NM Medicaid
School-Based Services

INSTRUCTIONS FOR COMPLETING THE SCHOOL-BASED DIRECT SERVICES COST REPORT

August 2016

NM Human Services Department
Medical Assistance Division
NEW MEXICO HUMAN SERVICES DEPARTMENT

INSTRUCTIONS FOR COMPLETING THE

SCHOOL-BASED DIRECT SERVICES COST REPORT

General

Interim payments will be made to each LEA on an ongoing basis throughout the fiscal year. On an annual basis, a Cost Report and Reconciliation will be completed for each LEA to reconcile the interim payments to its total Medicaid allowable costs/expenses, including the federal share and the nonfederal share for the fiscal year.

This Cost Report Instruction Guide and related Cost Report template is designed to demonstrate the data that will be collected, compiled, and ultimately calculated by applying time study results to allowable costs. The cost report and instructions demonstrate the calculations. The data and calculations contained herein will be completed in a web-based system that is designed to capture the elements identified in the Excel Schedules for each LEA.

For the cost report to be accurate, only the shaded areas of the cost report will be completed. The remaining sections will be loaded by other data inputs and information provided in the web-based system. Schedule 1 is used for each LEA to complete its signature, title, date and contact number.

Schedule 1 - Certification of Public Expenditure (CPE)

For Schedule 1, all that is needed is to verify the information is correct prior to the authorized individual’s signature, title and contact information. Each of this section’s information below will automatically fill in from other pages as they are completed. Schedule 1 should be submitted with the annual cost report.

1. The Government Provider Name and the Address field will automatically fill in as Schedule 2 is completed.
2. The Reporting Period field will automatically fill in after Schedule 2 has been completed.
3a. Verify the Type of Report that is completed. This should be Full Year Cost Report.
3b. Verify that all information in the Total Computable Expenditure is accurate based on the total on Line 12 of Schedule 9.

Fields H39 & J39: The Cost Report period dates will automatically fill in as Schedule 2 is completed.

Fields C58, I58, C61, I61: Sign/Date Certification and provide Title/Phone number.
Schedule 2 - Provider Data

General demographic information is compiled in this section. Below provides the line numbers and descriptions of the sections that will be completed.

<table>
<thead>
<tr>
<th>Cost Report Line Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Column C, Line 10:</strong> Enter the Provider Name. (School District/REC)</td>
<td></td>
</tr>
<tr>
<td><strong>Column E, Line 10:</strong> Enter the Cost Report Period Start Date</td>
<td></td>
</tr>
<tr>
<td><strong>Column E, Line 11:</strong> Enter the Cost Report Period End Date</td>
<td></td>
</tr>
<tr>
<td><strong>Column G, Line 10:</strong> Enter the Cost Report Submission Date</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 11:</strong> Enter Medicaid Provider Number as assigned by the NM Human Services Department/Medical Assistance Division for the LEA. If the Medicaid Provider Number changed during the cost report period, please provide the prior Medicaid provider number.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 17:</strong> Enter the County &amp; State.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 19:</strong> Enter the name of the Business Manager/Finance Director.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 21:</strong> Enter the cost report preparer’s name. This should be the contact person if there are questions about the cost report.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 23:</strong> Enter the contact phone number for the person who completes the cost report or person in charge of the cost report.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 25:</strong> Enter a contact email address.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 27-28:</strong> Enter a contact address.</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 29:</strong> Enter the city, state, and zip code. (Ex. Anytown, NM 87505)</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 34:</strong> Enter the Type of Time Study that was conducted. (Ex. Random Moment)</td>
<td></td>
</tr>
<tr>
<td><strong>Column C, Line 36:</strong> Enter the time period the time study was conducted that is applicable for this Cost Report. (Ex. 7/1/2015 – 6/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>
Column C, Line 41: Enter the cost report year’s Unrestricted Indirect Cost Rate, which must cover the same period of time as the cost report period.

