

Washington Apple Health (Medicaid)

School-Based Health Care Services (SBHS) Billing Guide

January 1, 2019

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

About this guide*

This publication takes effect January 1, 2019, and supersedes earlier billing guides to this program.

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

What has changed?

Subject	Change	Reason for Change
Entire Guide	Housekeeping changes throughout to formatting, titles and tables. This includes new sections, updating hyperlinks, updating language for clarification, and updating billing information.	Clarification
I am a new SBHS coordinator, how do I gain access to ProviderOne?	Added new section with information for new SBHS coordinators on how to access ProviderOne.	Clarification
Student Eligibility	Updated section title (formerly <i>Client Eligibility</i>) and clarified language.	Clarification
Are students enrolled in a Washington Apple Health (Medicaid) managed care organization eligible for SBHS?	Updated section title (formerly <i>Are clients enrolled in an agency contracted managed care organization eligible?</i>) and clarified language.	Clarification
Are students who are covered by private insurance eligible for SBHS?	Updated section title (formerly <i>How does third party liability affect claims submitted to the agency?</i>) and clarified language.	Clarification
Which students are not eligible for reimbursement?	Updated section title (formerly <i>Which recipient aid category (RAC) codes are not eligible for reimbursement?</i>) and clarified language.	Clarification
How can I tell if a provider is eligible to participate in SBHS?	Added new section to clarify which providers can participate in SBHS.	Clarification

* This guide is a billing instruction.

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Subject	Change	Reason for Change
Eligible SBHS Provider Table	Added title and a column with hyperlinks to the DOH license requirements for each provider type.	Clarification
What do I do when a servicing provider no longer participates in SBHS?	Added section to clarify when providers should be end-dated in ProviderOne.	Clarification
Non-licensed people	Added new section to clarify which people are not eligible to participate in SBHS.	Clarification
Covered Services	Updated section title (formerly <i>Coverage</i>) and moved <i>Procedure Codes</i> and <i>What is the National Correct Coding Initiative</i> subsections from the <i>Billing Section</i> to the <i>Covered Service</i> section. Added new <i>NCCI Resources</i> subsection. Added title for <i>Telemedicine</i> subsection.	Clarification
Billing for services provided via telemedicine?	Added language clarifying billing instructions for services provided via telemedicine.	Update reflects policy change
Audiology services	Added procedure code S9152.	Update
Psychological assessments and services	Replaced procedure code 96101 with four new codes: 96130, 96131, 96136, and 96137.	Update reflects CMS code change
Speech-language therapy services	Added procedure code S9152.	Update
I am a self-billing school district. How do I submit claims in ProviderOne?	Renamed section (formerly <i>How do I bill claims electronically?</i>) and clarified language.	Clarification
Do I need to report SBHS payments on the SEFA?	Added new section.	Clarification
Remittance advice	Moved information from <i>Payment</i> section and clarified language.	Clarification

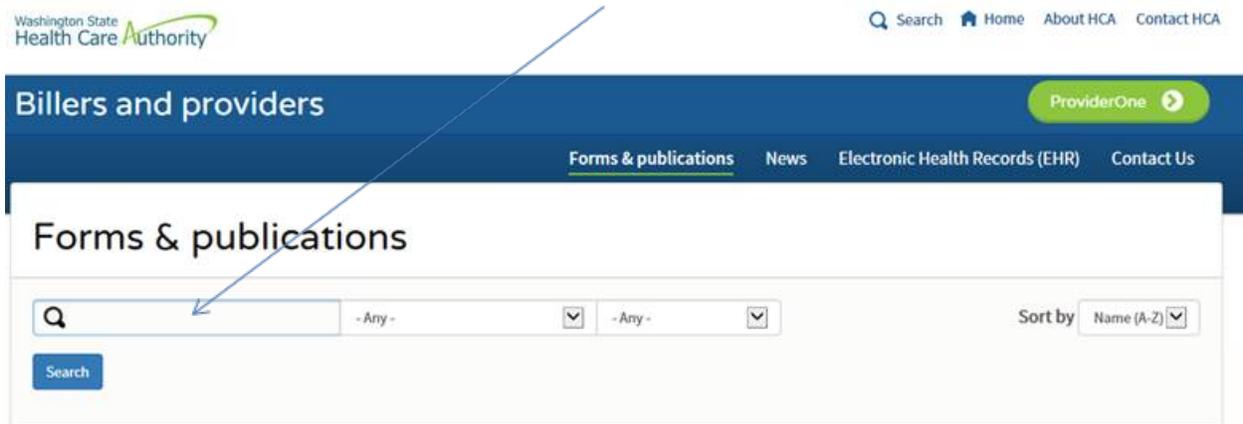
How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

