Washington State Health Care Authority

Washington Apple Health (Medicaid)

School-Based Health Care Services (SBHS) Billing Guide

January 1, 2018

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect January 1, 2018, and supersedes earlier billing guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
All	Reorganized some sections in the guide without changing the content.	Clarification
Resources Available	Added hyperlinks to the School-Based Health Care Services (SBHS) webpage and the How to Enroll Servicing Providers training. Updated the SBHS GovDelivery hyperlink.	Clarification
Definitions	Added definitions for Centers for Medicare and Medicaid Services, Core Provider Agreement, Health Care Authority, interagency agreement, and ProviderOne.	Clarification
What is the SBHS program?	Updated the section title (formerly titled *What is the purpose of the SBHS program?*).	Clarification
Who can participate in the SBHS program?	Added section with information about which entities can participate in the SBHS program. Charter and tribal schools are eligible to participate in the SBHS program as of April 1, 2017.	Clarification and policy update
What are the participation requirements of the SBHS program?	Added section with information about the requirements that must be met for school districts to participate in the SBHS program.	Clarification

* This guide is a billing instruction.

Subject	Change	Reason for Change
What is the role of the SBHS coordinator?	Added section with information about responsibilities of the SBHS coordinator.	Update
What is the intergovernmental transfer (IGT) process?	Previously located in the *Billing* section. Added clarifying language to explain the intergovernmental transfer process.	Clarification
What is the Provider and Contact Update Form?	Previously located in the *Documentation* section. Added clarifying language and updated section title (formerly *What documents are due to the SBHS program specialist annually?).*	Clarification
Will receiving SBHS affect a child's Medicaid or other benefits?	Updated the section title (formerly *Who pays for SBHS?*) and updated language.	Clarification
Which recipient aid category (RAC) codes are not eligible for reimbursement?	Added RAC codes 1215 and 1216 as codes not eligible for reimbursement through the SBHS program.	Policy update
Who may provide school-based health care services (SBHS)?	Reinserted information about nursing services that had been removed. (corrected January 4, 2018)	Correction
Who may provide school-based health care services (SBHS)?	Clarified language regarding Department of Health (DOH) licensure or certification. Added clarifying language regarding noncredentialed school staff providing delegated services.	Clarification
How do school districts enroll providers in ProviderOne?	Updated the section title (formerly titled *How do school districts enroll providers?*) and updated information in the section.	Clarification
What is the provider revalidation process?	Added section to explain how the agency implements the provider revalidation process.	Clarification
Which providers cannot participate in the SBHS program?	Added a new section title with two subsections in order to clarify which providers are not eligible for SBHS reimbursement.	Clarification
What is covered?	Added language to clarify when the agency reimburses for evaluations and reevaluations.	Clarification

Subject	Change	Reason for Change
Referrals and prescriptions	Added section to clarify language around referrals and prescriptions for SBHS.	Clarification
Coverage Tables	Added a new section title. Added clarifying language to the “blue box” note about billing untimed codes.	Clarification
Audiology services	Clarified which provider type can provide audiology services. Removed procedure code 97532 and added procedure code 97127.	Clarification and CMS code change
Counseling services	Clarified which provider types can provide counseling services. Added procedure code 90791.	Clarification and update
Nursing services	Clarified which provider types can provide nursing services. Added information that non-credentialed staff may provide certain health care tasks under the delegation and supervision of an RN.	Clarification
Psychological assessments and services	Clarified which provider type can provide psychological assessments and services. Added procedure code 90791.	Clarification and update
Occupational therapy services	Clarified which provider types can provide occupational therapy services. Removed procedure codes 97532 and 97762. Added procedure codes 97127 and 97763.	Clarification and CMS code changes
Physical therapy services	Clarified which provider types can provide physical therapy services. Removed procedure code 97762 and added procedure code 97763.	Clarification and CMS code change
Speech-language therapy services	Clarified which provider types can provide speech-language therapy services. Removed procedure code 97532 and added procedure code 97127.	Clarification and CMS code change
What is the National Correct Coding Initiative (NCCI)?	Added information about National Correct Coding Initiative (NCCI) edits.	Billing clarification

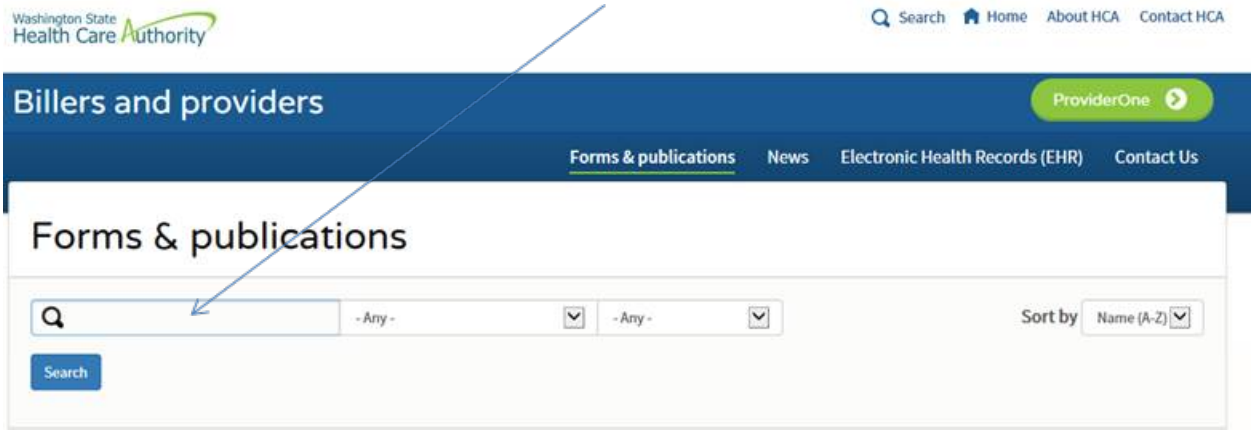
How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource Information
Who do I contact if I'm interested in contracting with the SBHS program or have questions regarding SBHS program policy?	**SBHS Program Specialist** 360-725-1153 Shanna.Muirhead@hca.wa.gov
Where can I find more information about the SBHS program?	School-Based Health Care Services (SBHS) webpage
Who do I contact if I need help enrolling providers or to check on status of an application?	**Provider Enrollment** 1-800-562-3022 ext. 16137 ProviderEnrollment@hca.wa.gov How to Enroll Servicing Providers training
Who do I contact if I need help with ProviderOne?	ProviderOne Billing and Resource Guide **Provider Relations** ProviderRelations@hca.wa.gov **ProviderOne Help Desk** provideronesecurity@hca.wa.gov
Who do I contact if I have questions on denied claims?	**School District Contracted with Billing Agent** Contact your Billing Agent **Self-Billing School District** Contact Shanna.Muirhead@hca.wa.gov
Who do I contact if I have questions on the IGT process, invoice inquiries, or need copies of my invoices?	**Accounting** HCASchoolBased@hca.wa.gov
Who do I contact if I need a copy of my SBHS interagency agreement?	**Contract Services** Contracts@hca.wa.gov
How do I sign up for SBHS GovDelivery messages?* *SBHS program and policy updates are sent via GovDelivery. At least one contact per district should be signed up to receive these messages.	GovDelivery Subscription