Column C, Line 43: Enter the name of the Cognizant Agency. (The cognizant agency that determines the Unrestricted Indirect Cost Rate is the New Mexico Public Education Department.)

Column C, Line 45: Enter the Period of Time for which the Unrestricted Indirect Cost Rate was approved for. (Ex. 7/1/2015-6/30/2016)

Column C, Line 47: Enter the Date in which the Unrestricted Indirect Cost Rate was approved. (Ex. 7/1/2015)

Schedule 3 - Cost Allocation Statistics

Column H, Line 14: Enter the total number of Medicaid Covered students with IEP/IFSPs receiving services.

Column H, Line 15: Enter the total number of IEP/IFSP students receiving services in the LEA during the applicable period.

Column H, Line 16: Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Schedule 4A, 4B.

Column H, Line 19: Enter the total IEP/IFSP students receiving specialized transportation.

Column H, Line 20: Enter the total students in the LEA receiving transportation.

Column H, Line 21: Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Schedule 4C.

Column H, Line 24: Enter the total Medicaid IEP/IFSP students receiving specialized transportation.

Column H, Line 25: Do not enter information into this column, this column is automatically calculated.

Column H, Line 26: Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Schedule 4C.

Schedule 4A - Personnel Cost Summary

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Schedules 2, 3, 5, 6A, 6B, 6C and 6D are completed.
Schedule 4B - Non-Personnel Costs Summary

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Schedules 2, 3 and 7 are completed.

Schedule 4C – Special Education Transportation Summary

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Schedules 2, 3, 8A and 8B are completed.

Schedule 5 - Time Study Results

**Column D:** Enter the percentages calculated from the completed time study for each field. Enter the percentage in decimal form. (Ex. If the percentage from the time study or Direct Medical Services Covered is 23.57%, enter .2357 in Column D)

*The percentage calculated in cell F31 will carry to Schedule 4A.

Schedule 6A & 6B - Direct Cost by Discipline

For each type of service, enter all the required information as you move across the rows. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Schedule 4A.

First, enter your Trial Balance totals along the top line of each discipline. (Line 11, 23, 35, 47 and 59 – Columns G, N, O, P and Q).

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

**Column B:** Enter the vendor’s/employee’s Position Number or Employee ID.

**Column C:** Enter the vendor’s/employee’s last name.

**Column D:** Enter the vendor’s/employee’s first name.

**Column E:** Enter the vendor’s/employee’s job title.

**Column F:** Enter who performed the services. (Enter either Vendor or Employee)

**Column G:** Enter the vendor’s/employee’s total gross salary.

**Column H:** Enter whether or not the vendor’s/employee’s salary is **fully** funded by a Federal grant
payment(s). (Enter either Yes or No) This amount will automatically calculate column I.

**Column I:**  Do not enter information into this column.

**Column J:**  Enter whether or not the vendor’s/employee’s salary is **partially** funded by a Federal grant payment(s). (Enter either Yes or No)

**Column K:**  Enter the amount of Federally Funded salary.

**Column L:**  Enter any other reductions to the total gross salary.

**Column M:**  Do not enter information into this column.

**Column N:**  Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

**Column O:**  Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

**Column P:**  Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

**Column Q:**  Enter the amount of Vendor/Contractor payments paid from federal or other excluded funds.

**Column R:**  Do not enter information into this column, this column is automatically calculated.

---

**Schedule 6C & 6D - Direct Cost by Discipline - Continuation**

For each type of service, enter all the required information as you move across the rows. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Schedule 4A.

First, enter your Trial Balance totals along the top line of each discipline. (Line 11, 29, and 47 – Columns G, N, O, P and Q).

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

**Column B:**  Enter the vendor’s/employee’s Position Number or Employee ID.

**Column C:**  Enter the vendor’s/employee’s last name.
Column D: Enter the vendor’s/employee’s first name.

Column E: Enter the vendor’s/employee’s job title.