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



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Resources Available

Topic	Resource Information
Who do I contact if I'm interested in contracting with the SBHS program or have questions regarding SBHS program policy?	<p>Shanna Muirhead, SBHS Program Specialist 360-725-1153 Email Shanna Muirhead</p>
Where can I find more information about the SBHS program and how do I enter into a contract with SBHS?	<p>School-Based Health Care Services (SBHS) webpage</p> <p>SBHS Checklist for Interested/New School Districts</p> <p>SBHS 101 Training</p>
I am a new SBHS coordinator. What resources are available to me?	<p>Checklist for New SBHS Coordinators</p> <p>SBHS 101 Training</p> <p>Additional training is available on the SBHS webpage</p>
Who do I contact if I need help enrolling providers in ProviderOne or to check on status of an application?	<p>Provider Enrollment 800-562-3022 ext. 16137 Email Provider Enrollment</p> <p>How to Enroll Servicing Providers training</p> <p>How to Enroll as a Billing Provider training</p>
I am a newly contracted school district. Who do I contact if I need help setting up my ProviderOne account?	<p>Provider Enrollment 800-562-3022 ext. 16137 Email Provider Enrollment</p>

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Topic	Resource Information
Who do I contact to reset my ProviderOne password, or if I am locked out of ProviderOne?	<p>ProviderOne Security 800-562-3022 ext. 19963</p> <p>Email ProviderOne Security</p>
Who do I contact if I have questions about denied claims?	<p>School District Contracted with Billing Agent Contact your Billing Agent</p> <p>Self-Billing School District Email Shanna Muirhead</p> <p>Email Provider Relations</p>
Who do I contact if I have questions on the IGT process, invoice inquiries, or need copies of my invoices?	<p>Email Accounting</p>
Who do I contact if I need a copy of my SBHS contract?	<p>Email Contract Services</p>
Who do I contact with questions about the provider revalidation process?	<p>Provider Enrollment 800-562-3022 ext. 16137</p> <p>Email Provider Enrollment</p>
<p>How do I sign up for SBHS GovDelivery messages?*</p> <p>*SBHS program and policy updates are sent via GovDelivery. At least one contact per district should be signed up to receive these messages.</p>	<p>GovDelivery Subscription</p>

Definitions

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

Assessment – Medically necessary tests given to a child by a licensed provider to evaluate whether a child with a disability is in need of early intervention or special education and related services. Assessments are a part of the individualized education program (IEP) or individualized family service plan (IFSP) evaluation and reevaluation processes.

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

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

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

[\(WAC 392-172A-01035\)](#)

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

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

Early intervention services – Developmental services provided to children ages birth through two. For the purposes of this billing guide, early intervention services include:

- Audiology services
- Nursing services
- Occupational therapy
- Physical therapy
- Psychological services
- Speech-language pathology

Electronic signature - See WAC 182-500-0030.

Evaluation – Procedures used to determine whether a student has a disability, and the nature and extent of the early intervention and special education and related services that the student needs. See [WAC 392-172A-01070](#) and [34 C.F.R. Sec. 303.321](#).

Fee-for-Service – See [WAC 182-500-0035](#).

GovDelivery email system – A tool the agency uses to send targeted messages to partners, customers, and stakeholders on topics of their choice.

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

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

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

Health care-related services – For the purposes of this billing guide, means developmental, corrective, and other supportive services required to assist a student eligible for special education, and includes audiology, counseling, nursing services, occupational therapy, physical therapy, psychological assessments and services, and speech-language therapy.

Individuals with Disabilities Education Act (IDEA) – A United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with

disabilities. It addresses the educational needs of children with disabilities from birth through age 20.

Individualized Education Program (IEP) – A written educational program for a child, who is age three through twenty and eligible for special education. An IEP is developed, reviewed, and revised in accordance with [WAC 392-172A-03090](#) through [392-172A-03115](#). ([WAC 392-172A-01100](#))

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

Medically necessary – See [WAC 182-500-0070](#).

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

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

Qualified health care provider – See [WAC 182-537-0350](#).

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

Reevaluation – Procedures used to determine whether a student continues to need early intervention or special education and related services. See [WAC 392-172A-03015](#) and C.F.R. Sec. 303.342 through Sec. 303.343.

Related services – See [WAC 392-172A-01155](#).

