

## ATTACHMENT (A)

Please see Title 42 CFR --Public Health

---

### CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

#### PART 440--SERVICES: GENERAL PROVISIONS

Sec. 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) Physical therapy. (1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist.

(b) Occupational therapy. (1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist.

(c) Services for individuals with speech, hearing, and language disorders. (1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

You may view other parts of section 440 that pertain to nurses, diagnostics, psychs etc.

## **ATTACHMENT (B)**

Components for written recommendation from physician or practitioner of the healing arts within the scope of practice.

**Patient name**

Patient DOB

Patient ID (for the health insurance coverage)

Patient Treating Diagnosis and ICD9 code

Reason for referral

Service to be provided (OT, PT, Speech, etc)

Scope of referral (consultation, Diagnostic testing, etc)

Dates of service beginning and ending dates

Amount of service, Frequency and Duration

Location of service

Practitioner contact information Location/ phone number

Practitioner's name and credentials

You should also add the recommendation for the service is for the IEP dated \_\_\_/\_\_\_/\_\_\_ in order to tie it in with the prescription for SBHS.

By adding the date specified IEP/IFSP to your form it will indicate the amount, duration, frequency, location, and beginning and ending dates for services to be provided. You would not need to reiterate that information on your form unless you wanted to provide that information for the team as a suggested amount of time for service etc.

# EXAMPLE FORMS

**This form was created as an individual request from an individual practitioner of the healing arts recommendation for service.**

## Practitioner's Written Recommendation for School-Based Health Services pursuant to IEP/IFSP

Student Name: _____ DOB: ____/____/____ Medicaid ID#: _____ School: _____
Diagnosis: _____ ICD9 Diagnosis Code(s): _____ Physician printed Name: _____ Physician Telephone: _____
Medically Qualified Staff Practitioner Printed Name and Credentials _____ Practitioners Telephone _____
For and within the frequency and duration of the IEP/IFSP dated: ____/____/____

### Recommendation for Service

Based upon my assessment of the student's health status, I am recommending the student

would benefit  continues to benefit  would not benefit from the health service indicated below.

- |   |                                    |                                       |
|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Speech Therapy       | <input type="checkbox"/> Treatment | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Treatment | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Treatment | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Audiology Services   | <input type="checkbox"/> Services  | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Nurse Services       | <input type="checkbox"/> Treatment | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Psychological        | <input type="checkbox"/> Services  | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Mental Health        | <input type="checkbox"/> Services  | <input type="checkbox"/> Consultation |

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapists Signature and Credentials

The purpose of this form is to meet the Licensed Practitioner Recommendation under SBHS rule 410-133-0160, and is to be used for Medicaid billing procedures provided to a child pursuant to his/her IEP/IFSP. The form will be maintained as part of the student's educational record and will be kept for a period of seven (7) years for Medicaid supporting documentation requirements under SBHS rule 410-133-020 Recordkeeping Requirements.

410-133-0160 – Licensed Practitioner Recommendation

Request for payment of medical services required by a child's IEP/IFSP must be supported by written recommendation from a physician or a licensed practitioner of the healing arts within the scope of their practice. The recommendation must be updated annually.



**THIS FORM CAN BE USED BY ONE INDIVIDUAL PRACTITIONER REQUESTING SERVICE OR MULTIPLE PRACTITIONERS REQUESTING SERVICES. THIS FORM INSTRUCTS THE PRACTITIONER TO INDICATE SCOPE OF RECOMMENDATION BY CIRCLING CHOICE AS ONE OR THE OTHER OR BOTH.**

**WRITTEN RECOMMENDATION  
FOR MEDICAID BILLABLE SCHOOL-BASED HEALTH SERVICES**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Medicaid ID#: \_\_\_\_\_ School: \_\_\_\_\_  
For and within the frequency and duration of the IEP/IFSP dated: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Diagnosis Code \_\_\_\_\_

I have assessed the student's status and recommend the following treatment be included in the IEP/IFSP:

\_\_\_\_ **Speech Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Scope of Recommendation circle one or both:  
**Treatment** **Consultation**

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_ **Occupational Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Scope of Recommendation circle one or both:  
**Treatment** **Consultation**

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_ **Physical Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Scope of Recommendation circle one or both:  
**Treatment** **Consultation**

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_ **Psychological Services** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Scope of Recommendation circle one or both:  
**Treatment** **Consultation**

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_ **Nursing Services** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Scope of Recommendation circle one or both:  
**Treatment** **Consultation**

\_\_\_\_\_  
Signature/Credentials Telephone Date

The purpose of this form is to meet the Licensed Practitioner Recommendation under SBHS rule 410-133-0160, and is to be used for Medicaid billing procedures only. The form will be maintained as part of the student's Medicaid record.  
410-133-0160 - Licensed Practitioner Recommendation  
Request for payment of medical services required by a child's IEP/IFSP must be supported by written recommendation from a physician or a licensed practitioner of the healing arts within the scope of their practice. The recommendation must be updated annually.

**THIS FORM CAN BE USED BY ONE INDIVIDUAL PRACTITIONER REQUESTING SERVICE OR MULTIPLE PRACTITIONERS REQUESTING SERVICES. PLEASE NOTE THIS FORM INDICATES SCOPE OF RECOMMENDATION FOR ALL BELOW LISTED SERVICES IS TREATMENT SERVICES**

**Written Recommendation  
for Medicaid Billable Treatment Services**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Medicaid ID#: \_\_\_\_\_ School: \_\_\_\_\_  
For and within the frequency and duration of the IEP/IFSP dated: \_\_\_\_\_  
Scope of Recommendation: **Treatment Services**

I have assessed the student's status and recommend the following treatment be included in the IEP/IFSP:

\_\_\_\_\_ **Speech Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_\_ **Occupational Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_\_ **Physical Therapy** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_\_ **Psychological Services** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature/Credentials Telephone Date

\_\_\_\_\_ **Nursing Services** - ICD-9 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature/Credentials Telephone Date

The purpose of this form is to meet the Licensed Practitioner Recommendation under SBHS rule 410-133-0160, and is to be used for Medicaid billing procedure only. The form will be maintained as part of the student's Medicaid record.  
410-133-0160 - Licensed Practitioner Recommendation Request for payment of medical services required by a child's IEP/IFSP must be supported by written recommendation from a physician or a licensed practitioner of the healing arts within the scope of their practice. The recommendation must be updated annually.



