



# TennCare Billing Manual

## Tennessee School Districts

Tennessee Division of TennCare & Tennessee Department of Education | July 2023



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# Purpose

The purpose of this manual is to provide program information and technical assistance regarding Federal and State Medicaid requirements associated with seeking Medicaid reimbursement for school-based services related to the Individualized Education Program (IEP) and Individual Health Plan (IHP). Additionally, this manual addresses the coverage by TennCare of medical services provided in a school setting. Specifically, TennCare covered medically necessary services in the student's IEP or IHP may be reimbursed by TennCare in the school setting. This manual does not supersede TennCare policy and is not to be used in lieu of TennCare policy. The information contained in this manual will be updated as needed to reflect changes to the TennCare program impacting reimbursement for school-based services.

Covered services can be performed by a TennCare provider, or a school can contract with TennCare's managed care organizations (MCOs) to be reimbursed for providing these services.

This manual outlines how a school district can become eligible to bill for services as a TennCare provider and the responsibilities in determining what services are appropriate and for which to seek reimbursement.

*Schools must contract with a TennCare Managed Care Organization to be reimbursed for services.*

# How to Become a TennCare Provider

The school district and any individual healthcare provider treating the student must be an “in-network” provider with a TennCare enrolled student’s MCO to be eligible to bill the MCO for health care services delivered to that student. A school district and treating staff must complete the following four (4) steps, **in the order listed below**, to become a TennCare provider.

1. The school district and each individual healthcare provider treating the student must register to receive a National Provider Identifier (NPI).
2. The school district and each individual healthcare provider treating the student must register to receive a Medicaid Identification Number (Medicaid ID).
3. The school district and each individual healthcare provider treating the student must complete credentialing with at least one TennCare MCO.
4. The school district and each individual healthcare provider treating the student must contract with at least one TennCare MCO.

**Note: All TennCare members are enrolled in one of four MCOs (Amerigroup, United Healthcare, BlueCare, and TennCare Select), each of which operates on a statewide basis. This means that school districts will likely have students enrolled in each of the four MCOs and should contract with all four MCOs to maximize the ability to bill for eligible health care services.**

## STEP 1: Obtain a National Provider Identifier (NPI)

To apply for an NPI, visit the Centers for Medicare & Medicaid Services (CMS) website ([here](#)). A NPI is required for all covered health service providers by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). There are two types of NPIs:

- Type 1 will be necessary for each individual health care provider treating the student who is associated with the school district and who will provide/render the health care services for which the district intends to bill.
- Type 2 is required for the school district itself.

**Note: Both school districts and individual healthcare providers must complete this process for all applicable NPIs before the MCOs can pay the claims. For claiming purposes, the school district will be listed as the billing entity and the individual healthcare provider treating the student will be listed as the rendering provider on the claim form.** For school-based nursing services, the supervising Physician, Physician Assistant or Nurse Practitioner, is considered the “individual healthcare provider treating the student” for the purposes of billing because the school nurse (i.e., an LPN or RN) cannot obtain a Medicaid ID or contract or credential with the TennCare MCOs.

## **STEP 2: Register for a Medicaid Identification Number**

The Medicaid Identification Number is assigned to a provider by the Division of TennCare. There are certain Medicaid provider screenings and enrollment requirements, which are pursuant to federal regulations set forth by the CMS. For more information, please visit the Centers for Medicaid and CHIP Services Informational Bulletin ([here](#)).

Information on how to apply for a TennCare Medicaid Identification Number is located on the Division of TennCare's website ([here](#)).

TennCare utilizes the Council for Affordable Quality Healthcare (CAQH) ProView application process for individual providers using a Type 1 NPI (see above). Individual providers will enter key pieces of data into the TennCare system ([here](#)). TennCare then submits the individual provider's information to CAQH. If CAQH has the individual provider's data on file, it will be returned to TennCare for processing and assignment of a Medicaid ID. If CAQH does not have the individual provider's information on file, CAQH will send instructions on how to complete the CAQH ProView application to the email address entered on the TennCare website. Once the provider completes the CAQH ProView application, CAQH will return the provider's data to TennCare for processing and assignment of Medicaid ID.

Organizational providers (i.e., school districts) will create an account and enter all data for the organization on TennCare's website ([here](#)). Once the provider submits a completed electronic application, TennCare will process and assign a Medicaid ID.

For questions, schools and providers should call (800) 852-2683, and select option 5.