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Assessment – Medically necessary tests given to a child by a licensed professional to evaluate whether a child is determined to be a child with a disability, and is in need of special education and related services. Assessments are a part of the evaluation and reevaluation process, and must accompany the individualized education program (IEP) or individualized family service plan (IFSP).

Centers for Medicare and Medicaid Services (CMS) –See WAC 182-500-0020.

Child with a disability – A child evaluated and determined to need special education and related services because of a disability in one or more of the following eligibility categories:

- Autism
- Deaf – blindness
- Developmental delay for children ages three through nine, with an adverse educational impact, the results of which require special education and related direct services
- Hearing loss (including deafness)
- Intellectual disability
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Serious emotional disturbance (emotional behavioral disturbance)
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment (including blindness)

(WAC 392-172A-01035)

Core Provider Agreement (CPA) – A contract, known as the Core Provider Agreement (CPA), governs the relationship between the agency and Apple Health (Medicaid) providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, agency rules and regulations, and agency program policies, provider notices, and provider guides, including this guide. Providers must submit a claim according to agency rules, policies, provider alerts, and provider billing guides in effect for the date of service.

Current procedural terminology (CPT) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

Early intervention services - Services designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development, as identified in the infant or toddler's individualized family service plan (IFSP), in any one or more of the following areas, including:

- Physical development;
- Cognitive development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Electronic signature - A signature in electronic form attached to or associated with an electronic record including, but not limited to, a digital signature.

Evaluation – Procedures used in accordance with WAC 392-172A-03005 through 392-172A-03080 to determine whether a child has a disability, and the nature and extent of the special education and related services that the child needs. (WAC 392-172A-01070)

Evaluation Report – See WAC 392-172A-03035.

Fee-for-Service – See WAC 182-500-0035.
Habilitation – Services that address cognitive, social, fine motor, gross motor, or other skills that contribute to mobility, communication, and performance of activities of daily living skills (ADLs) to enhance the quality of life.

Handwritten signature – A scripted name or legal mark of an individual on a document to signify knowledge, approval, acceptance, or responsibility of the document.

Health care common procedure coding system (HCPCS) – Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes.

Health Care Authority (HCA) – The single state agency that oversees the Washington State Apple Health (Medicaid) program. Throughout this guide, HCA is referred to as the agency.

Health care-related services – Developmental, corrective, and other supportive services required to assist an eligible child to benefit from special education. For the purpose of the School-Based Health Care Services program, related services include audiology, counseling, nursing, occupational therapy, physical therapy, psychological assessments, and speech-language therapy.

Individuals with Disabilities Education Act (IDEA) – A United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities from birth through age 20.

Individualized Education Program (IEP) – A written educational program for a child, who is age three through twenty and eligible for special education. An IEP is developed, reviewed, and revised in accordance with WAC 392-172A-03090 through 392-172A-03135. (WAC 392-172A-01100)

Individualized Family Service Plan (IFSP) - A plan for providing early intervention services to a child, birth through age two, with a disability or developmental delay and the child's family. The IFSP is based on the evaluation and assessment described in 34 CFR 303.321 and includes the content specified in 34 CFR 303.344. The IFSP is developed under the IFSP procedures in 34 CFR 303.342, 303.343, and 303.345.

Interagency agreement – A contract, also known as an interagency agreement, which describes and defines the relationship between the state Medicaid agency, the SBHS program, and the school district. The SBHS interagency agreement allows the agency to establish an Intergovernmental Transfer framework to reimburse the school district for providing Medicaid covered services by qualified health care professionals that are included in a child's current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

Medically necessary – See WAC 182-500-0070.

National Provider Identifier (NPI) – See WAC 182-500-0075.

ProviderOne – Washington State's consolidated single payment system for Medicaid, medical, and similar health care provider claims.

Qualified health care provider – See WAC 182-537-0350.

Recipient Aid Category (RAC) – Categories assigned to a Medicaid recipient that are used to assign benefits.

Reevaluation – Procedures used to determine whether a child continues to be in need of special education and related services. See WAC 392-172A-03015.

Rehabilitation – Services provided to address a child's physical, sensory, and mental capabilities lost due to an injury, illness, or disease. Services are prescribed in the IEP or IFSP and are designed to assist a child in compensating for deficits that cannot be reversed medically.

