 60 months
D4230	ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4231	ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	Limit of 4 units per 60 months
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP ENTRY AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Limit of 4 units per 60 months
D4263	BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - FIRST SITE IN QUADRANT	Limit of 4 units per 60 months
D4264	BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - EACH ADDITIONAL SITE IN QUADRANT	Limit of 4 units per 60 months
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION, PER SITE	Limit of 4 units per 60 months
D4266	GUIDED TISSUE REGENERATION, NATURAL TEETH - RESORBABLE BARRIER, PER SITE	Limit of 4 units per 60 months

D4267	GUIDED TISSUE REGENERATION, NATURAL TEETH - NON- RESORBABLE BARRIER, PER SITE	Limit of 4 units per 60 months
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	Limit of 4 units per 60 months
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	Limit of 4 units per 60 months
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	Limit of 4 units per 60 months
D4320	PROVISION SPLINTING-INTERCORONAL	Limit of 4 units per 60 months
D4321	PROVISION SPLINTING-EXTRACORONAL	Limit of 4 units per 60 months
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	Limit of 4 units per 12 months- Service limitations are for students age 14+
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	Limit of 4 units per 12 months- Service limitations are for students age 14+
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	Limit of 1 unit per 12 rolling months
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	Limit of 1 unit per 12 rolling months
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	Limit of 1 unit per 12 rolling months
D4910	PERIODONTAL MAINTENANCE	Limit of 1 unit per 3 months
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN - PER VISIT	Limit of 1 unit per day 2 units per 6 months
D9120	FIXED PARTIAL DENTURE SECTIONING	Limit of 1 unit per 60 months
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	
D9215	LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	Limit of 1 unit per day
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	Limit of 4 units per day
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA	Limit of 6 units per 12 rolling months
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	1 unit per day
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	4 units per day
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	Limit of 6 units per 12 rolling months
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN	Payable for providers at different service location; not in the same office
D9311	CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL	Limit of 1 unit per 6 months
D9410	HOUSE/EXTENDED CARE FACILITY CALL	
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS	Limit of 1 unit per 12 months
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	Limit of 1 unit per 12 months
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS	Limit of 1 unit per 12 months
D9630	DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	

D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT	Limit of 1 unit per 12 rolling months
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	Once in a lifetime
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	Limit of 1 unit per 36 months
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	Limit of 1 unit per 36 months
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	Limit of 1 unit per 36 months
D9950	OCCLUSION ANALYSIS-MOUNTED CASE	Once in a lifetime
D9951	OCCLUSAL ADJUSTMENT-LIMITED	Once in a lifetime
D9952	OCCLUSAL ADJUSTMENT-COMPLETE	Once in a lifetime
D9991	DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT COMPLIANCE BARRIERS	Limit of 1 unit per 6 months
D9992	DENTAL CASE MANAGEMENT - CARE COORDINATION	Limit of 1 unit per 6 months
D9993	DENTAL CASE MANAGEMENT - MOTIVATIONAL INTERVIEWING	Limit of 1 unit per 6 months
D9994	DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	Limit of 1 unit per 6 months
OPTOMETRY SERVICES		
92002	OPTHALMOLOGICAL SERVICES MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM; INTERMEDIATE, NEW PATIENT	Encounter = 1 unit Limit of 1 unit per 12 months
92012	ESTABLISHED PATIENT PROBLEM FOCUSED EXAM OF VISUAL SYSTEM	Encounter = 1 unit Limit of 1 unit per 12 months
92014	ESTABLISHED PATIENT COMPLETE EXAM OF VISUAL SYSTEM	Encounter = 1 unit Limit of 1 unit per 12 months
92015	TEST TO DETERMINE IF PRESCRIPTION EYE WEAR IS NEEDED	Encounter = 1 unit Limit of 1 unit per 12 months
92018	COMPLETE EXAM OF VISUAL SYSTEM UNDER GENERAL ANESTHESIA	Encounter = 1 unit Limit of 1 unit per 12 months
92019	LIMITED EXAM OF VISUAL SYSTEM UNDER GENERAL ANESTHESIA	Encounter = 1 unit Limit of 1 unit per 12 months
92020	EXAM OF THE INTERNAL DRAINAGE SYSTEM OF EYE	Encounter = 1 unit Limit of 1 unit per 12 months
92060	EXAM TO MEASURE EYE DEVIATION AND RANGE OF MOTION	Encounter = 1 unit Limit of 1 unit per 12 months
92081	EXAM OF VISUAL FIELD WITH LIMITED TESTING	Encounter = 1 unit Limit of 1 unit per 12 months
92082	EXAM OF VISUAL FIELD WITH INTERMEDIATE TESTING	Encounter = 1 unit Limit of 1 unit per 12 months
92083	EXAM OF VISUAL FIELD WITH EXTENDED TESTING	Encounter = 1 unit Limit of 1 unit per 12 months
V2020	FRAMES, PURCHASES	Encounter = 1 unit Limit of 1 unit per 12 months
99366	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99367	MEDICAL TEAM CONFERENCE WITH PHYSICIAN, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day

		Limit of 8 units 99366, 99367, 99368 combined per student per year
99368	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
CASE MANAGEMENT SERVICES		
T1016	CASE MANAGEMENT, EACH 15 MINUTES	15 minutes = 1 unit 10 hours for initial calendar month, 5 hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year. (17 years of age and younger).
T1016	CASE MANAGEMENT, EACH 15 MINUTES	15 minutes = 1 unit 10 hours for initial calendar month, 5 hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year. (18 years of age and older).
99366	MEDICAL TEAM CONFERENCE WITH PATIENT AND/OR FAMILY, AND NONPHYSICIAN HEALTH CARE PROFESSIONALS, 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
99368	MEDICAL TEAM CONFERENCE WITH NONPHYSICIAN HEALTH CARE PROFESSIONALS. 30 MINUTES OR MORE	Encounter = 1 unit Limit of 1 unit per day Limit of 8 units 99366, 99367, 99368 combined per student per year
TELEHEALTH		
Q3014	TELEHEALTH ORIGINATING SITE FACILITY FEE	Limit of 1 unit per day