## **STEP 3: Credentialing with an MCO**

Prior to contracting, the MCO will request additional information as part of their credentialing process. Information regarding the process of credentialing with each MCO is available by contacting each MCO as follows:

### **Amerigroup Network Access**

- Go to [Tennessee Providers | Amerigroup](#)
- Select "Join our Network"
- Scroll down and complete the fields under "To get started, please indicate your provider type" and select "Continue"
- Create Account and select "Continue"

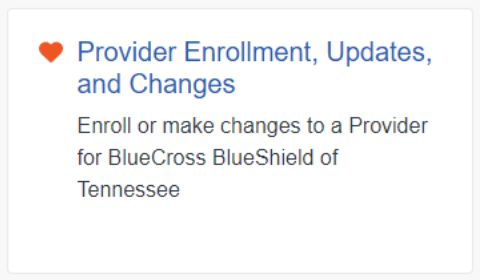
### **United Healthcare Network Access**

- Provider Help Line (National Credentialing Center): 1-877-842-3210 Go to
- <https://www.myoptumhealthphysicalhealth.com>
- Select "Interested in Becoming a Provider"
- Complete the fields on the Application request and select "Submit"

## BlueCare Network Access

**Provider Enrollment, Updates and Changes go to:** <https://provider.bcbst.com/working-with-us/enroll-a-provider>

- Step 1: Enter/update your information in [CAQH ProView](#)
- Step 2: Enter/update your information in [Change Healthcare's Payer Enrollment Services portal](#)
- Step 3: Register/log in with [Avality](#) & complete your enrollment application or change form by selecting the Provider Enrollment, Updates and Changes tile



- [BlueCare Tennessee Provider Administration Manual](#)

## STEP 4: Contracting with an MCO

Providers must contract with a MCO before payments for school-based services can be made. The MCO shall only process and pay claims for medically necessary, covered school-based medical services provided to TennCare members included in the student's IEP and specific nursing services in the IHP. Medically necessary, covered behavioral health services are not required to be in the student's IEP to be reimbursed by TennCare. Providers may include physicians, nurse practitioners, occupational therapists, physical therapists, speech pathologists, audiologists, and licensed behavioral health clinicians.

Covered services are defined in [TennCare Rule](#). Prior to contracting, the MCO will request additional information as part of their credentialing process.

For more information on how to contract with a MCO, contact the individuals listed below for each of TennCare's four MCOs.

**Note: TennCare MCOs shall contract with any school district that seeks to contract with the MCO to receive reimbursement for medically necessary, covered school-based services based on the MCOs' standard fee schedule.**

*For a service to be considered medically necessary, it must meet five criteria:*

- 1. Be ordered by a treating licensed physician or other treating licensed health care provider.*
- 2. Required to diagnose or treat a medical condition.*
- 3. Be safe and effective.*
- 4. Not be experimental or investigational.*
- 5. Be the least costly alternative.*

# MCO Provider Services Contact Information

Amerigroup	BlueCare & TennCare <i>Select</i>	United Healthcare Community Health Plan
<p><b>Renea Bentley</b> Ed.D., LPC- MHSP (Statewide) (615) 316-2411 <a href="mailto:renea.bentley@amerigroup.com">renea.bentley@amerigroup.com</a></p> <p>For contracting/billing questions:</p> <p><b>Phillip Morrison</b> (Statewide) (615) 316-2400 <a href="mailto:Phillip.Morrison@amerigroup.com">Phillip.Morrison@amerigroup.com</a></p>	<p><b>Becky Hodge</b> (Statewide) (615) 348-3004 <a href="mailto:Becky_Hodge@bcbst.com">Becky_Hodge@bcbst.com</a></p> <p><b>Cathy Overstreet</b> Behavioral Health (Statewide) (423) 341-2260 <a href="mailto:Cathy_Overstreet@bcbst.com">Cathy_Overstreet@bcbst.com</a></p>	<p><b>Melissa Glass</b> (Statewide) (952) 202-7273 <a href="mailto:melissa_d_glass@uhc.com">melissa_d_glass@uhc.com</a></p> <p><b>Justin Campbell</b> (Statewide- Backup) (763)-273-9718 <a href="mailto:justin_m_campbell@uhc.com">justin_m_campbell@uhc.com</a></p> <p><b>Stephanie Dowell</b> (Behavioral Health Statewide) (612) 428-6629 <a href="mailto:stephanie_dowell@uhc.com">stephanie_dowell@uhc.com</a></p>

## Important Note Regarding Provider Screening Requirements for Physical Therapists

All providers seeking to participate in TennCare are subject to TennCare's provider screening requirements. The level of screening required is based on the provider type's level of risk for fraud, waste, or abuse (i.e., Limited-Risk, Moderate Risk and High Risk). Provider types deemed to pose a higher risk of fraud, waste, and abuse are subject to more screening requirements than provider types that generally pose a lower risk of fraud, waste, and abuse. In general, TennCare assigns provider types to the same categorical risk levels used by CMS in the Medicare program. This assignment of provider types to different risk levels is based on CMS' assessment of each provider type's relative risk for fraud, waste, or abuse. Physical therapists enrolling as individuals or as group practices are in the Moderate risk category. As such, physical therapists as individuals or as group practices are subject to the following screening requirements:

1. Verification that the provider meets any applicable federal regulations or state requirements for the provider type prior to registering the provider;
2. Verification that the provider meets applicable licensure requirements; and
3. Database checks on an ongoing basis to ensure that the provider continues to meet the applicable criteria for their provider type.

Additionally, physical therapists as individuals or as group practices are subject to unscheduled or unannounced site visits as described at 42 CFR §455.432. TennCare providers are required to permit TennCare, TennCare's managed care organizations (MCOs), and/or CMS to conduct these site visits at any and all provider locations.