Column F: Enter who performed the services. (Enter either Vendor or Employee)

Column G: Enter the vendor’s/employee’s total gross salary.

Column H: Enter whether or not the vendor’s/employee’s salary is **fully** funded by a Federal grant payment(s). (Enter either Yes or No) This amount will automatically calculate column I.

Column I: Do not enter information into this column.

Column J: Enter whether or not the vendor’s/employee’s salary is **partially** funded by a Federal grant payment(s). (Enter either Yes or No)

Column K: Enter the amount of Federally Funded salary.

Column L: Enter any other reductions to the total gross salary.

Column M: Do not enter information into this column.

Column N: Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

Column O: Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

Column P: Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

Column Q: Enter the amount of Vendor/Contractor payments paid from federal or other excluded funds.

Column R: Do not enter information into this column, this column is automatically calculated.

**Schedule 7 - Other Direct Medical Cost**

Report costs paid by the district for direct medical materials, supplies and other costs used to provide covered services for a single item costing $5000 or less with a useful life of one year or less. Any single item costing more that $5000 will not be included in the cost report. Examples of direct medical
services materials, supplies and other costs are provided as Attachment 2, Examples of Direct Medical Supplies, Materials and other costs.

For each discipline, enter all the required information as you move across each row.

First, enter your Trial Balance total in Column F, Line 11.

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

**Column B:** Enter the trial balance account number.

**Column C:** Enter the trial balance account description.

**Column F:** Enter the trial balance amount.

**Column G:** Enter whether or not the cost is **fully** funded by a Federal grant payment(s). (Enter either Yes or No). This amount will automatically calculate column H.

**Column H:** Do not enter information into this column.

**Column I:** Enter whether or not the cost is **partially** funded by a Federal grant payment(s). (Enter either Yes or No.)

**Column J:** Enter the amount of Federally Funded cost.

**Column K:** Enter any other reductions to the trial balance.

**Column L:** Do not enter information into this column, this column is automatically calculated.

**Schedule 8A and 8B – Specialized Transportation Cost**

For each discipline, enter all the required information as you move across each row. The Adjusted Trial Balance totals will carry to Schedule 4C.

**To complete Rows 13 to 41 of this Schedule:**

First, enter your Trial Balance totals along the top line of each discipline. (Line 13, 22, 30 and 38 – Columns G, P, Q, R, and S).

Next, enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.
**Column B:** Enter the vendor’s/employee’s Position Number or Employee ID.

**Column C:** Enter the vendor’s/employee’s last name.

**Column D:** Enter the vendor’s/employee’s first name.

**Column E:** Enter the vendor’s/employee’s job title.

**Column F:** Enter who performed the services. (Enter either Vendor or Employee)

**Column G:** Enter Total Gross Salary

**Column I:** Enter whether or not the vendor’s/employee’s salary is **fully** funded by a Federal grant payment(s). (Enter either Y or N). This amount will automatically calculate column J.

**Column J:** Do not enter information into this column.

**Column K:** Enter whether or not the vendor’s/employee’s salary is **partially** funded by a Federal grant payment(s). (Enter either Y or N).

**Column L:** Enter the amount of Federally Funded salary.

**Column M:** Enter any other reductions to the total gross salary.

**Column O:** Do not enter information into this column.

**Column P:** Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

**Column Q:** Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

**Column R:** Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

**Column S:** Enter the amount of transportation related Vendor/Contractor payments paid from federal or other excluded funds.

**Column T:** Do not enter information into this column.
To complete Rows 51 to 55 of this Schedule:

Report costs paid by the LEA for Fuel, Repairs and Maintenance, Rentals, Contract and Vehicle Depreciation.

First, enter your Trial Balance totals in Column G. All costs should be reported as LEA-wide costs for all students (general education and special education) with the exception of Vehicle Depreciation. Vehicle Depreciation costs should be reported for only Specialized (Specially Equipped) Transportation.

