Washington State Health Care Authority

Medicaid Provider Guide

School-Based Health Care Services for Children in Special Education [Chapter 182-537 WAC]

A Billing Instruction

What is the purpose of this guide?

This guide supersedes all previously published agency *School-Based Health Care Services for Children in Special Education Medicaid Provider Guides*. For more resources, see the agency's *Resources Available* web page.

What is the effective date of this guide?

See the "What has changed?" table for the effective date of this guide.

What has changed?

Reason for Change	Effective Date	Page No.	Subject	Change
Updated per changes to Chapter 182-537 WAC.	03/10/13	6-8	Definitions	Added/modified multiple definitions, including "amount, duration, and scope" and "special education."
See WSR 13-05-017.		9	About the program	Updated the description of the purpose of the program.
Notice sent via PN 13-13.		12-13	Provider qualifications	Extensively changed entire section.
		21	Psychological services	Added CPT codes S9445 and S9446.
		14-20	Covered services	Added CPT codes 95851 and 95852 under Physical therapy and updated code descriptions throughout.
		22-23	Noncovered services	Added and amended multiple items.
		24-25	Payment	Extensively changed entire section.
		26	Documentation	Extensively changed entire section.
		27	Program monitoring	Extensively changed entire section.
		28	Third-party liability	Amended provider requirements.

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.

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Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—do a "control + click" on a page number to go directly to a spot. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. If you don't immediately see the bookmarks, right click on the gray area next to the document and select Page Display Preferences. Click on the bookmark icon on the left.)

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Definitions

This section defines terms and abbreviations, including acronyms, used in the Medicaid Provider Guide. Please refer to the agency's *Medical Assistance 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 services will be provided, and *what* the service is). [WAC 182-537-0200]

Assessment – An assessment is made up of 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 re-evaluation process, and must accompany the IEP. [WAC 182-537-0200]

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)

[WAC 182-537-0200]

Core Provider Agreement – The basic contract the agency holds with providers serving medical assistance clients. [WAC 182-537-0200]

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. [WAC 182-537-0200]

Evaluation – Procedures used to determine whether a child has a disability, and the nature and extent of the special education and related services are needed.
[See WAC 392-172A-03005 through WAC 392-172A-03080] [WAC 182-537-0200]

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. [WAC 182-537-0200]

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 Authority (HCA) or **Agency** – See WAC 182-500-0010.

"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 all of the following:

- Audiology
- Counseling
- Nursing
- Occupational therapy
- Physical therapy
- Psychological assessments
- Speech-language therapy

[WAC 182-537-0200]

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. [See WAC 392-172A-03095 through WAC 392-172A-03135.]

Medical necessity or **"medically necessary"** See WAC 182-500-0070.

Plan of Care - A written document designed to ensure that a child's medical needs are properly met during school hours. The plan is based on input from the health care practitioner and written approval from the parent or guardian. [WAC 182-537-0200]

Qualified health care provider – See WAC 388-537-0350.

Re-evaluation – Procedures used to determine whether a child continues to be in need of special education and related services. [See WAC 392-172A-03015] [WAC 182-537-0200]

Regular consultation – Face-to-face contact between the supervisor and supervisee that occurs no less than once per 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 or **SBS** – School-based health care services for children in special education that are diagnostic, evaluative, habilitative, or rehabilitative in nature and must be based on the child's medical needs. The agency pays school districts for school-based health care services delivered to Medicaid-eligible children in special education in accordance with Section 1903 (c) of the Social Security Act. [WAC 182-537-0200]

School-Based Health Care Services Program Manager or SBS Manager – This individual is identified on page one (1) of the Interagency Agreement School District Reimbursement contract.

Special education -- Specially designed instruction, at no cost to the parents, to meet the unique needs of a student eligible for special education, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings, and instruction in physical education. [WAC 392-172A-01175]

About the Program

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

[Refer to 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 (i.e., mental, emotional, and physically) of a child in special education.
- Be prescribed or recommended by physicians or other licensed health care providers within their 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

Who is eligible?

[Refer to WAC 182-537-0300]

Please see the agency's *ProviderOne Billing and Resource Guide* for instructions on how to verify a child's eligibility.

> **Note:** Refer to the *Scope of Coverage Chart* web page for an up-to-date listing of Washington State's medical coverage.

How is eligibility for school-based health care services determined?

To determine if a child is eligible for medical assistance from the State of Washington, the parent or guardian must file an application with the Community Service Office (CSO). Applications may be completed and filed on-line or mailed to the local CSO.

To determine eligibility, all the information must be filed with the CSO. When all the information has been received, an eligibility worker will determine if the child qualifies for medical assistance.

For further information regarding applying for benefits, the parent or guardian may contact the Medical Assistance Customer Service Center. (See the agency's *Resources Available* web page.)

Are clients enrolled in a managed care plan eligible?