As a provider type assigned as moderate risk, TennCare requires physical therapists as individuals or as group practices seeking to participate in TennCare be enrolled in Medicare, pursuant to authority granted to states under 42 CFR §431.51.

TennCare will verify the provider's enrollment in Medicare using the Provider Enrollment, Chain, and Ownership System (PECOS). If TennCare can verify the provider's enrollment in Medicare through PECOS, then TennCare will rely on the provider screening conducted by Medicare to register the provider. If the provider's enrollment in Medicare cannot be verified through PECOS, then TennCare will not register the provider. For more information regarding PECOS, including enrollment tutorials, please visit the following CMS site: <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>.

TennCare's complete policy regarding provider screening requirements can be found at the following link: <https://www.tn.gov/content/dam/tn/tenncare/documents2/pro16001.pdf>.

**Note: Physical therapists who are only affiliated with a school district are not required to enroll in Medicare (i.e., register in PECOS)**

## **Contracting with TennCare MCOs**

This document addresses the process for a school district to bill TennCare for medically necessary services (i.e., the school district is the Billing Entity) that are included in an IEP or IHP and provided in a school setting. In some situations, a school district may invite an individual healthcare provider (e.g., physical therapist, speech therapist, occupational therapist) to deliver services in the school setting with the understanding that the provider would bill the TennCare MCO directly. In these situations, the provider must contract with the MCO in the same manner as they would if the service was being delivered in another setting (e.g., provider office or member home). All requirements in this manual would apply in such a situation, except that the school district would not need to become a TennCare provider and would not be the billing provider.

MCOs may choose not to contract with an individual healthcare provider if they have an adequate network to facilitate access to the service. If this occurs in the case of school-based services, the school should contact the MCO to advise them of their need for service and to discuss with the MCO options for obtaining those services. MCOs may then choose to contract with the requested provider or may facilitate access to the service through an alternative in-network provider. If a school or family feels that the services provided outside of the school setting are not adequate (e.g., do not meet IDEA requirements or follow the student's IEP or IHP), the school or family can file an appeal with the MCO. Appeal processes are outlined in the TennCare member handbooks and the TennCare



MCO provider manuals. TennCare member handbooks are available to enrollees on the MCOs' websites and are mailed upon request. Providers can also access the member handbook and provider manuals on the MCOs' websites.

## Billing Requirements

For a school district to bill and be reimbursed by a TennCare MCO, the following criteria must be met:

**Inclusion in the IEP or IHP:** The medical service must be included in the student's IEP or IHP, including information regarding the medical service type, amount, and frequency. The services recorded in the IEP or IHP must be consistent with services that would be included in the IEP or IHP for any student with similar needs, regardless of TennCare eligibility. Medical services that are not in an IEP or IHP are not covered by the process outlined in this document. TennCare MCOs do not require that the IEP, IHP or parental consent form be submitted to the MCO before a school may bill for services; however, these documents must be made available by the school district upon request. Medically necessary, covered behavioral health services are not required to be in the student's IEP to be reimbursed by TennCare.

**Physician's order:** The health care service must have been ordered by the student's primary care provider (PCP) or other treating licensed healthcare provider in the student's MCO network. Effective with dates of services beginning July 1, 2022, Local Education Agencies (LEAs) may obtain a referral or order from the child's licensed Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP), or Audiologist who has appropriately evaluated and assessed the child for IEP services, or alternatively, the child's Primary Care Provider (PCP) or treating provider when billing a TennCare Managed Care Organization (MCO) for physical therapy, occupational therapy, speech therapy, and audiology services in the IEP. LEAs must continue to obtain a referral or order from the child's PCP or treating provider when billing TennCare for all other covered, medically necessary IEP or IHP services. Medically necessary, covered behavioral health services do not require an order from the student's PCP. These services must be recommended by an independently licensed behavioral health clinician who is registered with TennCare (i.e., has obtained a Medicaid ID) and credentialed and contracted with the student's TennCare MCO.

**Parental Consent Form:** Effective with date of services beginning July 1, 2022, the Division of TennCare updated the parent consent form that the students' parent or legal guardian is required to sign to allow LEAs to bill TennCare for medically necessary, covered school-based services. Based on the updates, the signed consent form shall be valid for as long as the student is receiving IEP or IHP services or until the parent revokes consent. Therefore, the TennCare MCOs shall no longer require a new signed consent form at least annually or whenever the IEP or IHP is updated beginning with the implementation of the updated consent form. The updated consent form is also available in Spanish and Arabic.

