Washington State Health Care Authority

Medicaid Provider Guide

School-Based Health Care Services for Children in Special Education

Chapter 182-537 WAC

January 1, 2014

Washington State Health Care Authority

A Billing Instruction

About this guide

This guide supersedes all previous *School-Based Health Care Services for Children in Special Education Medicaid Provider Guides* published by the Health Care Authority (agency).

Note: The underlined words and phrases are links in this guide. Some are internal, taking you to a different place within the document, and some are external to the guide, leading you to information on other websites.

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-114 Changes to Chapter 182-537 WAC.	01/01/14	Determining client eligibility	Updated the information to include wahealthplanfinder.
		Provider qualifications	Clarified that school districts' qualified health care providers must be enrolled with the Medicaid agency.
		Licensing and certificate requirements	Clarified that a supervising therapist must see the child face-to-face at the beginning of services and at least once more during the school year.
		Nursing Services	Added additional details about covered nursing services.
		Coverage	Deleted CPT code 92506 and replaced it with CPT codes 92521, 92522, 92523, and 92524.
		Payment	Deleted the school district requirement related to prior, informal, written notification for parents or guardians.
		All	Made minor changes throughout the document.

How can I get agency provider documents?

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

Copyright Disclosure

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Definitions

This section defines select terms used in this provider guide.
Refer to the agency's Medical Assistance Glossary for additional 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 nine, with an adverse educational impact, the results of which require special education and related direct services
- Hearing impairment (including deafness)
- Mental retardation
- 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)

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

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 (ADL's) 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) – A written statement of an educational program for a child eligible for special education. (WAC 392-172A-03095 through WAC 392-172A-03135).

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 (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.

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

Special education – See WAC 392-172A-01180.

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

What are the eligibility basics?

Children in special education must be receiving Title XIX Medicaid under a categorically needy program (CNP) or medically 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.

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.

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
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 a new, completed School-based Health Care Provider Update Form, 12-325 by October 31. This form must be submitted along with copies of current licenses of all current and newly hired performing providers.

  - ✓ 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.

- 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

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

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, please 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
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 his or her 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
- Dressing/wound care
- Intravenous care/feedings
- Medication administration: oral, enteral, parenteral inhaled, rectal, subcutaneous, intramuscular. Also includes eye drops and ear drops.
- Seizure management (direct care during seizures)
- Vital signs monitoring (per encounter)
- Nebulizer treatment
- Nurse delegation (training and supervision only)
- Stoma care
- 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)

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
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.
- 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
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

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

Recommendations for services must be updated at least annually.

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
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

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
- Telehealth practices
- 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 the applicable requirements in Chapter 182-502 WAC.
- Comply with the agency's ProviderOne Billing and Resource Guide, and the general provider requirements according to Chapter 182-502 WAC.
- 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.
- Meet the documentation requirements in this guide (see Documentation).

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

- For any code reimbursed based on time, each measure of time as defined by the code equals one unit.
- If the code description does not include time, the service described by the code equals one unit.

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 any documentation in accordance with the supervisory requirements for the provider type. Sufficient documentation to support and justify the billed and paid claims must be maintained for at least 6 years, and include:
  - ✓ Professional assessment reports.
  - ✓ Evaluation and reevaluation reports.
  - ✓ Individualized education program (IEP).
  - ✓ Treatment notes for each date of service the provider billed to the agency. Treatment notes must include:
    - ➢ The activity and intervention involved.
    - ➢ The child's name.
    - ➢ The child's ProviderOne Client ID.
    - ➢ The child's date of birth.
    - ➢ 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.
    - ➢ The licensed provider's original signature, title, and National Provider Identifier (NPI) number. For more information regarding NPIs, refer to the agency's School-Based Health Care Services webpage.
- 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 each health care professional's current license
  - ✓ Verification of the National Provider Identifier (NPI) number

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

Providers must follow the agency's ProviderOne Billing and Resource Guide. The guide explains how to complete the CMS-1500 Claim Form. For questions regarding claims, call the Washington Apple Health customer service center: 800-562-3022.

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

In field	Enter
24B	03
24E	*V41.9* (Unspecified problem with special functions).

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

Note: The updated fee schedule may not be available until January 1, 2014, so check the agency's website often until the fee schedule you are looking for appears.

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