School-Based Health Care Services Program (SBHS) – School-based health care services for infants and toddlers receiving early intervention services and children who require special education services which are diagnostic, evaluative, habilitative, and rehabilitative in nature; are based on the child's medical needs; and are included in the child's IEP or IFSP. The agency pays school districts for school-based health care services delivered to Medicaid-eligible children who require special education services under Section 1903 (c) of the Social Security Act, and Individuals with Disabilities Education Act (IDEA) Part B (3 through 20 years of age) and Part C (birth through 2 years of age)

School-Based Health Care Services Program Specialist or SBHS Specialist - An individual identified by the agency who is responsible for managing the SBHS program.

Signature log - A typed list that verifies a licensed provider's identity by associating each provider's signature with their name, handwritten initials, credentials, license and national provider identification (NPI) numbers.

Special education – See WAC 392-172A-01175.

Supervision - Supervision that is provided by a licensed health care provider either directly or indirectly in order to assist the supervisee in the administration of health care-related services outlined in the IEP or IFSP.

Telemedicine – See WAC 182-531-1730.

Program Overview

What is the purpose of this billing guide?

The purpose of this billing guide is to provide program policy and guidance to contracted school districts in order to successfully implement and maintain the School-Based Health Care Services (SBHS) program to receive Medicaid reimbursement. The billing guide does not supersede federal Centers for Medicare and Medicaid Services (CMS) policy.

What is the SBHS program?

WAC 182-537-0100

The Health Care Authority (the agency) pays school districts for school-based health care services (SBHS) provided to children who require special education services consistent with Sections 1905(a) and 1903 (c) of the Social Security Act. The services must do all of the following:

- Identify, treat, and manage the education-related disabilities (mental, emotional, and physical) of a child who requires special education services
- Be prescribed or recommended by a physician or other licensed health care provider operating within the provider's scope of practice under state law (See Referrals and prescriptions)
- Be medically necessary
- Be diagnostic, evaluative, habilitative, or rehabilitative in nature
- Be included in the child's current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP)
- Be provided in a school setting

Who can participate in the SBHS program?

Washington State public school districts, educational service districts (ESDs), public charter schools, and tribal schools are eligible to participate in the SBHS program. Throughout this guide, these entities will be referred to as school districts.

What are the participation requirements of the SBHS program?

In order to participate in the SBHS program, school districts must:

- Enter into an interagency agreement with the SBHS program.
- Apply for a National Provider Identifier (NPI) through National Plan and Provider Enumeration System (NPPES).
- Enroll as a billing provider in ProviderOne and sign a Core Provider Agreement (CPA).
- Enroll school district providers and contracted providers who participate in SBHS as servicing providers under the school district's ProviderOne account.
- Bill according to this billing guide, Chapter 182-537 WAC for SBHS, and the SBHS interagency agreement.
- Participate in the intergovernmental transfer (IGT) process.
- Assign one or two staff to be the SBHS coordinator(s).
- Sign up to receive SBHS GovDelivery email messages.
- Complete and submit the *Provider and Contact Update Form* (HCA form 12-325) (see Where can I download agency forms?) the agency's SBHS program specialist annually and as changes occur.

What is the role of the SBHS coordinator?

Each school district should assign at least one staff member as the SBHS coordinator. The role of the SBHS coordinator may vary by school district. Tasks and activities will most likely include:

- Enrolling eligible providers in ProviderOne
- Collecting treatment notes from providers and entering claims in ProviderOne
- Maintaining and submitting the *Provider and Contact Update Form* (HCA Form 12-325)
- Forwarding IGT A-19 invoices to appropriate school district fiscal or accounting staff
- Receiving SBHS GovDelivery messages and communicating program updates with providers and school district staff

What is the intergovernmental transfer (IGT) process?

Schools are reimbursed for SBHS through an intergovernmental transfer (IGT) process. IGT is the transfer of public funds between governmental entities. Public funds are derived from local tax-based dollars, are not local funds being used as match for other federal programs, and meet federal matching regulations.

- The SBHS program is funded by a 50/50 federal and nonfederal split. School districts are required to submit 60% (local match) of the nonfederal split, and the agency is responsible for providing 40% of the nonfederal split.
- After the school district submits claims in ProviderOne, the agency's accounting office emails an invoice to the SBHS coordinator and the school district business manager within 30-60 days.
- The SBHS coordinator and school district business manager are responsible for forwarding the invoice to the appropriate school district staff member who will process the invoice and submit local match to the agency.
- School districts have 120 days from the invoice date to provide local match. Once the local match is received from the school district, the agency releases claims for payment.
- The reimbursement, or total computable, provided to the school district includes the return of the local match, the state matching funds, and the federal funds.

Note: If local match is not received within 120 days of the invoice date, the agency will deny claims. School districts may resubmit denied claims within 24 months of the date of service.

What is the Provider and Contact Update Form?

The *Provider and Contact Update Form* (HCA 12-325) is a form that must be completed and submitted to the SBHS program specialist at the beginning of each school year. By providing updated information to the agency, the school district ensures that the SBHS program updates are sent to the appropriate contact, ensures timely payment of claims, and ensures program success.

- The SBHS coordinator at each school district is required to submit the completed form to the agency's SBHS program specialist annually by October 31st and throughout the year as provider and staff changes occur.
- Page 1 of the *Provider and Contact Update Form* must include current school district contact information.
- Page 2 must include all providers who will be billing the agency for reimbursement and any providers who have resigned within the past year.
- Detailed instructions are included on pages 3 and 4 of the form to assist school districts with completing the form.
- The form can be found on the SBHS webpage or the agency's Billers and providers webpage (see Where can I download agency forms?).

Note: School districts are not required to submit copies of provider licensure, NPI verification, and transcripts with the update form. However, these documents must be current and on file with the school district and available for review upon request.