[Refer to WAC 182-537-0300]

YES! When verifying eligibility using ProviderOne, if the child is enrolled in an agency managed care plan, managed care enrollment will be displayed on the child's benefit inquiry screen. Children who are enrolled in a managed care plan receive school-based health care services on a fee-for-service basis.

All other health care services covered under a managed care plan must be obtained by the child's designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, check the child's eligibility **prior** to scheduling services, at the **time of the service,** and whether prior authorization or referral has been obtained. See the agency's *ProviderOne Billing and Resource Guide* for instructions on how to verify a child's eligibility. Any questions related to Medicaid must be directed to the Medical Assistance Customer Support Center (MACSC) at: https://fortress.wa.gov/dshs/p1contactus/ or 800-562-3022. For training-only questions related to ProviderOne, please contact Provider Relations at: providerrelations@hca.wa.gov.

Provider Qualifications

Who may deliver school-based health care services?

[Refer to WAC 182-537-0350]

The agency pays school districts to provide certain health care-related services (see Coverage). These services must be delivered by qualified health care providers who hold a current professional license (see the following table).

Service	Qualified Provider
Audiology	A licensed audiologist.
Counseling	• A licensed independent social worker (LiCSW). • A licensed advanced social worker (LiACSW). • A licensed mental health counselor (LMHC). • A licensed mental health counselor associate (LMHCA) under the supervision of a licensed professional.
Nursing Services	• A licensed registered nurse (RN). • A licensed practical nurse (LPN) who is supervised by an RN. • A non-credentialed school employee who is delegated certain limited health care tasks by an RN and is supervised according to professional practice standards.
Occupational Therapy	• A licensed occupational therapist (OT). • A licensed occupational therapist assistant (OTA) supervised by a licensed OT.
Physical Therapy	• A licensed physical therapist (PT). • A licensed physical therapist assistant (PTA) who is supervised by a licensed PT.
Psychology	A licensed psychologist.
Speech Therapy	• A licensed speech-language pathologist (SLP). • A speech-language pathology assistant (SLPA) who: ✓ Has graduated from a speech-language pathology assistant program from a board-approved institution. ✓ Is supervised by a speech-language pathologist with a current Certificate of Clinical Competence (CCC) and two years of work experience.

What are the licensure/certificate requirements and practitioner qualifications?

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

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

  - ✓ The supervising therapist must see the child face-to-face at the beginning of service and periodically 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 it's designee upon request.

- Annually in October, school districts must submit to the agency a new, completed School-based Health Care Provider Update Form, 12-325. This form must be submitted with copies of current licenses of all current and newly hired performing providers.

- School districts are responsible for submitting a School-based Health Care Provider Update Form, 12-325, along with a copy of the health care professional's license. 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 to the agency within thirty (30) days after the start of employment.

- School districts must ensure that health care providers meet professional licensing requirements.

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

  - ✓ 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?

[Refer to WAC 182-537-0400]

Agency-covered services include the following:

- Evaluations when the child is determined to have a disability, and is in need of special education and health care-related services.
- Re-evaluations to determine whether a child continues to need special education and health care-related services.
- Direct health care-related services, which include all of the following:

What audiology services are covered?

Audiology services include all of the following:

- Assessment of hearing loss.
- Determination of 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.
- Provision of rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the need for individual amplification.

Audiology Services (cont.)

Listed below are the descriptions of covered audiology services with the corresponding billing codes. Services must be provided by a licensed audiologist.

Procedure Code	Modifier	Short Description	Maximum Allowable Fee
92552	None	Pure tone audiometry air	Click here for current fee schedule
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 refl threshold tst	
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	Maximum Allowable Fee
92506	None	Speech/hearing evaluation	Click here for current fee schedule
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	

What speech therapy services are covered?

Speech therapy services include all of the following:

- Assessment of speech disorders, language disorders, or both.
- Diagnosis and appraisal of specific speech disorders, language disorders, or both.
- Provision of speech or language services for the prevention of communicative disorders.
- Referral for medical and other professional attention necessary for the rehabilitation of speech disorders, language disorders, or both.

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	Maximum Allowable Fee
92607	None	Ex for speech device rx 1 hr	Click here for current fee schedule
92608	None	Ex for speech device rx addl	
92609	None	Use of speech device service	
92610	None	Evaluate swallowing function	
92506	None	Speech/hearing evaluation	
92507	None	Speech/hearing therapy	
92508	None	Speech/hearing therapy	
92551	None	Pure tone hearing test air	
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 counseling services are covered?

Counseling services are for the purpose of assisting a child with adjustment to their 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	Click here for current fee schedule
S9446	None	Pt education noc group	

What nursing services are covered?

Nursing services include all of the following:

- Medical and remedial services ordered by a physician or other licensed health care provider within his/her 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	Click here for current fee schedule
T1002*	None	RN services up to15 minutes	
T1003*	None	LPN/LVN services up to 15 minutes	

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 singe billable unit of service.

