MTS Collaborative He-W589 Rule Crosswalk FAQs
1. Consultation used to be billed by discipline (e.g., Speech Consult, OT Consult) with distinct codes. Under the new rule, consultation is no longer discipline-specific. Will there be a single, generic consultation billing code that we should use going forward? The rule does not create discipline-specific consultation categories; for therapy services, the only billable types are evaluation, individual treatment, group treatment, and supplies/equipment: Occupational Therapy: evaluation, individual, group, supplies/equipment (He W 589.04(s)) Physical Therapy: evaluation, individual, group, supplies/equipment (He W 589.04(w)) Speech/Language: evaluation, individual, group, supplies/equipment (He W 589.04(as)) Audiology: hearing evaluation, individual, group, supplies/equipment (He W 589.04(au)) **Key billing points:** Consultation can be billed only if the student is present at least 51%. Therapy disciplines must bill under evaluation or treatment categories; There are no specific codes for consult under Medicaid. Claims must use existing procedural codes and reflect actual cost (He W 589.06(b)).
2. What is a physician's associate? Did the rule mean to state Physician's Assistant? Under RSA 328-D Physician Assistants are licensed as Physician Associates in New Hampshire. RSA 328-D:19 **"Effect of Name Change from Physician Assistant to Physician Associate"** *I. "…the title of "physician assistant" in New Hampshire is changed to "physician associate." This change is not intended to change any rights or privileges of those who have been or continue to hold themselves out to be a "physician assistant" and anywhere in the law that says, "physician associate" shall also mean "physician assistant."* *II. This name change shall not alter, affect, or impact any billing, reimbursement, or payment policies currently in place for physician assistants. All billing practices, insurance reimbursement policies, and agreements that apply to physician assistants shall continue to apply in the same manner to physician associates…"* ***Effective June 17, 2025***

3. I thought speech specialist was removed as a DOE credential.

The condition of a "certified speech language specialist as described in RSA 326-F:, IV(b)" has been incorporated into the rule. While the rule has been revised, alignment with the RSA is still necessary.
Based on the current rule language, it appears to recognize individuals previously licensed by NHED before 2022. According to the Department of Education, the speech language specialist credential has been phased out, and NHED has not issued this license since 2023. Any individual still practicing under that designation should now be licensed as a speech language pathologist through OPLC.

4. Please address doctor diagnosis of autism vs identification of autism in SPED process (e.g. "pervasive developmental disability"). Does the rule change provide more flexibility re: who can diagnose?

Under He-W 589.04(ag)–(aj), ABA is covered only for students with a clinical diagnosis of:

- Autism Spectrum Disorder, or
- Pervasive Developmental Disability

The diagnosis and ABA recommendation must come from a licensed clinician who has experience diagnosing/treating ASD or PDD and is one of the following:

- Physician
- Psychologist
- Nurse practitioner specializing in developmental medicine
- Physician associate specializing in developmental medicine

Special education eligibility categories (such as "Autism" under IDEA) are educational determinations and **do not** meet Medicaid requirements for ABA. School evaluation teams, special education teams, school psychologists without a clinical license, and educators cannot issue a medical diagnosis for Medicaid purposes.
Therefore:

- A SPED identification of "Autism" does **not** qualify a student for Medicaid ABA.
- A clinical diagnosis from one of the licensed clinicians above is still required.

The rule does not expand who may diagnose ASD or PDD. It maintains that ABA must be recommended by a licensed clinician with diagnostic experience in ASD/PDD, per He-W 589.04(ag) and (aj).

5. Please define ALL involved personnel for the OIG

Under He-W 589.04(a)(3), "all involved personnel" refers to any individual who administers, delivers, or supports the delivery of Medicaid-covered services for an LEA/SAU. These individuals must be screened against the federal OIG exclusion list upon hire and monthly thereafter.
Relevant rule sections confirming who must be screened:

- He-W 589.04(a)(3) – Requires OIG exclusion screening for "all providers, employees, contractors, and school personnel that are involved with administering or delivering Medicaid services."
- He-W 589.04(c) – Defines who may deliver services (licensed clinicians, performing-only providers, BCBAs), all of whom fall under OIG screening.
- He-W 589.04(r–ar) – Identifies all clinician and assistant provider types (e.g., OT, PT, SLP, assistants), all of whom are considered involved personnel when delivering Medicaid services.
- He-W 589.04(bb) – Includes specialized transportation staff when the transportation is Medicaid-billable.