Will receiving SBHS affect a child's Medicaid or other benefits?

School districts may not charge parents for the costs of SBHS included in a child's IEP or IFSP. The school receives federal, state, and local funding to cover the costs of these services so the child may receive a Free and Appropriate Public Education (FAPE) as required by law.

Parents should understand that allowing the school district to bill the agency for their child's in-school services does not in any way minimize Medicaid services the child receives outside of school. Parents are not required to enroll in Medicaid or insurance programs in order for their child to receive a FAPE under Part B of the Individuals with Disabilities Education Act (IDEA). See 34 C.F.R. 300.154.

Client Eligibility

Children who require special education services must be receiving Title XIX Medicaid under a categorically needy program (CNP) or medical needy program (MNP) to be eligible for school-based health care services.

How can I verify a child's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for. Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Program benefit packages and scope of services webpage.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's webpage at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization eligible?

Yes. SBHS for eligible clients enrolled in an agency-contracted managed care organization (MCO) are covered under Washington Apple Health fee-for-service. Bill the agency directly for all SBHS provided to eligible agency-contracted MCO clients.

Which recipient aid category (RAC) codes are not eligible for reimbursement?

The agency reimburses school districts for medically necessary SBHS provided to children receiving Title XIX Medicaid. School districts are responsible for conducting monthly eligibility checks (see How can I verify a child's eligibility?) since student eligibility can change from one month to the next. The following RAC codes are not eligible for reimbursement through the SBHS program:

1032	1179	1189	1211-1213
1033	1184	1193-1195	1215
1138-1142	1185	1206	1216
1176	1187	1207	

Provider Qualifications

Who may provide school-based health care services (SBHS)?

WAC 182-537-0350

The agency pays school districts to provide certain healthcare-related services (see Coverage). These services must be delivered by a qualified health care provider who meets federal and state licensing and certification requirements and who is enrolled with the agency under Chapter 182-502 WAC. Providers must hold active and unrestricted licensure or certification with the Washington State Department of Health (DOH).

School districts must ensure that health care providers meet DOH licensing and certification requirements. Each provider must have their own individual national provider identifier (NPI) and be enrolled as a servicing provider under the school district's ProviderOne account.*

*Non-credentialed staff who have been delegated certain health care tasks by a registered nurse (RN) do not need to apply for an NPI or be enrolled in ProviderOne. Services provided by non-credentialed staff must be billed under the supervising RN's NPI in ProviderOne.

Services	Provider Qualifications
Audiology	Audiologists must meet requirements of Chapter 246-828 WAC and Chapter 18.35 RCW
Counseling	The following counseling professionals must meet requirements of Chapter 246-809 WAC and Chapter 18.225 RCW: Licensed independent clinical social workers (LiCSW) Licensed advanced social workers (LiACSW) Licensed mental health counselors (LMHC) Licensed mental health counselor associates (LMHCA) under the direction and supervision of a qualified LiCSW, LiACSW, or LMHC.

Services	Provider Qualifications
Nursing Services	The following nursing professionals must meet requirements of Chapter 246-840 WAC and Chapter 18.79 RCW: Licensed registered nurses (RN) Licensed practical nurses (LPN) under the direction and supervision of a qualified RN Exception: Non-credentialed school employees who are delegated certain limited health care tasks by an RN and are supervised according to professional practice standards in RCW 18.79.260
Occupational Therapy	The following occupational therapy professionals must meet requirements of Chapter 246-847 WAC and Chapter 18.59 RCW: Licensed occupational therapists (OT) Licensed occupational therapist assistant (OTA) under the direction and supervision of a qualified OT
Physical Therapy	The following physical therapy professionals must meet requirements of Chapter 246-915 WAC and Chapter 18.74 RCW: Licensed physical therapists (PT) Licensed physical therapist assistants (PTA) under the direction and supervision of a licensed PT
Psychology	Psychologists must meet requirements of Chapter 246-924 WAC and Chapter 18.83 RCW
Speech Therapy	The following speech language pathology professionals must meet requirements of Chapter 246-828 WAC and Chapter 18.35 RCW: Licensed speech-language pathologists (SLP) Speech-language pathology assistants (SLPA) under the direction and supervision of a licensed SLP

Which provider taxonomy codes are used for the SBHS program?

School districts must ensure that all providers have the correct taxonomy code listed in ProviderOne. Providers can have multiple taxonomy codes listed based on their specialty.

School districts must follow the coverage section of this billing guide and submit claims identifying the servicing provider using a provider taxonomy code for the following:

Service provider types	Servicing provider taxonomy codes
Audiologist	231H00000X
Licensed practical nurse	164W00000X
Mental health counselor	101YS0200X
Occupational therapist	225X00000X
Occupational therapist assistant	224Z00000X
Physical therapist	225100000X
Physical therapist assistant	225200000X
Psychologist	103TS0200X
Registered nurse	163WS0200X
Social worker	1041S0200X
Speech therapist	235Z00000X
Speech therapist assistant	2355S0801X

Note: Claims must include an identifying servicing provider taxonomy code and a billing provider taxonomy code (251300000X). The agency will deny claims with incorrect taxonomy codes.

What are the provider supervision requirements?

For services provided under the supervision of a physical therapist, occupational therapist, speech-language pathologist, nurse, counselor, or social worker, the following requirements apply:

- The nature, frequency, and length of the supervision must be provided in accordance with professional practice standards, and be sufficient to ensure a child receives quality services.

- The supervising provider must see the child face-to-face when services begin and at least once more during the school year.

- Supervisors are responsible for approving and cosigning all treatment notes written by the supervisee before submitting claims for payment.

- Documentation of supervisory activities must be recorded and available to the agency or its designee upon request.

How do school districts enroll providers in ProviderOne?