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

**Column I:** Enter whether or not the cost is **fully** funded by a Federal grant payment(s) (Enter either Y or N). This amount will automatically calculate column J.

**Column J:** Do not enter information into this column.

**Column K:** Enter whether or not the cost is **partially** funded by a Federal grant payment(s). (Enter either Y or N.)

**Column L:** Enter the amount of Federally Funded cost.

**Column M:** Enter any other reductions, rebates, revenues, non-related activities to the trial balance.

**Column O:** Do not enter information into this column, this column is automatically calculated.

**Column T:** Do not enter information into this column.

**Schedule 9 - Settlement**

**Column F, Line 17:** Enter the Total Medical Claims paid.

**Column E, Line 28:** Enter the end date for the Cost Report period.

**Column F, Line 28:** Enter the begin date of the approved FFP for the previous year to calculate the applicable FFP for the Cost Report period.

**Column G, Line 28:** Enter the begin date of the approved FFP for the current year to calculate the applicable FFP for the Cost Report period.

**Column F, Line 31:** Enter the Medical Federal Financial Participation percentage for the applicable period.
**Column G, Line 31:** Enter the Medical Federal Financial Participation percentage for the applicable period.

**Column F, Line 20:** This will confirm the cost report settlement. If the value is noted in a parenthesis, this indicates that an overpayment has occurred. Full Refund is to be remitted with the cost report and signed certification page to the New Mexico Human Services Department/Medical Assistance Division. Make checks payable to: NM Human Services Department.

This refund should be mailed under separate cover, **via US Mail**, to:

HSD/Medical Assistance Division  
School Health Office  
Ark Plaza  
Post Office Box 2348  
Santa Fe, NM 87504
NM Medicaid
School-Based Services

INSTRUCTIONS FOR COMPLETING THE SCHOOL-BASED DIRECT SERVICES COST REPORT

Attachment 1

August 2016
# Medicaid School-Based Services

## Provider Type Information

### Physical Therapy (procedure codes: 97001, 97002, 97110 and 97150)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapists licensed by the Physical Therapy Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical Therapy Assistants licensed by the Physical Therapy Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must be supervised by a physical therapist and claims must be submitted using the supervisor’s rendering provider number.</td>
<td>Yes, must be supervised by a Physical Therapist that meets the licensure requirements above.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Occupational Therapy (procedure codes: 97003, 97004, 97110 and 97150)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapists licensed by the Occupational Therapy Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox. and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Certified Occupational Therapy Assistants licensed by the Occupational Therapy Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must be supervised by an occupational therapist and claims must be submitted using the supervisor’s rendering provider number.</td>
<td>Yes, must be supervised by a Occupational Therapist that meets the licensure requirements above.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Nursing Services (procedure codes: T1001, T1002, T1003 and T1502)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Registered Nurses licensed by the NM Board of Nursing.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Practical Nurses licensed by the NM Board of Nursing.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>Yes, must be supervised by a Registered Nurse that meets the licensure requirements above.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Speech Therapy (procedure codes: 92521, 92522, 92523, 92524, 92507 and 92508)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Pathologists licensed by the Speech Language Pathology, Audiology and Hearing Aid Dispensers Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Speech-language pathology clinical fellows licensed by the Speech Language Pathology, Audiology and Hearing Aid Dispensers Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Board license will reflect the fellowship status of this provider and the provider will submit a provider participation agreement to Xerox. The school must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>Yes, must be supervised by a Speech Pathologist that meets the licensure requirements above.</td>
<td>Yes</td>
</tr>
<tr>
<td>Speech-language pathology apprentices licensed by the Speech Language Pathology, Audiology, and Hearing Aid Dispensers Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Must be supervised by an speech pathologist and claims must be submitted using the supervisor’s rendering provider number.</td>
<td>Yes, must be supervised by a Speech Pathologist that meets the licensure requirements above.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Audiology Services (procedure codes: 92552, 92553, 92555, 92557, 92587, 92588, 92630, 92633 and V5010)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologists licensed by the Speech Language Pathology, Audiology and Hearing Aid Dispensers Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Transportation (procedure code: A0110)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billable transportation is by provided by the school district and not by the child’s parent(s) or guardian.</td>
<td>No</td>
<td>No rendering provider number is required on the claim. The school should submit the claim using it’s group number.</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
### Nutritional Counseling (procedure codes: 97802 and 97803)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Nutritionists licensed by the NM Nutrition and Dietetics Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>No rendering provider number is required on the claim. The school should submit the claim using its group number.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Licensed Dieticians licensed by the NM Nutrition and Dietetics Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>No rendering provider number is required on the claim. The school should submit the claim using its group number.</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

