

AA

Medicaid

Section AA Forms

Written Consent to Bill Medicaid Form (Indiana IEP)

Medicaid Referral Form: Speech-Language Therapy/Occupational Therapy

Medicaid Referral Form: Nursing/Physical Therapy

Medicaid Guidelines

Indiana Code 12-15-1-16 requires all school corporations to enroll in a program to use federal funds under the Medicaid program with the intent to share the costs of services that are reimbursable under the Medicaid program and that are provided to eligible children by the school corporation.

School corporations must ensure that students with disabilities receive all appropriate services regardless of whether Medicaid reimbursement is available for the services in an IEP or Service Plan.

Indiana school districts must obtain signed, written consent only one time in order to disclose the student's personally identifiable information to the Medicaid agency for the purposes of claiming Medicaid reimbursement for services in the student's IEP or Service Plan.

The parent's refusal to consent or withdrawal of consent to disclose personally identifiable information to the agency responsible for the administration of the state's public benefits does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parent.

Billable Medicaid Services:

- Speech and/or Language evaluations, reevaluations, and direct services
- Occupational Therapy evaluations, reevaluations, and direct services
- Physical Therapy evaluations, reevaluations, and direct services
- Nursing services provide by a licensed Registered Nurse (R.N.)
- Special Transportation on the day the student receives a Medicaid eligible service



Medicaid Procedures

1. At initial case conferences and move-in case conferences, the teacher of record (TOR) is responsible for generating the **Written Consent to Bill Medicaid Form** in Indiana IEP. TOR will provide parent(s)/guardian(s) with a verbal Statement of Medicaid Informed Consent:

“With your consent, the school may use Medicaid or other public benefits to provide or pay for special education or related services. If you decline to give consent for the school to bill Medicaid for covered services in your child’s IEP or Service Plan, the school must continue to provide all required IEP or Service Plan services at no cost to you. If you give your consent, you have the right to withdraw your consent at any time. The school will not require you to enroll in Medicaid or other public health coverage programs as a condition of providing IEP or Service Plan services. The school may not use your public benefits (Medicaid) if doing so would cause you to pay a deductible, co-payment, or other out-of-pocket expenses or jeopardize your child’s eligibility for home and community-based waiver services.”

Note: If the parent is unwilling to sign the **Written Consent to Bill Medicaid Form**, TOR should write, “parent declined to sign” and date it.

2. The TOR must upload the **Written Consent to Bill Medicaid Form** into the documents tab of Indiana IEP and provide an electronic copy to the student records administrative assistant at Adams Wells Special Services Cooperative along with the case conference paperwork.
3. Medicaid referrals must be obtained at least annually and as necessary to support significant changes in services listed in the IEP.
4. The TOR is responsible for completing the **Medicaid Referral Form: Speech-Language Therapy/Occupational Therapy** for students who are receiving billable Medicaid service(s) including speech and/or language and/or occupational therapy. All services should be listed on a single **Medicaid Referral Form: Speech-Language Therapy/Occupational Therapy**. TOR will provide an electronic copy to the student records administrative assistant at Adams Wells Special Services Cooperative.
5. If a student receives nursing services in the IEP, the TOR is responsible for communicating with the family and sending the **Medicaid Referral Form: Nursing/Physical Therapy** to the student’s physician. TOR will provide an electronic copy to the student records administrative assistant at Adams Wells Special Services Cooperative.
6. The Adams Wells Special Services Cooperative physical therapist is responsible for securing a prescription from a licensed M.D., D.O. or referral practitioner identified under I.C. 25-27-1-2(b) using the **Medicaid Referral Form: Nursing/Physical Therapy**. Physical therapist will provide an electronic copy to the student records administrative assistant at Adams Wells Special Services Cooperative.



7. Therapists must enter Medicaid billing on at least a monthly basis.
8. Record retention is required for a period of seven years from the date of Medicaid services are provided. Records include, but are not limited to: progress notes, practitioner service documentation, clinician/therapist attendance records, licensure/certification, and student attendance, as are necessary to fully disclose and document the extent of the services provided to Medicaid-enrolled students.
9. Adams Wells Special Services Cooperative is responsible for maintaining signed Medicaid Referral forms, Written Consent to Bill Medicaid forms, Occupational Therapy notes/service logs, Physical Therapy notes/service logs, and IEPs/Service Plans. Districts are responsible for maintaining other records required for documentation purposes.



Medicaid Referral

Clinician/Therapist Name: _____ School Corporation: _____

Speech-Language

_____ Evaluation

_____ Treatment Services: _____

_____ Other: _____

Occupational Therapy

_____ Evaluation

_____ Treatment Services: _____

Other: _____

Precautions:

Additional Comments:

Authorized Signature:

Print Name & Title:

National Provider Identifier (NPI) #:

Date:

Note: Visit NPPES NPI Registry to perform a search



**Medicaid Referral
Nursing/Physical Therapy Services**

**For P.T.: to be completed by a M.D., D.O., or referral practitioner identified in the
P.T. practice act, Indiana Code 25-27-1-2(b)**

For R.N.: to be completed by a licensed physician (M.D. or D.O.)

Student Name: _____ DOB: _____

Diagnosis: _____

Physical Therapy

_____ Evaluation

_____ Treatment Services: _____

_____ Other: _____

Nursing Service

_____ Evaluation

_____ Treatment Services: _____

_____ Other: _____

Precautions: _____

Additional Comments: _____

Authorized Signature: _____

Print Name & Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

Note: Visit NPPES NPI Registry to perform a search