**Note: All TennCare students receiving IEP or IHP services as of July 1, 2022, must have a signed parent consent form based on the updated form, by June 30, 2023**

**Documentation of medical necessity and service delivery:** The health care service must be medically necessary. Documentation of medical necessity would include records indicating that appropriate screening and/or diagnostic testing was performed to determine the need for treatment. This is information that supports a physician's order for treatment or the PT, OT, SLP or audiologist's referral or order for IEP services. TennCare MCOs may require that some services be authorized prior to being eligible for reimbursement. Prior authorization means the MCO may require that they approve coverage of the services before it is performed. Generally, school-based services do not require prior authorization; however, TennCare MCOs reserve the right to require prior authorization for any medically necessary, covered service. If a service requires prior authorization, it will be indicated in the MCOs' provider manuals. In these cases, the MCO will determine the medical necessity during the prior authorization process. Medical necessity is determined by evaluating the case using clinical guidelines. Providers can request these guidelines from the MCO. As part of the prior authorization process, the MCO may require that additional documentation be provided before the service is approved. Additional documentation may include medical records describing screenings, test results, assessments, and progress notes. If a request is denied, the criteria for the denial will be provided in writing. Services provided without proper prior authorization, when required by the MCO, will not be reimbursed. In all cases, records maintained by the school district must clearly and specifically describe the need for the educationally relevant health care service and document each instance of delivery of the health care service in accordance with generally accepted medical documentation standards. This includes doctor's orders; PT, OT, SLP and audiologist's referrals and orders; and any evaluations or tests conducted to determine the service was necessary to begin the service or continue it, as well as a description of the treatment performed for each billing and any progress notes or other standards for the provider's profession. If guidance is needed regarding documentation requirements, schools should contact the MCO contacts listed in this document.

**Rendering providers:** While the school district may function as the billing provider, the individual delivering the health care service (i.e., the rendering provider) must be a health care professional with an active Tennessee health care license, working within the scope of their license, registered with TennCare, and under contract with a MCO. The rendering provider must be identified in the rendering provider field of the CMS 1500 claim form (Appendix A) or the electronic equivalent.

**Filing a claim:** To be reimbursed for medical services, a school district must file a claim with the member's (i.e., student) MCO. The school district must be contracted with a student's MCO to receive payment. Claims are submitted on a specific form (CMS Form 1500) or the electronic equivalent and provide detailed information that allows the MCO to pay for services. Generally, claims must be filed electronically. The form in Appendix A is a hard copy representation of the data that is to be submitted. This includes information about the member/student, the billing provider (e.g., the school district), the rendering provider (i.e., the licensed health care provider), the service delivery location (e.g., the school), and

the specific service that was provided. All TennCare medically necessary, covered services provided on school grounds shall be billed with the place of service code (03), defined by CMS as any facility whose primary purpose is education. School-based services rendered via telehealth shall be billed with place of service code (02), indicating telehealth was provided other than the student's home or place of service code (10) indicating telehealth was provided in the student's home. Additionally, the appropriate modifier should be used to indicate whether the telehealth service was delivered via a televisual visit (append using the GT modifier) or delivered via audio-only (append using the 93 modifier or FQ modifier as appropriate). Specific information/requirements regarding claim submission protocols, provider reimbursement, and procedures for resolution of any disputes regarding payment of claims can be found in the MCOs' provider manuals at the links listed below:

- [Amerigroup Community Care of Tennessee](#)
- [BlueCare of Tennessee/TennCare Select](#)
- [UnitedHealthcare Community Plan of Tennessee](#)

All MCOs require compliance with the National Correct Coding Initiative ([here](#)). This initiative provides guidance on the appropriate way to code for all types of patient encounters.

**Note:** Schools may find it beneficial to obtain assistance with coding and billing for services. This is permissible. If a school district does decide to employ a billing vendor, school districts remain liable for ensuring billing practices are in accordance with both their TennCare MCO provider agreements and all applicable state and federal laws. School districts should ensure vendors meet those requirements. A list of school-based Medicaid billing companies can be found on the Department of Education's website ([here](#)). The Department of Education has not formally vetted and does not endorse any vendor listed on this website. School districts are responsible for ensuring that contracted vendors and providers meet and follow all MCO, and state and federal requirements.

**Timely Filing Requirements:** In July 2021, TennCare extended timely filing to 365 calendar days from the date of service for all medically necessary, covered IEP services. Effective with date of services beginning July 1, 2022, this standard shall also apply to all medically necessary, covered school nursing services included in the IHP. These timely filing guidelines apply to both TennCare and CoverKids members. Corrected claims must be submitted within [60] days from the date of denial or [365] days from the date of service, whichever is later

**School-based Services for CoverKids Members:** Medically necessary, covered school-based services rendered to CoverKids members are reimbursable TennCare services. These services include school-based medical services included in the IEP, IHP, and school-based behavioral health services. Medically necessary, covered school-based behavioral health services are not required to be included in the student's IEP to be billable.

# School-Based Nursing Guidelines

The Division of TennCare implemented school-based nursing services guidelines effective July 2021. The initial guidelines were limited to school-based nursing services in the IEP only. Effective July 1, 2022, TennCare updated the school-based nursing guidelines (Appendix D) to include the following changes:

- Medically necessary, covered school nursing services listed in the guidelines shall be billable when included in the IEP or Individual Health Plan (IHP); and
- Three additional billable school-based nursing services (i.e., assessment and treatment of acute and chronic illnesses, blood glucose monitoring and testing, and medication administration for medically fragile students) shall be reimbursable when determined medically necessary and included in student's IEP or IHP.