### Case Management (procedure code: T1017)

<table>
<thead>
<tr>
<th>Description of Provider</th>
<th>PED License Requirement</th>
<th>How to Submit Claim for Provider</th>
<th>Supervision Requirement</th>
<th>NPI Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor's Degree in Social Work, Counseling, Psychology, Nursing or a related health or social services field from an accredited institution and having one year experience serving medically-at-risk children or adolescents</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox specific to case management and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Registered or Practical Nurse</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox specific to case management and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Individuals with a bachelor's degree in another field and two years of direct experience in serving medically-at-risk children or adolescents.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox specific to case management and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Description of Provider</td>
<td>PED License Requirement</td>
<td>How to Submit Claim for Provider</td>
<td>Supervision Requirement</td>
<td>NPI Required?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Licensed Master's Level Independent Social Worker (LISW) or Licensed Clinical Social Worker (LCSW) licensed by the Social Worker's Examiner's Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Master's Level Social Worker (LMSW) licensed by the Social Worker's Examiner's Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>Yes, must be supervised by a Ph.D., Psy.D., Ed.D. or LISW/LCSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Bachelor's Level Social Worker (LBSW) licensed by the Social Worker's Examiner's Board under the State of NM Regulation and Licensing Dept.</td>
<td>Yes</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>Yes, must be supervised by a Ph.D., Psy.D., Ed.D. or LISW/LCSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychologist: Ph.D., Psy.D. or Ed.D licensed by the NM Psychologist Examiner's Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychologist: Master's level practitioners licensed by the NM Psychologist Examiners Board as Psychologist Associates or licensed by the NM Public Education Department as School Psychologists.</td>
<td>Yes for School Psychologists</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox. School Psychologists must submit the PED license with application.</td>
<td>Yes for Level 1 School Psychologists. Must be supervised by a Ph.D., Psy.D. Ed.D who is licensed by the NM Psychologist Examiner's Board or a Level 3 School Psychologist. No for Level 2 and 3 School Psychologists.</td>
<td>Yes</td>
</tr>
<tr>
<td>Licenses Professional Clinical Counselors (LPCC) licensed by the NM Counseling and Therapy Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Description of Provider</td>
<td>PED License Requirement</td>
<td>How to Submit Claim for Provider</td>
<td>Supervision Requirement</td>
<td>NPI Required?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Licensed Mental Health Counselors (LMHC) formally known as Licensed Professional Counselors (LPC).</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>Yes, must be supervised by a Ph.D., Psy.D., Ed.D., LISW/LCSW or LPCC</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapists (LMFT) licensed by the NM Counseling and Therapy Practice Board under the State of NM Regulation and Licensing Dept.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed Psychiatric Clinical Nurse Specialists (CNS) licensed by the NM Board of Nursing.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Physicians and Psychiatrists licensed by the Board of Medical Examiners.</td>
<td>No</td>
<td>Must submit Provider Participation Agreement to Xerox and must submit claims using the Medicaid rendering provider number issued by Xerox.</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
NM Medicaid
School-Based Services