School districts must enroll all licensed health care providers who participate in SBHS as servicing providers under the school district's ProviderOne account before submitting claims to the agency. Providers may be school district staff or subcontractors. Failure to enroll licensed health care providers will result in denied claims.

For assistance in enrolling providers, school districts can:

- View the How to Enroll Servicing Providers training located on the SBHS webpage.

- Schedule ProviderOne training with the agency's Provider Relations section by emailing them at ProviderRelations@hca.wa.gov.

- Contact Provider Enrollment for additional assistance with enrolling providers. (See Resources Available)

What is the provider revalidation process?

Federal regulations within the Affordable Care Act (ACA) require state Medicaid agencies to revalidate the enrollment of all Medicaid providers once every five years. The agency implemented a Medicaid provider revalidation process starting in December 2013.

When a school district is selected for revalidation, the agency's Provider Enrollment notifies the district via letter. The revalidation notice is sent to the contact and mailing address listed in ProviderOne.

- To ensure the revalidation notification reaches your school district, login to ProviderOne to confirm your mailing address is up-to-date. If you need assistance logging in to ProviderOne, contact ProviderOne Security.

- Revalidation letters specify the requirements for each school district. Requirements for all school districts include:

  ✓ Updated disclosures of ownership, managing employees, and other controlling interests in the ProviderOne portal (required under the Code of Federal Regulations 42 CFR 455.104).

    - Managing employee is defined as a general manager, business manager, administrator, director or other person who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. See 42 CFR 455.101.
    - All disclosing entities must provide the name, address, date of birth (DOB), and Social Security Number (SSN) of any managing employee. See 42 CFR 455.104.
    - It is at each school district's discretion to determine which school district personnel meets the definition of "managing employee."

  ✓ A signed Core Provider Agreement (form 09-015), Debarment Statement (form 09-016), and copy of current liability insurance. See Where can I download agency forms?

  ✓ An Internal Revenue Service (IRS) W-9 form.

  ✓ Other documents specific to your provider or organization type (if required).

- Additional information about the provider revalidation process can be found on the HCA webpage.

Which providers cannot participate in the SBHS program?

Interim permit holders

People who have been issued an interim permit from DOH are not eligible to receive Medicaid reimbursement through the SBHS program, even when performing services under the supervision of a DOH licensed provider. School districts can identify an interim permit holder by looking at the DOH documentation provided to the person or online through DOH's provider credential search.

Licensing exemptions

The licensing exemptions found in the following regulations do not apply to federal Medicaid reimbursement:

- Counseling as found in RCW 18.225.030
- Psychology as found in RCW 18.83.200
- Social work as found in RCW 18.320.010
- Speech therapy as found in RCW 18.35.195

People providing services under these exemptions are not eligible for Medicaid reimbursement through the SBHS program.

Coverage

What is covered?

WAC 182-537-0400

The agency covers:

- Evaluations when the child is determined to have a disability and needs special education and health care-related services.
- Reevaluations to determine whether a child continues to need special education and health care-related services.
- Health care-related services included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), limited to:
  - ✓ Audiology services
  - ✓ Counseling services
  - ✓ Nursing services
  - ✓ Occupational therapy services
  - ✓ Physical therapy services
  - ✓ Psychological assessments
  - ✓ Speech-language therapy services

All covered services under this section may be provided through telemedicine as described in WAC 182-531-1730. See When does the agency cover telemedicine?

Note: Evaluations and reevaluations are reimbursable only when they result in an IEP or IFSP in the specific service(s) being evaluated.

Referrals and prescriptions

In order to receive reimbursement for SBHS, services must be prescribed or referred by a physician *or other licensed provider of the healing arts within the provider's scope of practice under state law.*

Some services do not require a physician's referral or prescription. Providers participating in SBHS should review relevant sections of Title 246 WAC and Title 18 RCW specific to their provider type to confirm whether a physician's referral or prescription is required.

What is telemedicine?

WAC 182-531-1730

Telemedicine is when a qualified health care provider uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within the provider's scope of practice to a client at a site other than the site where the provider is located.

When does the agency cover telemedicine?

The agency covers telemedicine when it is used to substitute for an in-person face-to-face, hands-on encounter for only those services specifically listed in this billing guide. The provider furnishing services via telemedicine must be enrolled as a servicing provider under the school district's billing national provider identifier (NPI) in ProviderOne.

Originating site (location of client)

An originating site is the physical location of the client at the time the service is provided by a licensed professional through telemedicine. For the SBHS program, the approved originating site is the school.

Distant site (location of provider)

A distant site is the physical location of the qualified health care provider providing the service to a client through telemedicine

Billing for services provided via telemedicine

When the originating site is a school and the provider at the distant site is enrolled as a provider with the school district, the school district submits a claim on behalf of both the originating and distant site.

The school district bills for the telemedicine facility fee using HCPCS code Q3014 as well as the CPT code for the service provided. Schools must use the appropriate CPT code **with modifier GT** when submitting claims to the agency for payment. The payment amount for the service provided is equal to the current fee schedule amount.

> **Note:** To receive payment for the facility fee, HCPCS code Q3014 must be billed on the same claim as the corresponding CPT code. Treatment notes must clearly reflect when services were provided via telemedicine.

What is not covered?

WAC 182-537-0500

It is the responsibility of the school district to contact the SBHS program specialist for questions regarding covered and noncovered services. Noncovered services include, but are not limited to the following:

- Applied behavioral analysis (ABA) therapy
- Attending meetings
- Charting
- Equipment preparation
- Evaluations that do not result in an IEP or IFSP
- Instructional assistant contact
- Observation
- Parent consultation
- Parent contact
- Planning
- Preparing and sending correspondence to parents or other professionals
- Professional consultation
- Report writing
- Review of records
- School district staff accompanying a child who requires special education services to and from school on the bus
- Teacher contact
- Test interpretation
- Travel and transporting

Coverage Tables

Note: If no time is listed in the short description or comments column, the procedure code is untimed See Using Timed and Untimed Procedure Codes. Untimed codes can be billed once per provider, per client, per day, unless otherwise noted in the comments column.