## School-Based Behavioral Health Services

Medically necessary, covered behavioral health services are reimbursable by TennCare in a school setting. To be reimbursable, medically necessary, covered school-based behavioral health services are not required to be ordered by the student's PCP and are not required to be included in the student's Individualized Education Program (IEP). Additionally, Applied Behavior Analysis (ABA) services in the student's IEP are billable when medically necessary. ABA services require prior authorization by the student's MCO and must be performed by a Board-Certified Behavior Analyst (BCBA).

To be considered medically necessary, covered school-based behavioral health services must be recommended by an independently licensed behavioral health clinician who is registered with TennCare (i.e., has obtained a Medicaid ID) and credentialed and contracted with the student's TennCare MCO. If you have any questions regarding Provider Registration, please visit <https://www.tn.gov/tenncare/providers/provider-registration.html>. The following are the most common independently licensed behavioral health clinicians who contract with the TennCare MCOs for the delivery of school-based behavioral health services:

- Licensed Clinical Social Workers (LCSWs),
- Licensed Professional Counselors with a Mental Health Services Provider designation (LPC/MHSPs),<sup>1</sup>
- Psychologists,
- Licensed Marriage and Family Therapists (LMFT),

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<sup>1</sup> Licensed Professional Counselors (LPCs) must have a Mental Health Services Provider (MHSP) designation to diagnose and treat mental health disorders. Specifically, LPCs, without a MHSP designation, may not assess or diagnose under the Diagnostic and Statistical Manual of Mental Disorders (DSM) or treat, counsel, or develop plans of treatment for those with a DSM diagnosis. If an LPC, without a MHSP designation is counseling a student and begins to suspect that the student needs to be diagnosed, the LPC should refer that person to an LPC/MHSP or other independently licensed behavioral health clinician for mental health treatment.

- Licensed Psychological Examiners (LPEs),
- Psychiatric Nurse Practitioners, and
- Board-Certified Behavior Analysts (BCBAs)

Medically necessary, covered school based behavioral health services may be performed by a school counselor if the school counselor is an independently licensed behavioral health clinician who is registered with TennCare and is credentialed and contracted with the student's MCO.

## **Audits and Other Record Review Requirements**

TennCare requires that MCO provider contracts address access to records. Those contracts generally stipulate that TennCare or its authorized representative, the MCO, the Office of the Comptroller of the Treasury, and any health oversight agency—such as the Tennessee Office of the Inspector General, the Department of Health and Human Services Office of Inspector General, the Department of Justice, and any other authorized state or federal agency—have the right to review records related to billings to MCOs. They can elect to request copies of records or access records on site.

Records requests can occur from routine sampling of claims by any of the entities listed here, as part of quality reviews, or as part of an investigation of fraud, waste, or abuse. If a school has records selected for review or audit by a MCO, the MCO will generally send a letter requesting a copy of records supporting reimbursement of the services provided. MCOs can request to review records on site if they choose. Those records generally would include a copy of the IEP or IHP, referrals and orders, medical records documenting the need for and delivery of the billed service, and the parental consent form. Records requests from other entities may follow this same process but can vary. Failure to provide requested records or comply with the requirements outlined in this manual may result in action including but not limited to recoupment, imposition of prior authorization requirements, and/or disenrollment from the MCO network and/or loss of Medicaid ID number.

## **Record Retention Requirements**

TennCare requires that the MCO provider agreements contain a record retention policy that includes an adequate record system where all records be maintained for ten years from the termination of the provider agreement or retained until all evaluations, audits, reviews, investigations, or prosecutions are completed for recording enrollee services, servicing providers, charges, dates, and all other commonly accepted information elements for services rendered to enrollees pursuant to the provider agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement and administrative, civil, or criminal investigations and prosecutions).

# Understanding FERPA and HIPAA Regulations

There are several key aspects in the interplay between the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to the use and disclosure of information about students. The following table (on the next page) highlights the key points of the requirements imposed by the two regulatory structures governing education records and health records.

It should be noted this is a limited snapshot of the two frameworks. The applicability of either set of regulations to a facility for use or disclosure depends on the facts specific to the situation. For example, a school may be considered a health care provider under HIPAA if it provides health care to students in the normal course of business. If in connection with that health care, it conducts any covered transactions electronically, it is considered a covered entity under HIPAA and would have compliance obligations with respect to transactions. However, if the health records maintained by the school are considered education records under FERPA, these are excluded under HIPAA Privacy Rule, and the school would have to comply with FERPA's privacy requirements. The U.S. Departments of Health and Human Services and Education, as well as other entities, prepared and provided a variety of guidance documents on the relationship between HIPAA and FERPA. Some of those are listed below:

- [U.S. Department of Health and Human Services and U.S. Department of Education Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) and the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) To Student Health Records](#)
- [U.S. Department of Health and Human Services FAQ on FERPA and HIPAA](#)
- [The Association of State and Territorial Health Officials Comparison of FERPA and HIPAA Privacy for Accessing Student Health Data](#)
- [National Association of School Nurses](#)