*** Use this code when billing for the following services:**

- Blood glucose testing and analysis
- Catheterization
- 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.
- Nebulizer treatment
- Nurse delegation (initiation and re-evaluation)
- Stoma care
- Testing oxygen saturation levels and adjusting oxygen levels
- Tracheotomy care/suctioning
- Tube feedings
- Pump Feeding (Setup and take down only)

What occupational therapy services are covered?

Occupational therapy services include all of the following:

- 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	Maximum Allowable Fee
95851	None	Range of motion measurements	Click here for current fee schedule
95852	None	Range of motion measurements	
97003	None	Ot evaluation	
97004	None	Ot re-evaluation	
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 mngment training	
97537	None	Community/work reintegration	
97542	None	Wheelchair mngment training.	
97750	None	Physical performance test	
97755	None	Assistive technology assess	
97760	None	Orthotic mgmt and training	
97761	None	Prosthetic training	
97762	None	C/o for orthotic/prosthesis use	

What physical therapy services are covered?

Physical therapy services include all of the following:

- 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	Maximum Allowable Fee
95851	None	Range of motion measurements	Click here for current fee schedule
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 mngement training	
97537	None	Community/work reintegration	
97542	None	Wheelchair mngment training.	
97750	None	Physical performance test	
97755	None	Assistive technology assess	
97760	None	Orthotic mgmt and training	
97761	None	Prosthetic training	
97762	None	C/o for orthotic/prosthesis use	

What psychological services are covered?

Psychological services include psychological and developmental testing.

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	Maximum Allowable Fee
96101	None	Psycho testing by psych/phsy	Click here for current fee schedule
S9445	None	PT education noc individ	
S9446	None	PT education noc group	

Recommendations for services must be updated at least annually.

What is not covered?

[WAC 182-537-0500]

Non-covered services include, but are not limited to the following:

- Applied behavior analysis therapy.
- Attending meetings.
- Charting.
- Equipment preparation.
- School district staff accompanying a child in special education to and from school on the bus.
- Instructional assistant contact.
- Parent consultation.
- Parent contact.
- Planning.
- Preparing and sending correspondence to parents or other professionals.
- Professional consultation.

- Report writing.
- Review of records.
- Set-up.
- 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 Manager 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 do all of the following:

- 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.
- Meet the applicable requirements in Chapter 182-502 WAC.
- Comply with the agency's published *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).
- Give parents or guardians prior, informal, written notification on an annual basis, that the school district may be submitting claims for third-party insurance or Medicaid reimbursement as required by their child's IEP.

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.

How do I access the current fee schedule?

You may access the agency's School-Based Health Care Services Fee Schedule.

Documentation

What documentation requirements are there for school districts?

[Refer to WAC 182-537-0700]

- 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 a minimum of six years, and include at a minimum:

  - ✓ Professional assessment reports.
  - ✓ Evaluation and re-evaluation reports.
  - ✓ Individualized education program (IEP).
  - ✓ Treatment notes for each date of service the provider billed to the agency. Treatment notes must include all of the following information:
    - ➢ Activity and intervention involved.
    - ➢ Child's name.
    - ➢ Child's ProviderOne Client ID.
    - ➢ Child's date of birth.
    - ➢ 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, please 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/auditing does the agency conduct?

[WAC 182-537-0800]

- School districts must participate in all 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 agency 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.
  - ✓ Bases the monitoring and auditing activities on levels of Medicaid reimbursement.
- The agency conducts audits and recovers overpayments according to RCW 74.09.200, 74.09.220, and 74.09.290—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 health care professional's current license.
  - ✓ Verification of the National Provider Identifier (NPI) number.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's *ProviderOne Billing and Resource Guide*. These billing requirements include, but are not limited to, all of the following:

- What time limits exist for submitting and resubmitting claims and adjustments.
- How to submit claims according to National Correct Coding Initiative (NCCI[1]).
- When providers may bill a client.
- How to bill for services provided by a primary care case management (PCCM) clients.
- What standards to use for record keeping.

What about third-party liability?

[Refer to WAC 182-501-0200]

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

What does this mean?

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 stipulates that Medicaid is 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.

[1] The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods.

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 do all of the following:

- 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*.

How do I complete the CMS-1500 claim form?

Note: Refer to 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 specifically to school-based health care services providers.

Field No.	Name	Entry
24B.	**Place of Service**	Use Place of Service code **03 (School)**
24E.	**Diagnosis Code**	A diagnosis code related to the child's disability must be entered. (**Diagnosis Code: *V41.9****;*** *Unspecified problem with special functions*, can no longer be utilized for special education and related services.)

Note: For questions regarding claims information, please call *Medical Assistance Customer Service Center* at: **1-800-562-3022.**