

NORTH CAROLINA LOCAL EDUCATIONAL AGENCY
SELF ASSESSMENT
REVIEW IEP HEALTH RELATED SERVICES

School District Name _____

Date of Review ___/___/___ Reviewer Name _____

Student Name _____ Date of Birth _____

Service(s) provided _____

Services provide from ___/___/___ to ___/___/___

Payment information from Remittance Advice production date ___/___/___

CONSENT/RELEASE

Parent/legal representative received information about third party billing and gave consent for release of information to Medicaid. Yes / No Date signed ___/___/___

LEA has copy of student's Medicaid card Yes / No

Parent/legal representative signed revocation on _____ or N/A

Consent for billing public (Medicaid) insurance is valid for only up to one year. If student is covered by private insurance, no Medicaid billing can take place for this student's school based services in order to ensure compliance with FAPE.

COMMENTS:

MEDICAL ORDERS/MEDICAL NECESSITY

Physician orders signed on _____ begin date ___/___/___ end date ___/___/___

Release to contact medical office for information signed: Yes / No Date ___/___/___

Special Education category of eligibility: _____

Medical diagnosis/condition: _____

COMMENTS:

CATEGORY OF SERVICE	MONTH/YEAR	#UNITS BILLED	ON IEP
Audiology Therapy	____/____	_____	Yes / No
Occupational Therapy	____/____	_____	Yes / No
Physical Therapy	____/____	_____	Yes / No
Speech Therapy	____/____	_____	Yes / No
Psychological/counseling	____/____	_____	Yes / No

The effective date of the IEP begins ____/____/____ ends ____/____/____

Is each service billed identified on the IEP and goals sufficiently outlined, including frequency, amount, and duration?
Yes / No

If a service(s) was not on the IEP, was the service billed part of an evaluation that resulted in an IEP?
Yes / No

Service(s) billed does not exceed services indicated on IEP. Yes / No

COMMENTS:

SUPERVISION

SLP-A, COTA or PTA supervision is clearly documented Yes / No
Documentation is located _____

QUALIFICATION OF PROVIDER

Audiologist has current North Carolina license: Yes / No

Occupational Therapist has current North Carolina license: Yes / No

Occupational Therapy Assistant has current North Carolina license: Yes / No

Physical Therapist has current North Carolina license: Yes / No

Physical Therapist Assistant has current North Carolina license Yes / No

Speech therapist has a current North Carolina license and

- CCCs from ASHA or Yes / No

- completed equivalent for CCCs or Yes / No

- is acquiring supervision for CCCs Yes / No

Psychological associate or practicing psychologist has a current North Carolina license or is certified as a school psychologist: Yes / No

Clinical Social worker providing counseling services has a current North Carolina license: Yes / No

Documentation is located _____

COMMENTS:

DOCUMENTATION (activity logs, service logs)

Documentation requirements are met if each billing service note meets all of the following criteria:

- (1) Documentation is legible;
- (2) Student's name and date of birth is on each page;
- (3) Student's diagnosis is listed;
- (4) Each encounter includes the date, length, and type of service;
- (5) Daily service progress note includes student's response/results/progress.
- (6) Service Progress notes are dated and signed including practitioner's title;
- (7) Supervisor signature present, if needed;
- (8) School calendar supports the date(s) service was provided; and
- (9) Student attendance record supports date(s) service was provided.

Audiology	Yes / No	Requirement not met _____
Occupational Therapy	Yes / No	Requirement not met _____
Physical Therapy	Yes / No	Requirement not met _____
Speech Therapy	Yes / No	Requirement not met _____
Psychology	Yes / No	Requirement not met _____

COMMENTS:

DENIAL FROM PRIVATE PLAN

Public only no denial necessary

Letter/claim sent to private plan and response received that services are covered: Yes / No

Letter/claim sent and private plan does not cover the service: Yes / No

Denial period from ___/___/___ to ___/___/___

Three attempts with plan with no response. Dates of attempts:

1) ___/___/___

2) ___/___/___

3) ___/___/___

COMMENTS:

NORTH CAROLINA LOCAL SCHOOL AGENCY
SELF ASSESSMENT
REVIEW IEP HEALTH RELATED SERVICES
FINDINGS AND OUTCOMES

Date self assessment completed _____

Self assessment completed by _____

Findings reported to _____ Date: _____

Corrective Action(s) requested:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Follow up review will be completed on _____

Results of the follow-up review:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Review indicates all corrective action completed and billing should continue:
Yes / No

Review indicates some or all corrective actions remain pending and billing must stop
until all corrections are made: Yes / No

Corrective actions complete: Date ____/____/____

Follow up review was completed by _____

CONFIDENTIAL

Exceptional Children Division
NC Department of Public Instruction

•If mistakes or errors are found, the LEA can request the Division of Medical Assistance PI to do a voluntary self-audit. Over payments will have to be refunded if erroneous claims are found. •