Audiology services

Audiology services include:

- Assessing hearing loss
- Determining the range, nature, and degree of hearing loss; and including the referral for medical and other professional attention for restoration or rehabilitation due to hearing disorders
- Providing rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determining the need for individual amplification

Listed below are the descriptions of covered audiology services with the corresponding CPT® codes. Licensed audiologists can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
92552	Pure tone audiometry air	
92553	Audiometry air & bone	
92555	Speech threshold audiometry	
92556	Speech audiometry complete	
92557	Comprehensive hearing test	
92567	Tympanometry	
92568	Acoustic reflex testing, threshold	
92570	Acoustic immittance testing	
92579	Visual audiometry (vra)	
92582	Conditioning play audiometry	

Procedure Code	Short Description	Comments
92587	Evoked auditory test limited	
92588	Evoked auditory tst complete	
92620	Auditory function 60 min	Timed 60 minutes
92621	Auditory function + 15 min	Each additional 15 minutes
92521	Evaluation of speech fluency	
92522	Evaluate speech production	
92523	Speech sound lang comprehen	
92524	Behavral qualit analys voice	
92507	Speech/hearing therapy	
92508	Speech/hearing therapy	
92551	Pure tone hearing test air	
92630	Audio rehab pre-ling hear loss	
92633	Audio rehab postling hear loss	
97127	Ther ivntj w/focus cog funcj	
97533	Sensory integration	Timed 15 minutes

Counseling services

Counseling services are for the purpose of assisting a child with adjustment to the child's disability.

Listed below are the descriptions of covered counseling services with the corresponding billing codes. Licensed psychologists, licensed independent clinical social workers (LiCSWs), licensed advanced social workers (LiACSWs), licensed mental health counselors (LMHCs), and licensed mental health counselor associates (LMHCAs) can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
90791	Psych diagnostic evaluation	
S9445	Pt education noc individ	Review MUE guidelines for maximum allowable billable units
S9446	Pt education noc group	
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Nursing services

Nursing services include:

- Medical and remedial services ordered by a physician or other licensed health care provider within the provider's scope of practice.

- Assessments, reassessments, and treatment services, provided to do all of the following:

  ✓ Prevent disease, disability, or the progression of other health conditions
  ✓ Prolong life
  ✓ Promote physical health, mental health, and efficiency

Listed below are the descriptions of covered nursing services with the corresponding billing codes. Licensed registered nurses (RNs) and licensed practical nurses (LPNs) can provide the following services within their scope of practice. Services provided by non-credentialed staff who have been delegated certain tasks by an RN must be billed under the supervising RN's NPI in ProviderOne.

Procedure Code	Short Description	Comments
T1001	Nursing assessment/evaluatn	Review MUE guidelines for maximum allowable billable units.
T1002**	RN services up to15 minutes	Timed 15 minutes
T1003**	LPN/LVN services up to 15 minutes	Timed 15 minutes

**See the services used with these codes below.

Use codes T1002 and T1003 when billing for the following services. Covered nursing services include but are not limited to:

- Blood glucose testing and analysis
- Bowel/diarrhea/urination care (including colostomy care)
- Catheterization care
- Chest wall manipulation/postural drainage
- Dressing/wound care
- Feeding by hand (oral deficits only)
- Intravenous care/feedings
- Medication administration: oral, enteral, parenteral inhaled, rectal, subcutaneous, and intramuscular. Also includes eye drops and ear drops.
- Nebulizer treatment
- Pump feeding
- Seizure management
- Stoma care
- Testing oxygen saturation levels and adjusting oxygen levels
- Tracheostomy care
- Tube feedings
- Vital signs monitoring

Psychological assessments and services

Psychological assessments include psychological and developmental testing and therapy.

Listed below is the description of the covered psychological service with the corresponding billing code. Licensed psychologists can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
96101	Psycho testing by psych/phys	Timed 60 minutes
90791	Psych diagnostic evaluation	
S9445	Pt education noc individ	Review MUE guidelines for maximum allowable billable units.
S9446	Pt education noc group	
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Occupational therapy services

Occupational therapy services include:

- Assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving ability to perform tasks for independent functioning when functions are lost or impaired.
- Preventing initial or further impairment or loss of function through early intervention.

Listed below are descriptions of covered occupational therapy services with the corresponding billing codes. Licensed occupational therapists (OTs) and occupational therapist assistants (OTAs) can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
95851	Range of motion measurements	Review MUE guidelines for maximum allowable billable units.
95852	Range of motion measurements	

Procedure Code	Short Description	Comments
97110	Therapeutic exercises	Timed 15 minutes
97112	Neuromuscular reeducation	Timed 15 minutes
97127	Ther ivntj w/focus cog funcj	
97150	Group therapeutic procedures	
97165	OT eval low complex, 30 min	
97166	OT eval mod complex, 45 min	
97167	OT eval high complex, 60 min	
97168	OT re-eval est plan care	
97530	Therapeutic activities	Timed 15 minutes
97533	Sensory integration	Timed 15 minutes
97535	Self-care management training	Timed 15 minutes
97537	Community/work reintegration	Timed 15 minutes
97542	Wheelchair management training	Timed 15 minutes
97750	Physical performance test	Timed 15 minutes
97755	Assistive technology assess	Timed 15 minutes
97760	Orthotic management and training	Timed 15 minutes
97761	Prosthetic training	Timed 15 minutes
97763	Orthc/prostc mgmt sbsq enc	Timed 15 minutes

Physical therapy services

Physical therapy services include assessing, preventing, and alleviating movement dysfunction and related functional problems.