## Understanding FERPA and HIPAA

	<b>Applicability</b>	<b>Restriction</b>	<b>Types of Information</b>	<b>Disclosure without Consent</b>	<b>Interplay</b>
<b>HIPAA</b>	Applies to covered entities (e.g., health plans, health transaction clearinghouses, and healthcare providers) regardless of source for funding or administration model.	A covered entity may not use or disclose protected health information (PHI) except either: 1. as the Privacy Rule permits or requires; or 2. as the individual (or their representative) authorizes in writing.	PPHI is individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or medium.	Permitted for treatment, payment and healthcare operations, public health activities, research, and law enforcement purposes.	The HIPAA Privacy Rule applies to school districts because: It is a covered entity and maintains health information related to claiming that is not typically found in education records. Records related to the claiming process are subject to HIPAA requirements of covered entities.
<b>FERPA</b>	All educational agencies and institutions (and non-school entities) that receive funds under any program administered by the U.S. Department of Education.	Entity is prohibited from disclosing education records or personally identifiable information (PII) without a parent or eligible student's (at least 18) written consent.	PII includes name, address, personal identifiers, like social security number or date of birth that can be used to identify a student (with an exception to directory information). Education records are 1. directly related to a student, and 2. maintained by an educational agency or by a party acting for the agency.	Permitted for health and safety of the individual, some research purposes, to other school officials for normal operations, and law enforcement purposes.	

\*Applicability of regulations is fact specific.

# Glossary

- **Amerigroup Community Care of Tennessee** – One of four managed care organizations serving TennCare eligible Tennesseans.
- **BlueCare of Tennessee** – One of four managed care organizations serving TennCare eligible Tennesseans.
- **Center for Medicare and Medicaid Services (CMS)** – Federal organization that manages Medicare and Medicaid rules and regulations including funding for TennCare.
- **Council for Affordable Quality Healthcare (CAQH)** – A vendor utilized by TennCare to assist in the registration of each individual provider of medical services.
- **Individuals with Disabilities Education Act (IDEA)** – This is a federal law with rules and regulations that public school districts must follow to appropriately educate students with educational disabilities.
- **Individualized Education Program (IEP)** – A legal document required by IDEA for children identified with one or more educational disabilities that require special education. This document may include medically necessary, covered healthcare services eligible for Medicaid (TennCare) reimbursement. For the purposes of TennCare reimbursement, IEP services do not replace the Physician orders, is part of the student's educational record and must be made available to the TennCare MCO upon request.
- **Individual Health Plan (IHP)** – A plan of care for students with or at risk for physical or mental health needs that require more complex school nursing services. It is the responsibility of the school RN to annually evaluate the IHP, as well as to update the plan if deemed appropriate, to reflect changes in the student's healthcare needs and address nursing interventions and/or student healthcare outcomes.
- **Managed Care Organization (MCO)** – Refers to the four companies in Tennessee who manage the healthcare for TennCare enrollees (i.e., Amerigroup, BlueCare of Tennessee, UnitedHealthcare Community Plan, and TennCare Select).
- **Medicaid Identification Number** – The number TennCare assigns to eligible providers who have completed the TennCare registration process. Without a valid, active Medicaid ID, providers cannot be considered for contracting with any TennCare Managed Care Organization or receive payment for services rendered to TennCare enrollees.



- **Medical Necessity** – For a service to be considered medically necessary, it must meet five criteria:
  1. Must be ordered by a treating licensed physician or other treating licensed health care provider.
  2. Must diagnose or treat a medical condition.
  3. Must be safe and effective.
  4. Must not be experimental or investigational.
  5. Must be the least costly alternative.
- **National Correct Coding Initiative** – Program designed to prevent improper payment of procedures that should not be submitted together.
- **National Provider Identifier (NPI)** – National provider number assigned to each approved provider of Medicaid services. Speech and language pathologists, occupational therapists, and physical therapists are a few providers that must apply for these numbers. A separate NPI is required for the school district.
- **TennCare Select** – A MCO operated by BlueCross/Blue Shield of Tennessee that manages the care of specific populations in TennCare.
- **Treating (Rendering) Provider** – A licensed TennCare provider acting within the scope of their practice that has a treatment relationship with the patient. For the purposes of billing for school-based nursing services, the treating (rendering) provider includes the supervising licensed clinician (i.e., a Physician, Physician Assistance or Nurse Practitioner) who is supervising the school nurse who is performing the school-based nursing services as school nurses (i.e., an LPN or RN) cannot obtain a Medicaid ID or credential or contract with the TennCare MCOs.
- **UnitedHealthcare Community Plan** – One of four managed care organizations serving TennCare eligible Tennesseans.