Based on those sections, "involved personnel" includes:

- Licensed clinicians (medical, behavioral health, therapy, vision, audiology)
- Performing-only providers (rehabilitative assistants, personal care workers, BCBAs when not independently enrolled)
- Paraprofessionals/assistants delivering Medicaid services under clinician direction
- Specialized transportation staff when billing Medicaid
- Any employee or contractor whose role touches Medicaid service delivery or administration

If a person's duties involve a Medicaid-billable service in any capacity, He-W 589 requires they be included in monthly OIG exclusion screening.

6. **For the rehab assistant training required within the 30-day supervisory review, do we need to document when *no* additional training occurred? And can the training be informal and student-specific, or are they expecting formal workshop or professional development activities?**

The 30-day review of Rehabilitative Assistance Services must include a list of any trainings completed in the past 30 days (He-W 589.04(ao) (3)).
The rule does **not** require that:

- training occur every 30 days

- training be formal
- training be workshops/PD
- a minimum number of trainings be completed

You only need to document whatever training occurred. If none took place, it is acceptable to note:

- "No trainings completed during this 30-day period," or
- "None."

7. To confirm, can BCBAs sign off on RA services?

Yes. Under He-W 589, BCBAs may sign off on rehabilitative assistant (RA) services as long as they are nationally certified, hold the required supervisory credential (if supervising), and act within their scope of practice.
He-W 589.04(c)(2) lists BCBAs as recognized providers, and RAs must work under the direction of an appropriate licensed clinician (He-W 589.04(ak)). The 30-day RA review also requires documentation and the supervising clinician's signature (He-W 589.04(ao)(8)).
Because BCBAs are explicitly included as licensed clinicians and can supervise behavioral plans and RA tasks, they may sign off on RA service reviews and documentation.

8. If the 30-day reviewer is already attesting that services were provided on the review form, do they also need to attest to the same information on the RA log, or is the review form sufficient?

No. The rule does not require the licensed clinician to attest twice.
For the 30-day review, He-W 589.04(ao)(7)–(8) requires:

- an attestation that services were provided, and
- the licensed clinician's signature and attestation that services were delivered according to the care plan.

This attestation belongs **only** on the 30-day review documentation.
The rehabilitative assistant log has a separate requirement in He-W 589.06(d)(13):

- the *performing provider* (the RA or other service provider) must sign each entry to attest to the medical, non-academic nature of the service.

The rule does **not** require the licensed clinician to attest again on the daily RA log.
Therefore, the clinician's attestation on the 30-day review is sufficient, and no additional clinician attestation is needed on the RA log.

9. Regarding electronic signatures, can a signature stamp be used on paper forms?

No. A signature stamp cannot be used on paper forms.
He-W 589.02(ab) defines a signature as either:

1. A person's name **handwritten by that person** (excluding any photocopy, stamp, or facsimile), or
2. An electronic signature that complies with RSA 294-E.

For paper documentation:

- The signature must be handwritten.
- Stamped, photocopied, or otherwise reproduced signatures are not permitted.

For electronic documentation:

- An electronic signature is acceptable only if it meets RSA 294-E requirements.

10. For ABA services, my understanding is that the ABA provider cannot sign the recommendation/order. In that case, can I submit it to EHS for a third-party signature from the ARNP? Would that be acceptable?

Yes, He-W 589.04(aj) states that ABA services must be recommended by a licensed clinician who has experience diagnosing and treating autism or pervasive developmental disorder, and holds one of the following licenses:

- Physician
- Psychologist
- Nurse practitioner specializing in developmental medicine
- Physician's associate specializing in developmental medicine

11. For clinician notes that must be dated and signed: if our clinicians keep them in a spreadsheet and type in the date and their initials, does that meet the signature requirement, or do they need to insert an actual handwritten or electronic signature into the spreadsheet?