Listed below are descriptions of covered physical therapy services with the corresponding billing codes. Licensed physical therapists (PTs) and physical therapist assistants (PTAs) can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
95851	Range of motion measurements	See MUE guidelines for maximum allowable billable units.
95852	Range of motion measurements	
97110	Therapeutic exercises	Timed 15 minutes
97112	Neuromuscular reeducation	Timed 15 minutes
97116	Gait training therapy	Timed 15 minutes
97124	Massage therapy	Timed 15 minutes
97139	Physical medicine procedure	Timed 15 minutes
97150	Group therapeutic procedures	
97161	PT eval low complex, 20 min	
97162	PT eval mod complex, 30 min	
97163	PT eval high complex, 45 min	
97164	PT re-eval est plan care	
97530	Therapeutic activities	Timed 15 minutes
97535	Self-care management training	Timed 15 minutes
97537	Community/work reintegration	Timed 15 minutes
97542	Wheelchair management training	Timed 15 minutes
97750	Physical performance test	Timed 15 minutes

Procedure Code	Short Description	Comments
97755	Assistive technology assess	Timed 15 minutes
97760	Orthotic management and training	Timed 15 minutes
97761	Prosthetic training	Timed 15 minutes
97763	Orthc/prostc mgmt sbsq enc	Timed 15 minutes
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Speech-language therapy services

Speech-language therapy services include:

- Assessing speech and language disorders
- Diagnosing and appraising speech and language disorders
- Providing speech or language services to prevent communicative disorders
- Referring to medical and other professionals necessary for rehabilitation of speech and language disorders

Listed below is the description of the covered speech-language pathology services with the corresponding billing code. Licensed speech language pathologists (SLPs) and speech language pathologist assistants (SLPAs) can provide the following services within their scope of practice:

Procedure Code	Short Description	Comments
92521	Evaluation of speech fluency	
92522	Evaluate speech production	
92523	Speech sound lang comprehen	
92524	Behavral qualit analys voice	
92507	Speech/hearing therapy	
92508	Speech/hearing therapy	
92551	Pure tone hearing test air	
92568	Acoustic reflex testing, threshold	

Procedure Code	Short Description	Comments
92570	Acoustic immittance testing	
92607	Ex for speech device rx 1 hr	Timed 60 minutes
92608	Ex for speech device rx addl	Timed additional 30 minutes
92609	Use of speech device service	
92610	Evaluate swallowing function	
92630	Aud rehab pre-ling hear loss	
92633	Aud rehab postling hear loss	
97127	Ther ivntj w/focus cog funcj	
97533	Sensory integration	Timed 15 minutes

Payment

What are the requirements for payment?

WAC 182-537-0600

To receive payment from the agency for providing school-based health care services (SBHS) to eligible children, a school district must:

- Have a current, signed core provider agreement (CPA) with the agency.
- Have a current, signed, and executed interagency agreement with the agency.
- Meet and comply with the applicable requirements in Chapter 182-502 WAC.
- Enroll providers as a servicing provider under the district's ProviderOne account and ensure providers have their own National Provider Identifier (NPI).
- Comply with the agency's current ProviderOne Billing and Resource Guide.
- Bill according to the SBHS Billing Guide and the SBHS Fee Schedule.
- Comply with the intergovernmental transfer (IGT) process.
- Meet and comply with the applicable requirements in Chapter 182-537 WAC.
- Provide only health care-related services identified in a current individualized education program (IEP) or individualized family service plan (IFSP).
- Use only qualified health care professionals, as described in this billing guide, who are acting within the scope of their license or certification according to Provider Qualifications.
- Meet the documentation requirements in this billing guide (see Documentation).

How do I review my remittance advice (RA) and why is this important?

The remittance advice (RA) provides needed information for school districts to check the status of claims. It is important for school districts to review their RAs weekly to determine if claims were paid, determine if any claims were denied and review the explanation for the denial. School districts should contact the agency's SBHS program specialist, Provider Relations Unit, or their billing agent with questions about denied claims (See Resources Available). Instructions on how to review the RA are available in the ProviderOne Billing and Resource Guide.

Documentation

What documentation requirements are there for school districts?

WAC 182-537-0700 and 182-502-0020

Providers must document all school-based health care services (SBHS) as specified in this billing guide. Sufficient documentation to justify billed claims must be maintained for at least 6 years from the date of service.

Maintaining records in an electronic format is acceptable. Each school district is responsible for determining what standards are consistent with state and federal electronic record requirements.

Records for each student must include:

- A referral or prescription for services by a physician or licensed health care professional. See Referrals and prescriptions.
- Professional assessment reports completed by a licensed professional.
- Evaluation and reevaluation reports.
- A comprehensive individualized education program (IEP) or individualized family service plan (IFSP).
- Attendance records for each student receiving services.
- Treatment notes. Treatment notes must include the:
  - ✓ Child's name
  - ✓ Child's date of birth
  - ✓ Child's ProviderOne client ID
  - ✓ Date of service, and for each date of service:
    - ➢ Time-in
    - ➢ Time-out
    - ➢ A corresponding procedure code(s) and number of billed units for each service provided
    - ➢ A description of each service provided

- The child's progress related to each service
- Whether the treatment described in the note was individual or group therapy

- All required documentation and treatment notes for each date of service require the licensed provider's printed name, handwritten or electronic signature, and title.

- Assistants, as defined in the Provider Qualifications section of this billing guide, who provide health care-related services, must have their supervisor cosign all documentation in accordance with the supervisory requirements for the provider type.

- As described in WAC 182-502-0020, all records must be easily and readily available to the agency upon request.

Note: If a school district contracts with a billing agent, the agency does not require the servicing provider to sign for each date of service on the service log. One signature per page is acceptable only if the service log is used as backup documentation to the treatment notes.