# Appendix A: CMS Form 1500



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					CITY					STATE				
ZIP CODE					TELEPHONE (Include Area Code) ( )					ZIP CODE					TELEPHONE (Include Area Code) ( )				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FEE SCHEDULE										a. INSURED'S DATE OF BIRTH MM DD YY SEX									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes complete items 9, 10, 11									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DOES PATIENT WORK IN CURRENT OCCUPATION? YES <input type="checkbox"/> NO <input type="checkbox"/>									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										17a. HOSPITALIZATION DATE FROM MM DD TO MM DD									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										17b. NPI									
A. _____ B. _____ C. _____										17c. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>									
E. _____ F. _____ G. _____										17d. \$ CHARGES									
I. _____ J. _____ K. _____										21. SUBMISSION ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										22. AUTHORIZATION NUMBER									
B. PLACE OF SERVICE										F. \$ CHARGES									
C. EMG										G. DAYS OR UNITS									
D. PROCEDURES (Exp'n Unusual) CPT/ACPT										H. ICD-9-CM									
E. PROVIDER										I. ID. QUAL.									
J. RENDERING PROVIDER ID. #										NPI									
25. FEDERAL TAX I.D. NUMBER										NPI									
26. PATIENT'S ACCOUNT NO.										NPI									
27. ACCEPT ASSIGNMENT? (If gov. client, one tick) YES <input type="checkbox"/> NO <input type="checkbox"/>										NPI									
28. TOTAL CHARGE \$										NPI									
29. AMOUNT PAID \$										NPI									
30. Rsvd for NUCC Use										NPI									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS										32. SERVICE FACILITY LOCATION INFORMATION									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # ( )									
a. NPI										b. NPI									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND TRICARE PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate, and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate, and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license#, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties' payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment

claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

# Appendix B: Parental Consent Form

## Consent to Access Information

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ School \_\_\_\_\_

District: \_\_\_\_\_

By signing this Release form, you allow your child's school, along with the Division of TennCare, your child's health care providers, and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's Individualized Education Program (IEP), Individual Health Plan (IHP), and/or Individualized Family Service Plan (IFSP);
2. Medical and behavioral health records, including this type of information that is contained in your child's educational records; and
3. Education reports, records, or relevant special education evaluation results contained in your child's educational records

The purpose for allowing these records to be shared is so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also allows your child's school to verify whether your child is on TennCare so that the school can receive reimbursement for eligible school-based health services under the Individuals with Disabilities Education Act.

If you sign this release form, you will be giving consent for the records listed above to be released to the local education agency (school district), their billing agent(s), the insured's physician(s), and TennCare representatives as needed.

**Note:** You are not required to sign this Release form in order for your child to receive services in their IEP, IHP, or IFSP. Those services will still be provided to your child at no cost to you. If you do sign the Release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education in your child's school system. Revoking your consent does not change the school district's responsibility to provide required services to your child at no cost to you.

By signing this form, you are indicating the following:

- ✓ I have received a copy of the Notice of Access to Information.
- ✓ I understand and agree that \_\_\_\_\_ (name of school district) may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed in the IEP, IHP, or IFSP.
- ✓ I understand and agree that the records and information listed above may be released for the purposes described in this release to the people or organizations identified above.
- ✓ I understand that this release will be valid for as long as my child receives qualifying services or until I revoke my consent.

DATE: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_



# Appendix C: Notice of Access to Information Form

## Notice of Access to Information

This Notice is to inform parents that the following information may be accessed in order for their child's school to provide special education or related services:

- Insurance or public benefits information of the parents, legal guardians and children, and
- The child's educational records, including their Individualized Education Program (IEP), Individual Health Plan (IHP), Individualized Family Support Plan (IFSP), and any personally identifiable or medical information contained in the child's educational records

Along with this Notice, you will receive a Release form. The Release form allows your child's school, TennCare, your child's health care providers and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's IEP, IHP or IFSP;
2. Medical and psychology records, including this type of information that is contained in your child's educational records; and
3. Educations reports, records or relevant test results contained in your child's educational records

Allowing these records to be shared like this will make it so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also makes it so that your child's school can verify whether your child is on TennCare so that the school can ask TennCare to pay for eligible school-based health services under the Individuals with Disabilities Education Act. If you sign the release form, you will be giving consent for the records listed above to be released to the Department of Education, school districts and/or their billing agent(s), the insured's physician(s), and TennCare representatives as needed. This release will be valid for as long as your child receives qualifying services or until you withdraw or revoke consent.

**Note:** You are not required to sign the Release form in order for your child to receive services in their IEP, IHP or IFSP. Those services will still be provided to your child at no cost to you. If you do sign the Release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education.

TennCare nor the school may not:

- Require you to sign up or enroll your child in TennCare or any public benefits or insurance program so that your child can get a free appropriate public education;
- Require you to make an out-of-pocket payment of a deductible or a co-pay amount to file a claim for services
- Use your child's TennCare benefits to:
  - decrease your child's available lifetime coverage or other insured benefit, OR
  - make You pay for services that would otherwise be covered by TennCare or another program while your child is in school, OR
  - cost more or discontinue coverage for the program, OR
  - make your child miss out on home and community-based services because of the State's overall costs.

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Division of TennCare • TennCare Kids Connection

310 Great Circle Road • Nashville, Tennessee 37243 • Tel: 866-797-9469 • Fax: 615-532-7322 • [tn.gov/tenncare](http://tn.gov/tenncare)



TennCare Bureau Publication No. 318313

# Appendix D: TennCare School-Based Nursing Services Guidelines, Updated July 1, 2023

The Individualized Education Program (IEP) is the document developed by the school for a school child who is eligible for special education. This document is created by a multidisciplinary team that includes, but is not limited to the parent, special education professionals, the child's teacher(s), and other team members with knowledge of the services and school system (e.g., the child's Primary Care Provider (PCP) when appropriate). This planning is done at least annually or more frequently if needed.