Under He-W 589.02(ab), a valid signature must be either:

- a handwritten signature by the individual (not a photocopy, stamp, or other facsimile), or
- an electronic signature that meets RSA 294-E requirements.

Typed initials in a spreadsheet are considered a facsimile and do **not** meet the rule's definition of a signature.
To make spreadsheet documentation compliant, clinicians must use one of the following:

• an RSA 294-E–compliant electronic signature applied within the electronic document.

Without one of these valid signature types, the current spreadsheet practice does not meet the signature requirement.

12. Regarding autism diagnoses from clinicians specializing in developmental medicine: do we need to keep documentation, such as a CV, on file to verify the provider's qualifications?

No. The rule does **not** require LEAs/SAUs to keep a clinician's CV on file. Nothing in He-W 589 requires maintaining a résumé, proof of specialization, or any documentation beyond verifying licensure and certification.

He-W 589.04(a)(2) requires school providers to:

• verify the qualifications, licensure, and certifications of performing-only providers upon hire and at each renewal, and

• maintain proof of that verification.

This means the requirement is to verify credentials and keep proof of that verification, not to maintain the clinician's CV.

ABA Recommendation Requirements

Under He-W 589.04(aj), the ABA recommendation must come from a clinician who:

• has experience diagnosing/treating autism or PDD, and

• holds one of these licenses: physician, psychologist, NP specializing in developmental medicine, or PA specializing in developmental medicine.

However, the rule does *not* require LEAs to:

• keep a CV,

• document the clinician's specialization beyond verifying licensure, or

• maintain evidence of the clinician's experience.

Acceptable "proof of verification" typically includes: • a copy of the clinician's license,

• a licensing board lookup or screenshot, or

• similar documentation confirming current licensure.

13. Can you clarify when the requirement for a medical diagnosis first went into effect?

The requirement for a medical diagnosis for ABA services appears in He-W 589.04(ag)–(aj) in the rule version effective **November 25, 2025** ("eff 11-25-25"). This requirement has been in effect since that date.

14. Can we address the communication gaps between providers, supervisors, and the state? It seems that differences in medical versus educational terminology are causing misunderstandings, not only between providers and supervisors, but also during state reviews and audits. How can we improve clarity so that questions and documentation are interpreted correctly across all levels?

We understand how challenging it can be when medical and educational terminology are interpreted differently, and we appreciate you raising this concern. These gaps can create confusion not only between providers and supervisors, but also during state reviews and audits. Feedback like this helps us identify where clearer communication, translation, or cross-walk guidance is needed. As we continue advancing Medicaid to Schools, this is an important opportunity to strengthen consistency and ensure everyone, providers, supervisors, and state reviewers, has the information they need to feel confident in their work

15. As July 1 approaches, if there is a delay in approvals or guidance, will the implementation date be deferred? Additionally, what interim direction will be provided regarding training, participant lists, and Random Moment Time Study (RMTS)?

As July 1 approaches, we understand that providers are looking for clarity and adequate time to prepare. Transitioning to new methodologies requires coordination and formal CMS approval, and those steps must be completed before implementation. At this time, we remain on track for a July 1 transition and do not anticipate delays. If anything changes, we will communicate promptly and support districts and providers in adjusting as needed.

To support preparation, we have four upcoming training sessions scheduled:

- **April 21, 2026 |** 2:00 – 3:30 PM EDT
  https://attendee.gotowebinar.com/register/1877386871544665434
- **April 22, 2026** | 10:00 – 11:30 AM EDT
  https://attendee.gotowebinar.com/register/5746279118130387804
- **May 12, 2026** | 10:00 – 11:30 AM EDT
  https://attendee.gotowebinar.com/register/2461281421964478549
- **May 20, 2026** | 2:00 – 3:30 PM EDT
  https://attendee.gotowebinar.com/register/1154941761399176790

Note: You only need to attend one session. However, you're welcome to attend as many as you'd like. These training courses are intended for LEA staff only.

These sessions will provide guidance on requirements, processes, and implementation details to help ensure a smooth transition.
We appreciate your patience as we move through these final steps and remain committed to providing the information and training needed for successful implementation.

If you have additional questions, please email:
Medicaid to Schools, DHHS at MTS@dhhs.nh.gov