Signature requirements

The provider's signature on all records and treatment notes verifies the services have been accurately and fully documented, reviewed, and authenticated. It confirms the provider has certified the medical necessity and reasonableness for the service(s) provided.

For a signature to be valid, the following criteria must be met:

- Signatures are handwritten, electronic, or stamped (stamped signatures are permitted only in the case of an author with a physical disability who can provide proof of an inability to sign due to a disability).

- Signatures must be legible.

Signature log

School districts must maintain a signature log to support signature identity, which must include the provider's:

- Printed name
- Handwritten signature
- Initials
- Credentials
- License number
- NPI number

Note: If a provider has various signatures, all versions of the provider's signature must be included on the signature log.

School districts are responsible for the accuracy of the signature log. This log does not need to be provided to the agency, but must be kept on file at the school and made available for all monitoring activities.

A sample signature log is available on the SBHS webpage.

Electronic Signatures

The school district and the person whose name is represented by the electronic signature are responsible for the authenticity of the signature. Each school district should recognize the potential for misuse or abuse when using electronic signatures and should determine, at its own risk, what standards are consistent with state and federal electronic requirements. School districts should develop policies and procedures to ensure complete, accurate, and authentic records. These policies and procedures should include:

- Security provisions to prevent the use of an electronic signature by anyone other than the licensed provider to which the electronic signature belongs.
- Procedures that follow recognized standards and laws that protect against modification.
- Protection of the privacy and integrity of the documentation.
- A list of which documents will be maintained and signed electronically.

Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

How does third-party liability affect claims submitted to the agency?

WAC 182-501-0200

Providers must bill the child's primary insurance before seeking reimbursement from the agency for school-based health care services (SBHS). This means that knowing a child's eligibility status prior to billing is very important.

If the agency receives a bill for services provided to a child with primary insurance, the claim will be denied. Federal law makes Medicaid the payer of last resort.

The district may rebill a denied claim only after doing both of the following:

- Receiving a denial letter or Explanation of Benefits (EOB) from the child's primary insurance carrier.
- Attaching the written denial or EOB with the claim to the agency. For instructions on how to attach documents to claims, see Claims and Billing.

School districts may choose not to bill the agency for services provided to special education children who have third-party insurance. However, the school district must:

- Bill third-party carriers before billing the agency.
- Have on file at the school district written consent from the child's parent or guardian to bill their insurance carrier.

When the agency is being billed**,** follow the instructions found in the agency's ProviderOne Billing and Resource Guide.

What is the National Correct Coding Initiative?

The agency continues to follow the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare & Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the agency to control improper coding that may lead to inappropriate payment. The agency bases coding policies on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Procedure code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

Procedure-to-procedure (PTP) edits – Part of the NCCI policy is PTP edits. The purpose of PTP edits is to prevent improper payment when incorrect HCPCS or CPT code combinations are reported by a provider for the same patient on the same date of service. Not all HCPCS or CPT codes are assigned a PTP edit. The SBHS program adheres to the CMS PTP edits for all codes in this billing guide.

Medically Unlikely Edits (MUEs) - Part of the NCCI policy are MUEs. MUEs are the maximum unit of service per HCPCS or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a "Medically Unlikely Edit." Not all HCPCS or CPT codes are assigned an MUE. The agency follows the CMS MUEs for all codes.

The agency may have units of service edits that are more restrictive than MUEs.

The agency may perform a post-payment review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system. More information on NCCI can be found on the CMS webpage.

Procedure codes

The agency uses the following types of procedure codes within this billing guide:

- Current Procedure Terminology (CPT)
- Level II Healthcare Common Procedure Coding System (HCPCS)

Services performed must match the description and guidelines from the most current CPT or HCPCS manual for all covered SBHS.

Using untimed and timed procedure codes

School districts and providers are responsible for billing the appropriate procedure codes and units for the service(s) provided.

Untimed Codes

If a code's short description does not include time, the code is billed as one unit regardless of how long the service takes, unless otherwise noted in the "comments" column of the covered services tables. Providers should consult a current CPT or HCPCS manual, or the CMS webpage for additional guidance if needed.

The agency denies claims submitted for more than the maximum allowable units per day.

Timed Codes

For any code reimbursed based on time, each measure of time as defined by the code description equals one unit. For codes that are billed per 15 minutes, a minimum eight minutes of service must be provided to bill for one unit**.** Partial units must be rounded up or down to the nearest quarter hour.

To calculate billing units for 15-minute timed codes, count the total number of billable minutes for the calendar day for the eligible student and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples:

Minutes	**Units**
0 min-7 mins	0 units
8 mins-22 mins	1 unit
23 mins-37 mins	2 units
38 mins-52 mins	3 units
53 mins-67 mins	4 units
68 mins-82 mins	5 units

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

The following claim instructions relate to school-based health care services providers.

Name	Action
Place of Service	Enter 03 School
Diagnosis Code	Enter R69 (Illness, unspecified)
Charges	If billing for more than one unit, enter the total charge of the units being billed.

Note: Using a place of service code other than 03 will result in denied claims.

Fee Schedule

The SBHS Fee Schedule provides information about procedure codes and the maximum allowable payment rate per unit. The agency updates the fee schedule as the national codes are updated. School districts are expected to check the agency's webpage for the current program fee schedule.

Program Integrity

What program integrity activities does the agency conduct?

WAC 182-537-0800

To ensure compliance with program rules, the agency conducts program integrity activities under Chapter 182-502A WAC.

- School districts must participate in all program integrity activities.
- School districts are responsible for the accuracy, compliance, and completeness of all claims submitted for Medicaid reimbursement.
- The agency conducts reviews and recovers overpayments if a school district is found not in compliance with agency requirements according to RCWs 74.09.200, 74.09.220, and 74.09.290.