The IEP documents the annual plan of supports and services necessary to meet the educational needs of a child with disability to ensure they receive a free and appropriate public education (FAPE). This includes a statement of the child's present levels of educational performance, measurable annual goals, a description of how the child's progress will be measured toward the annual goals, the special education and related service, and other supplementary aids and supports necessary to advance appropriately toward attaining the annual goals and to be involved in and make progress in the general education curriculum. In addition to the educational components, the plan may include any medical or behavioral supports that are needed. Once the IEP for medically necessary, covered services is reviewed and agreed upon and parental consent is obtained, the plan is implemented. Medically necessary medical or behavioral services may be covered services and eligible for reimbursement by the child's TennCare Medicaid plan.

An Individual Health Plan (IHP) is a health care plan developed by a registered nurse for children with acute or chronic health issues. Parents and other health care providers involved with the child participate in the development and approval of the plan. The IHP should be developed using the five sequential steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

In accordance with State Board of Education Rules 0520-01-13-.01(3)(b), the IHP shall include:

1. Emergency care procedures;
2. A nursing assessment;
3. Physician's orders; and
4. Parental authorization

This document describes the guidelines for obtaining TennCare Medicaid reimbursement for medically necessary covered school-based nursing services as required by the IEP and as allowable by TennCare through the Individual Health Plan (IHP):

1. The billable services below are performed by the school nurse and shall be ordered by the primary care provider (PCP) or the child's treating provider. In addition to the supervision required for the performing school nurse, as described in section 4a (ii) below, the school nursing program shall have a physician to clinically supervise the

physician assistant or nurse practitioner in accordance with the Tennessee Board of Nursing Rules and Regulations and T.C.A., Title 63.

2. The school nurse will meet the clinical and licensing requirements, as required by the Tennessee Department of Health, as well as the training required to perform these services in the school setting.
3. The school will maintain policies and procedures for the provision and documentation of the services listed in the table below.
4. The following are the guidelines for billing:
  - a. Use 99211 with POS 03 as the daily billable CPT code, to include a global fee.
    - i. School nursing services eligible for reimbursement, as denoted by (Y) in the table below, are restricted to medically necessary covered services included in the IEP or IHP, as applicable.
    - ii. Medically necessary, covered services in the IEP or IHP that are ordered by the PCP or treating provider may be reimbursed. The IEP or IHP alone does not satisfy requirements for Medicaid reimbursement. Services are performed by the school nurse, under the clinical supervision of an in-network Physician, Physician's Assistant, or Nurse Practitioner licensed through the Tennessee Department of Health. Clinical supervision does not require the continuous and constant presence of the clinical supervisor; however, the clinical supervisor must always be available for consultation or shall arrange for a substitute provider to be available. Services are performed pursuant to the student's primary care provider's (PCP) or the child's treating provider's order.
    - iii. The supervising Physician, Physician's Assistant, or Nurse Practitioner shall serve as the rendering provider on the claim, as the school nurse is not credentialed and cannot contract with the MCOs as a network provider.
    - iv. Administrative services are not billable services
  - b. The billable items in the table below include the code to be used for the services.
  - c. TennCare MCOs will contract with any school district(s) that seek(s) to contract with the MCOs, based on the MCOs' standard reimbursement rates, to receive reimbursement for medically necessary, covered services in the IEP or IHP that are ordered by the PCP or treating provider and provided in a school setting.
  - d. The MCOs will monitor claims and will retrospectively audit claims for appropriate claims billing and the presence of a valid Provider order to ensure school-based providers are submitting claims appropriately.
  - e. The MCOs will document these guidelines in their MCO Provider Manual.



**If Billable, use corresponding CPT Code: 99211, POS 03. Note: This code is a global encounter code, billable once per day and includes ALL services received.**

Service	Billable (Y) / Non-Billable (N)
Assessment and Treatment of acute and chronic illnesses	Y
Blood glucose monitoring and testing	Y
Vital sign monitoring	N
Tracheostomy care and suctioning	Y
Colostomy care	Y
Catheterization	Y
Administration of oral medication – per tube	Y
O2 saturation monitoring (pulmonary and/or cardiac disease)	Y
G-Tube feeding	Y
Wound care	Y
Nebulizer treatment	Y
Postural drainage	N
Medication administration for medically fragile students as identified in IEP or IHP	Y
Development, implementation of Individual Health Plan (IHP)	N
Evaluation of Nursing service in the Individualized Education Program (IEP)	N

## Timely Filing for IEP and IHP Services

School Districts must submit claims with any required documentation within 365 days of the date of service for all IEP and IHP services. Any claims submitted outside of the 365-day timeframe will be denied for timely filing. Corrected claims must be submitted within sixty (60) days from the date of denial or three hundred and sixty-five (365) days from the date of service, whichever is later.