INSTRUCTIONS FOR COMPLETING THE SCHOOL-BASED DIRECT SERVICES COST REPORT

Attachment 2

August 2016
Attachment 2: Examples of Direct Medical Supplies, Materials and Other Costs

**Medical Supplies & Materials**
- Automatic electronic defibrillators
- Bandages, including adhesive (e.g., Band-Aids) and elastic, of various types and materials
- Basins (emesis, wash)
- Biohazard waste bags
- Bite sticks
- Blankets (disposable preferable)
- Blood Glucose Meters
- Blunt scissors
- BMI Calculators
- Catheterization and irrigation equipment
- Cold packs
- Cots (one per 200 students)
- Cotton balls
- Cotton-tipped applicators (swabs)
- CPR masks
- C-spine stabilizers
- Dental floss
- Disinfectant
- Disposable masks, gowns and gloves
- Emergency Childbirth kit
- Eye pads
- Eye wash bottles
- Eye wash solution
- Finger nail clippers
- First aid kits
- Gauze (dressings of various sizes)
- Hand sanitizer
- Ice (real ice preferred over chemical ice)
- Inhaler or nebulizer device and mouth pieces
- IPECAC
- Magnifying glass
- Medications: (in accordance with state law and pharmacy and nurse practice acts (depending on local policy) acetaminophen, Albuterol, Epinephrine pen for adult and child, albuterol, ASA, Glucagon, ibuprofen, oxygen & meter)
- Mobility equipment (e.g., walkers, wheelchairs, scooters)
- Normal saline
- Oral airways
- Otoscope/ophthalmoscope & batteries
- Peak Flow Meters
- Penlights
- Physician’s scale that has a height rod and is balanced
- Portable crisis kit
- Pulse oximeters
Attachment 2: Examples of Direct Medical Supplies, Materials and Other Costs, continued

- Record forms (e.g., emergency cards, logs, medical sheets, accident reports, state forms)
- Reflex hammers
- Refrigerator or cooler
- Re-sealable plastic bags
- Resuscitation bag (Ambu in two sizes, 500 ml and 1 L, with appropriate sized masks)
- Ring cutter
- Sanitizer (for equipment, cots, counters)
- Scoliometers
- Sharps container for disposal of hazardous medical waste
- Skin cleanser (gel or wipe)
- Skin tape
- Slings or Triangular bandages
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints
- Stethoscopes
- Suction Units (Disposable and electronic)
- Sugar source (oral glucose, i.e., frosting)
- Tape measures
- Thermometers & disposable covers
- Vision screening equipment (acuity measures, stereopsis cards, etc.)
- Vision testing machine, such as Titmus
- Wall-mounted height measuring tools
- Wheelchairs

Audiology Equipment & Supplies
- Audiometers (calibrated annually) including portable and clinical with sound field capabilities
- Battery testers, hearing aid stethoscopes, and ear mold cleaning materials
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- FM amplification systems or other assistive listening devices
- Loaner or demonstration hearing aids
- Portable acoustic emittance meters
- Sound-level meters
- Sound-treated test booth
- Test materials for central auditory processing assessment
- Typanometers
- Visual reinforcement audiometry equipment and other instruments necessary for assessing young or difficult-to-test children
Attachment 2: Examples of Direct Medical Supplies, Materials and Other Costs, continued

Therapy Supplies & Equipment
- Adaptive classroom tools (e.g., pencil grips, slant boards, self-opening scissors)
- Auditory, speechreading, speech-language, and communication instructional materials
- Current standardized tests and protocols for related services (e.g., Behavioral Health, OT, PT, Speech)
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Positioning equipment (e.g., wedges, bolsters, stands, adapted seating, Exercise mats)
- Self-help devices (e.g., spoons, zipper pulls, reachers)
- Supplies for adapting materials and equipment (e.g., strapping, Velcro, foam, splinting supplies)

Also included under EPSDT are any supplies and materials that are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening"