Notice: We launched a new web site. As a result, past versions of the billing guide, such as this one, have broken hyperlinks. Please review the current guide for the correct hyperlinks.

Washington Apple Health

SCHOOL-BASED HEALTH CARE SERVICES FOR CHILDREN IN SPECIAL EDUCATION

Provider Guide

October 1, 2015

Washington State Health Care Authority

About this guide*

This publication takes effect October 1, 2015, and supersedes earlier guides to this program.

> 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
Billing and Claim Forms	ICD-9 code has changed throughout this billing guide to ICD-10 codes **Effective for claims with dates of service on and after October 1, 2015,** the agency requires the use of ICD-10 coding. ICD-9 codes may only be used for claims with dates of service before October 1, 2015.	Policy change
Telemedicine	Added definition for telemedicine and coverage information	Policy change
Client Eligibility	Added clarification that clients enrolled in an agency-contracted managed care organization are eligible for school based health care services through fee-for-service	Coverage clarification
Provider Qualifications	Added clarification that "each provider must be enrolled as a servicing provider under the school district's billing NPI."	Clarification
Licensure and Certificate Requirements	Clarified that copies of all new health care professionals' licenses issued by the Department of Health and verification of their NPIs must be submitted to the agency annually.	Requirement clarification
Procedure codes	Added section regarding types of procedure codes allowed under the SBHS program	Billing clarification
Payment	Added bullet stating, "Ensure all providers are enrolled as servicing providers under the school district's billing NPI."	Payment clarification
Documentation requirements	Removed "Documentation the child was present at the IEP meeting."	Child is not required to be at the IEP meeting
Identifying servicing providers on a claim	Added a chart for service provider types and note about taxonomy code requirement	Billing information

* This guide is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's Provider Publications website.

Table of Contents

Definitions

This section defines terms and abbreviations, including acronyms, used in this guide. Refer to the agency's online Washington Apple Health Glossary for a more complete list of definitions.

Amount, duration, and scope – A written statement within the Individualized Education Program (IEP) that addresses sufficiency of services to achieve a particular goal (i.e., a treatment plan for *how much* of a health care-related service will be provided, *how long* a service will be provided, and *what* the service is).

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 IEP.

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 eight, with an adverse educational impact, the results of which require special education and related direct services
- Hearing impairment (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)

Direct health care-related services – Services provided directly to a child either one-on-one or in a group setting. This does not include special education.

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

Face-to-face supervision or direct supervision – Supervision that is conducted onsite, in-view, by an experienced licensed health care practitioner to assist the supervisee to develop the knowledge and skills to practice effectively, including administering the treatment plan.

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.

Health care common procedure coding system (HCPCS) - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

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.

Indirect supervision – Those activities (other than direct observation and guidance) conducted by an experienced licensed health care practitioner that may include demonstration, record review, review and evaluation of audio-or videotaped sessions, and interactive television.

Individualized Education Program (IEP) – Individualized education program or IEP means a written statement of an educational program for a student eligible for special education that is developed, reviewed, and revised in accordance with WAC 392-172A-03090 through 392-172A-03135. (WAC 392-172A-01100).

Plan of care or treatment plan – A written document that outlines the health care-related needs of a child in special education. The plan is based on input from the health care practitioner and written approval from the parent or guardian.

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

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

Regular consultation – Face-to-face contact between the supervisor and supervisee that occurs no less than once a month.

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 and 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 children in special education that are diagnostic, evaluative, habilitative, or rehabilitative in nature; are based on the child's medical needs; and are included in the child's individualized education plan (IEP). The agency pays school districts for school-based health care services delivered to Medicaid-eligible children in special education under Section 1903 (c) of the Social Security Act, and Individuals with Disabilities Education Act (IDEA) Part B (3-21 years old).

School-Based Health Care Services Program Specialist or SBHS Specialist – An individual identified in the Interagency Agreement School District Reimbursement contract.

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

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

Program Overview

What is the purpose of the school-based health care services program?

WAC 182-537-0100

The Health Care Authority (the agency) pays school districts for school-based health care services provided to children in special education consistent with Section 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 in special education
- Be prescribed or recommended by a physician or other licensed health care provider operating within the provider's scope of practice under state law
- Be medically necessary
- Be diagnostic, evaluative, habilitative, or rehabilitative in nature
- Be included in the child's current Individualized Education Program (IEP)

Client Eligibility

Children in special education 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 Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

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 website 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. School-based health care services 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 school-based health care services provided to eligible agency-contracted MCO clients.

Provider Qualifications

Who may deliver school-based health care services?

WAC 182-537-0350

The agency pays school districts to provide certain health-care-related services (see Coverage). These services must be delivered by a licensed health care provider who is enrolled with the agency and holds a current professional license. School districts must ensure that health care providers meet professional licensing and certification requirements and each provider must be enrolled as a servicing provider under the school district's billing national provider identifier (NPI).

Services	Licensed Providers
Audiology	Licensed audiologists
Counseling	Licensed independent social workers (LiCSW) Licensed advanced social workers (LiACSW) Licensed mental health counselors (LMHC) Licensed mental health counselor associates (LMHCA) under the supervision of a licensed professional
Nursing Services	Licensed registered nurses (RN) Licensed practical nurses (LPN) who are supervised by an RN Non-credentialed school employees who are delegated certain limited health care tasks by an RN and are supervised according to professional practice standards
Occupational Therapy	Licensed occupational therapists (OT) Licensed occupational therapist assistants (OTA) supervised by a licensed OT
Physical Therapy	Licensed physical therapists (PT) Licensed physical therapist assistants (PTA) who are supervised by a licensed PT
Psychology	Licensed psychologists

Services	Licensed Providers
Speech Therapy	Licensed speech-language pathologists (SLP) Speech-language pathology assistants (SLPA) who: ✓ Have graduated from a speech-language pathology assistant program at a board-approved institution ✓ Are supervised by a speech-language pathologist with a current Certificate of Clinical Competence (CCC) and two years of work experience

What are the licensure and certificate requirements and practitioner qualifications?

- 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 therapy services

  ✓ The supervising therapist must see the child face-to-face at the beginning of each school year and at least once more during the school year

  ✓ At a minimum, supervision must be face-to-face communication between the supervisor and the supervisee once per month. 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

- Annually, school districts must submit to the agency's SBHS Program Manager a new, completed School-based Health Care Provider Update Form, 12-325 by **October 31**. This form must be submitted along with copies of all new health care professionals' licenses issued by the Washington State Department of Health (DOH) and verification of the national provider identifier (NPI) number.

  ✓ School districts must maintain copies of all documents.

- ✓ To receive payment from the agency for providing services, school districts must provide verification of the health care professional's education, license, and NPI number within thirty (30) days after the start of employment.

- ✓ School districts must enroll their licensed health care providers under their Billing NPI number before submitting claims to the agency. Failure to enroll licensed health care providers will result in claims being denied automatically.

- Licensing exemptions found in the following regulations do not apply to federal Medicaid reimbursement for the services indicated:

  - ✓ 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

Procedure codes

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

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

Coverage

What is covered?

WAC 182-537-0400

Agency-covered services include:

- 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.
- Direct health care-related services, including:
  - ✓ Audiology services
  - ✓ Counseling services
  - ✓ Nursing services
  - ✓ Occupational therapy services
  - ✓ Physical therapy services
  - ✓ Psychological assessments
  - ✓ Speech-language therapy services
- Telemedicine

Audiology services

Audiology services include:

- Assessing hearing loss.
- Determining the range, nature, and degree of hearing loss, 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.
- The below-listed descriptions of covered audiology services with the corresponding CPT® codes. Services must be provided by a licensed audiologist.

Note: Due to its licensing agreement with the American Medical Association, the HCA publishes only the official, short CPT® code descriptions. To view the full descriptions, refer to a current CPT book.

Procedure Code	Modifier	Short Description
92552	None	Pure tone audiometry air
92553	None	Audiometry air & bone
92555	None	Speech threshold audiometry
92556	None	Speech audiometry complete
92557	None	Comprehensive hearing test
92567	None	Tympanometry
92568	None	Acoustic reflex testing, threshold
92570	None	Acoustic reflex testing
92579	None	Visual audiometry (vra)
92582	None	Conditioning play audiometry
92587	None	Evoked auditory test limited
92587	26	Evoked auditory test limited [professional component]
92587	TC	Evoked auditory test limited [technical component]
92588	None	Evoked auditory tst complete
92588	26	Evoked auditory tst complete [professional component]
92588	TC	Evoked auditory tst complete [technical component]
92620	None	Auditory function 60 min
92621	None	Auditory function + 15 min

The following services may be billed by a licensed speech-language pathologist or audiologist:

Procedure Code	Modifier	Short Description
92521	None	Evaluation of speech fluency
92522	None	Evaluate speech production
92523	None	Speech sound lang comprehen
92524	None	Behavral qualit analys voice
92507	None	Speech/hearing therapy
92508	None	Speech/hearing therapy
92551	None	Pure tone hearing test air
92630	None	Audio rehab pre-ling hear loss
92633	None	Audio rehab postling hear loss
97532	None	Cognitive skills development
97533	None	Sensory integration

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. Services must be provided by a licensed professional.

Procedure Code	Modifier	Short Description	Maximum Allowable Fee
S9445	None	Pt education noc individ	See the fee schedule.
S9446	None	Pt education noc group	

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, treatment services, and supervision of delegated health care 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 descriptions of covered nursing services with the corresponding billing codes.

Procedure Code	Modifier	Short Description	Maximum Allowable Fee
T1001	None	Nursing assessment/evaluatn	See the fee schedule.
T1002*	None	RN services up to15 minutes	
T1003*	None	LPN/LVN services up to 15 minutes	

*See the services used with these codes on the next page.

How to Bill for Nursing Services Correctly	
9:00 a.m. – 9:02 a.m. 9:09 a.m. – 9:10 a.m. 9:11 a.m. – 9:14 a.m. } Multiple nursing interventions involved up to 15 minutes	8:00 a.m. – 8:05 a.m. = 1 intervention 9:00 a.m. – 9:02 a.m. = 1 intervention 9:16 a.m. – 9:30 a.m. = 1 intervention 9:41 a.m. – 9:45 a.m. = 1 intervention } A maximum of 4 units of billable service per 1 hour

Multiple interventions within a 15-minute time frame may only be billed as one unit.
One or more interventions performed up to 15 minutes = A single billable unit of service.

Use codes T1002 and T1003 when billing for the following services:

- Blood glucose testing and analysis
- Catheterization care
- Chest wall manipulation/postural drainage
- Nebulizer treatment
- Nurse delegation (training, supervision, and delegated task performed by a nurse extender)
- Stoma care

- Dressing/wound care
- Intravenous care/feedings
- Medication administration: oral, enteral, parenteral inhaled, rectal, subcutaneous, and intramuscular. Also includes eye drops and ear drops.
- Seizure management (direct care during seizures)
- Vital signs monitoring (per encounter)
- Testing oxygen saturation levels and adjusting oxygen levels
- Tracheotomy care/(suction and equipment maintenance)
- Tube feedings
- Pump feeding (setup, administer and take down only)
- Feeding by hand (oral deficits only) under direct supervision of an RN.
- Bowel/diarrhea/urination care (including colostomy care)

Psychological assessments

Psychological assessments include psychological and developmental testing and therapy.

Listed below is the description of the covered psychological service with the corresponding billing code. Services must be provided by a licensed professional.

Procedure Code	Modifier	Short Description
96101	None	Psycho testing by psych/phsy
S9445	None	Pt education noc individ
S9446	None	Pt education noc group
CPT® codes and descriptions only are copyright 2014 American Medical Association. All Rights Reserved.		

Recommendations for services must be updated at least annually.

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.

Procedure Code	Modifier	Short Description
95851	None	Range of motion measurements
95852	None	Range of motion measurements
97003	None	Ot evaluation
97004	None	Ot reevaluation
97110	None	Therapeutic exercises
97112	None	Neuromuscular reeducation
97150	None	Group therapeutic procedures
97530	None	Therapeutic activities
97532	None	Cognitive skills development
97533	None	Sensory integration
97535	None	Self-care management training
97537	None	Community/work reintegration
97542	None	Wheelchair management training.
97750	None	Physical performance test
97755	None	Assistive technology assess

Procedure Code	Modifier	Short Description
97760	None	Orthotic management and training
97761	None	Prosthetic training
97762	None	C/o for orthotic/prosthesis use

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.

Procedure Code	Modifier	Short Description
95851	None	Range of motion measurements
95852	None	Range of motion measurements
97001	None	Pt evaluation
97002	None	Pt re-evaluation
97110	None	Therapeutic exercises
97112	None	Neuromuscular reeducation
97116	None	Gait training therapy
97124	None	Massage therapy
97139	None	Physical medicine procedure
97150	None	Group therapeutic procedures
97530	None	Therapeutic activities
97535	None	Self-care management training
97537	None	Community/work reintegration

Procedure Code	Modifier	Short Description
97542	None	Wheelchair management training.
97750	None	Physical performance test
97755	None	Assistive technology assess
97760	None	Orthotic management and training
97761	None	Prosthetic training
97762	None	C/o for orthotic/prosthesis use

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. Services must be provided by a licensed speech-language pathologist.

Procedure Code	Modifier	Short Description
92521	None	Evaluation of speech fluency
92522	None	Evaluate speech production
92523	None	Speech sound lang comprehen
92524	None	Behavral qualit analys voice
92507	None	Speech/hearing therapy

92508	None	Speech/hearing therapy
92551	None	Pure tone hearing test air
92568	None	Acoustic reflex testing, threshold
92570	None	Acoustic immittance testing
92607	None	Ex for speech device rx 1 hr
92608	None	Ex for speech device rx addl
92609	None	Use of speech device service
92610	None	Evaluate swallowing function
92630	None	Aud rehab pre-ling hear loss
92633	None	Aud rehab postling hear loss
97532	None	Cognitive skills development
97533	None	Sensory integration

Note:

A unit of service is based on the CPT and HCPCS code descriptions.

- Each 15 minutes equals one unit.
- If the code description does not include time, the service described by the code equals one unit regardless of how long the procedure takes.

Telemedicine

WAC 182-531-1730

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

For additional information on telemedicine, see Physician-Related Services/Health Care Professional Services Billing Guide.

Procedure Code	Modifier	Short Description
Q3014	None	Telehealth facility fee

What is not covered?

WAC 182-537-0500

Noncovered services are listed below; services marked with an asterisk are built in to the reimbursement rate for covered services:

- Applied behavioral analysis therapy*
- Attending meetings*
- Charting*
- Equipment preparation*
- Instructional assistant contact*
- 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 in special education to and from school on the bus
- Set-up (except for pump feeding)
- Teacher contact
- Test interpretation

- Travel and transporting

- Continuous observation of a child when direct school-based health care services are not actively provided

The agency pays for the act of watching carefully and attentively only if it involves actual interventions. For the purposes of this guide, the School-Based Health Care Services Program does not reimburse school districts for a registered nurse (RN) or licensed practical nurse (LPN) to monitor a child continuously throughout the school day. This is applicable to all therapeutic professionals, RNs, LPNs, and nurse extenders who have been trained and are under supervision of a nurse. It is the responsibility of the school district to contact the School-Based Health Care Services Program Specialist for questions regarding covered and noncovered services.

Payment

What are the requirements for payment?

WAC 182-537-0600

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

- Have a current, signed core provider agreement (CPA) with the agency. A copy of the CPA must be on-site within the school district.
- Have a current, signed, and executed interagency agreement with the agency. A copy of the agreement must be on-site within the school district for review as requested.
- Meet and comply with the applicable requirements in Chapter 182-502 WAC.
- Comply with the agency's ProviderOne Billing and Resource Guide.
- Bill according to this guide, the School-Based Health Care Services Fee Schedule, and the intergovernmental transfer (IGT) process. After school districts receive their invoice from the agency, they have 120 days to provide the agency with their local match.
- Meet the applicable requirements in Chapter 182-537 WAC.
- Provide only health care-related services identified in a current individualized education program (IEP).
- Use only licensed health care professionals, as described in this guide, who are acting within the scope of his or her license according to the Provider Qualifications section.
- Ensure all providers are enrolled as servicing providers under the school district's billing national provider identifier (NPI).
- Meet the documentation requirements in this guide (see Documentation).
- Duplicate occupational, physical, and speech-therapy services are not allowed for the same client when both providers are performing the same or similar interventions.

Documentation

What documentation requirements are there for school districts?

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

Providers must document all health care-related services as specified in this guide. Assistants, as defined in the Provider Qualifications section of this guide, who provide health care-related services, must have their supervisor co-sign all documentation in accordance with the supervisory requirements for the provider type. Sufficient documentation to justify billed claims must be maintained for at least 6 years from the date of service, and include:

- Professional assessment reports completed by a licensed professional.
- Evaluation and reevaluation reports by the individualized education program (IEP) team members.
- A comprehensive IEP.
- Treatment notes for each date of service the licensed provider billed to the agency. Treatment notes must include:

  ✓ **A descriptive narrative outlining the activities and interventions involved that are directly related to the current IEP.** Clinical treatment notes must reflect the amount, scope, and duration of the service (e.g., a brief description of the service provided, how long it took to complete the intervention or service, the reason for changes in interventions, changes in the student's behavior, and any training and supervision provided by a registered nurse). A few examples of the level of detail the SBHS program requires are:

    - Discussion on the activities of daily living, such as buttoning skills.
    - Description of the Range of Motion (ROM), such as elbow or wrist ROM.
    - Medication management, Tegretol, 200 mg (oral).
    - Narrative of the student's progress or response to each service delivered (required for nursing services and recommended for all other services).

  ✓ The child's name, date of birth, and ProviderOne Client ID.

  ✓ The date of service, actual time-in and time-out, and the number of billed units for the service.

- ✓ Indication if the treatment note was for individual or group therapy (e.g., counseling, occupational therapy, physical therapy, psychological services, and speech therapy).

- ✓ The licensed provider's original signature, title, date treatment note was signed, and National Provider Identifier (NPI) number. Electronic signatures are allowed only on electronic applications, enrollment forms, and eligibility documents in accordance to RCW 41.05.014.

- ✓ The following documents require the licensed provider's original signature—electronic signatures are not acceptable:

    - ➢ Individual Health Plans (nursing only)
    - ➢ Treatment notes
    - ➢ Therapy plans
    - ➢ Written treatment protocols
    - ➢ All documentation of Medicaid-covered services provided to a eligible child. Examples include:

        - Assessments
        - Treatment notes
        - Daily documentation (other notes that support treatment notes)
        - Encounter notes (nursing only)
        - Medication Administration Reports

- Nursing-services documentation must include the outcomes of service, for example, whether or not the services were effective, what the response was, and the method used if the initial method did not work. Documentation of results is required for all nursing services.

- In all clinical practice, treatment notes must give a clear, comprehensive picture of the continual status, the care being provided, and the child's response to the intervention.

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

Program Monitoring

What program monitoring and auditing does the agency conduct?

WAC 182-537-0800

- School districts must participate in all agency monitoring and auditing activities.
- School districts are responsible for the accuracy, compliance, and completeness of all claims submitted for Medicaid reimbursement.
- The agency conducts monitoring activities annually according to Chapter 182-502A WAC.
- The School-Based Health Care Services Program Specialist conducts a minimum of 10 school-based Medicaid program reviews annually. During this time frame, the agency:
  - ✓ Completes a minimum of 5 record reviews as a desk review.
  - ✓ Conducts a minimum of 5 record reviews on-site.
- The agency conducts audits 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, which concern audits and investigations of providers.
- Annually, school districts must submit to the agency or its designee the following information by October 31:
  - ✓ A completed Provider Update Form, 12-325, to include current and new providers
  - ✓ Copies of all new health care professionals' licenses issued by the Washington State Department of Health (DOH)
  - ✓ Verification of the National Provider Identifier (NPI) number for new providers

What about third-party liability?

WAC 182-501-0200

Providers must bill the child's primary insurance before seeking reimbursement from the agency for IDEA-related health care services. 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 the following:

- Receiving a denial letter or Explanation of Benefits (EOB) from the child's primary insurance carrier.
- Forwarding the written denial with the claim to the agency's Coordination of Benefits section.

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.

Billing and Claim Forms

How do I complete the CMS-1500 claim form?

The agency's online Webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- DDE Professional claim
- DDE Professional with Primary Insurance
- DDE Medicare Crossover Claim

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to school-based health care services providers.

In field	Enter
24B	03
24E	R69 (Illness, unspecified)

See the fee schedule for the agency's current maximum allowable fees.

Note: The fee schedule is updated typically each July. Providers are expected to check the agency's website for the current program fee schedule.

How do I identify servicing providers on a claim?

School districts must follow the coverage section of this 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
Licensed vocational nurse	164X00000X
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 are required to have an identifying servicing provider taxonomy code and a billing provider taxonomy code (251300000X). If claims are submitted without the correct taxonomy codes, the claim will be denied.