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

School-Based Health Care Services Program (SBHS)

– An agency-administered program that pays contracted school districts, educational service districts, charter schools, and tribal schools for providing early intervention services and special education health-related services to students ages birth through 20 who have an IEP or IFSP.

School-Based Health Care Services Program Specialist or SBHS Specialist

– A person identified by the agency who is responsible for managing the SBHS program.

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

Special education – See [WAC 392-172A-01175](#).

Student – For the purpose of this billing guide, means a person ages birth through 20 with a disability who is eligible for early intervention or special education and related services, has an active IFSP or IEP, and is covered by Title XIX Medicaid. The terms student and child may be used interchangeably throughout this billing guide.

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

Telemedicine – See [WAC 182-531-1730](#).

Program Overview

What is the purpose of this billing guide?

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

What is the SBHS program?

[WAC 182-537-0100](#)

The Health Care Authority (the agency) pays contracted school districts, educational service districts, charter schools, and tribal schools for school-based health care services (SBHS) provided to Medicaid-eligible children who require early intervention and special education services consistent with Sections [1905\(a\)](#) and [1903\(c\)](#) of the Social Security Act. School-based health care services must:

- Identify, treat, and manage the disabilities of a child who requires early intervention and special education services
- Be prescribed or recommended by a physician or other licensed health care provider operating within the provider's scope of practice under state law (See [Referrals and prescriptions](#))
- Be medically necessary. For the purposes of this billing guide, the services school-based providers render via an IEP or IFSP as a result of special education eligibility are health care-related by definition. Services are recommended to manage and treat the disability of a child who requires special education services and are recommended by a licensed health care provider (the school provider or other licensed Medicaid provider).
- Be included in the child's current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP)
- Be provided by Department of Health (DOH)-licensed providers
- Be provided in a school setting or by telemedicine

Who can participate in the SBHS program?

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

What are the participation requirements of the SBHS program?

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

- Enter into a contract with the SBHS program.
- Apply for a National Provider Identifier (NPI) through [National Plan and Provider Enumeration System \(NPPES\)](#).
- [Enroll as a billing provider](#) in ProviderOne, sign a Core Provider Agreement (CPA), and participate in all provider revalidation activities (See [What is the Provider Revalidation Process?](#))
- Enroll school district providers and contracted providers who participate in SBHS as servicing providers under the school district's ProviderOne account (See [How do I enroll providers in ProviderOne?](#)).
- Bill according to this billing guide, [Chapter 182-537 WAC](#) for SBHS, and the SBHS contract.
- Comply with the [intergovernmental transfer \(IGT\) process](#).
- Assign one or two staff to be the SBHS coordinator(s).
- Sign up to receive [SBHS GovDelivery email messages](#).
- Complete and submit the *Provider and Contact Update Form* (HCA form 12-325) (see [Where can I download agency forms?](#)) to the agency's SBHS program specialist annually by October 31 and throughout the year as changes occur.
- School districts interested in participating in the SBHS program may download the [SBHS Checklist for New School Districts](#) for more information.

What is the provider revalidation process?

Federal regulations within the Affordable Care Act (ACA) require state Medicaid agencies to revalidate the enrollment of all Medicaid providers once every five years.

By participating in the SBHS program, a school district and the servicing providers enrolled under the district's ProviderOne account are considered "Medicaid providers." When a school district is selected for revalidation, the agency's Office of Provider Enrollment notifies the school district via letter. The revalidation notice is sent to the contact and mailing address listed in ProviderOne.

- To ensure the revalidation notification reaches your school district, [login to ProviderOne](#) to confirm your mailing address is up-to-date. If you need assistance updating your address, contact Provider Enrollment. (See [Resources Available](#)).
- Revalidation letters specify the requirements for each school district. Requirements for all school districts include:
 - ✓ Updated disclosures of ownership, managing employees, and other controlling interests in the ProviderOne portal (required under the Code of Federal Regulations [42 CFR 455.104](#)).
 - Managing employee is defined as a general manager, business manager, administrator, director or other person who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. See [42 CFR 455.101](#).
 - All disclosing entities must provide the name, address, date of birth (DOB), and Social Security Number (SSN) of any managing employee. See 42 CFR 455.104.
 - It is at each school district's discretion to determine which school district personnel meets the definition of "managing employee."
 - ✓ A signed Core Provider Agreement (form 09-015), Debarment Statement (form 09-016), and copy of current liability insurance. See [Where can I download agency forms?](#)
 - ✓ An [Internal Revenue Service \(IRS\) W-9 form](#).
 - ✓ Other [documents specific to your provider or organization type](#) (if required).
- Additional information about the provider revalidation process can be found on the agency's [Billers, providers, and partners webpage](#).
- Questions about the revalidation process should be directed to [Provider Enrollment](#).

What is the role of the SBHS coordinator?

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

- Enrolling eligible providers in ProviderOne (See [How to Enroll Servicing Providers training](#))
- Collecting treatment notes from providers and entering claims in ProviderOne (for self-billing school districts)
- Maintaining the [Provider and Contact Update Form](#) (HCA Form 12-325) and submitting to the agency's SBHS program specialist annually and throughout the year as changes occur
- Forwarding IGT A-19 invoices to appropriate school district fiscal or accounting staff ([See What is the IGT process?](#))
- Receiving [SBHS GovDelivery](#) messages and communicating program updates with providers and school district staff
- New SBHS coordinators may download the [Checklist for New SBHS Coordinators](#) to assist with managing their school district's SBHS program

I am a new SBHS coordinator, how do I gain access to ProviderOne?

Contact the agency's [SBHS program specialist](#) for the name of the current ProviderOne System Administrator assigned to your district.

- If the system administrator is still employed with the district, they must add you as a "Super User" in ProviderOne by following directions in the [Creating ProviderOne users and adding profiles training](#).
- If the system administrator is no longer employed with the district, or if you want to replace the current system administrator, you must do all of the following:
 - ✓ Submit the [ProviderOne User Access Request form](#) and a letter on your organization's letterhead.
 - ✓ Ensure the letter states that the current system administrator (include their name) should no longer have access to ProviderOne.

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- ✓ Ensure the letter is signed by an office manager or provider who is not the same person requesting access to ProviderOne.
- ✓ Follow the contact information and instructions listed on the request form.
- ProviderOne Security will terminate the previous system administrator's access and assign confidential login credentials to the person named on the form as the new system administrator. The login credentials will be sent in two separate emails to the individual email address listed on the *ProviderOne User Access Request Form*.
- After you are set up as the system administrator, you will need to assign yourself as a "Super User" by following the directions in the [Creating ProviderOne users and adding profiles training](#).

What is the Provider and Contact Update Form?

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

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

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

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

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

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

Student Eligibility

Contracted school districts may receive Medicaid payment for providing SBHS to students who are receiving Title XIX Medicaid under a categorically needy program (CNP) or a medically needy program (MNP) and who are:

- Ages birth through two with an active individualized family service plan (IFSP); or,
- Ages three through 20 with an active individualized education program (IEP)

See [Which students are not eligible for reimbursement?](#)

How can I verify a student's Medicaid eligibility?

School districts must verify that a student has Washington Apple Health (Medicaid) coverage for the date of service, and that the benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for. School districts have two options when verifying Medicaid eligibility:

Option 1: View the [Checking Medicaid Eligibility](#) training on the [SBHS webpage](#).

Option 2:

Step 1. Review the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#) for detailed instructions on verifying a student's Medicaid eligibility.

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

Step 2. **Verify service coverage under the student's Washington Apple Health benefit package.** To determine if SBHS is a covered benefit under the student's Washington Apple Health benefit package, see the agency's [Program benefit packages and scope of services](#) webpage.

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

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

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

Are students enrolled in a Washington Apple Health (Medicaid) managed care organization eligible for SBHS?

Yes. SBHS provided to eligible students who are enrolled in an Apple Health managed care organization (MCO) is covered and paid under fee-for-service. School districts must bill the agency directly through ProviderOne for all SBHS provided to eligible students enrolled in an MCO. Receiving SBHS will not affect services the child receives outside of school.

Are students who are covered by private insurance eligible for SBHS?

Yes. Some students may be covered by a primary third party (private insurance) with Washington Apple Health (Medicaid) as secondary coverage. School districts may choose not to bill the agency for services provided to students who have private insurance. However, if a school district wants to bill for these students, they must bill the student's primary insurance before seeking Medicaid payment from the agency for SBHS. Federal law makes Medicaid the payer of last resort.

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If the agency receives a claim for services provided to a child with private insurance, the claim will be denied. To receive payment from the agency for services provided to a student with private insurance, the school district must:

- Bill the student’s private insurance carrier before billing the agency in order to receive a denial letter or Explanation of Benefits (EOB).
- Have on file at the school district written consent from the child’s parent or guardian to bill their insurance carrier (per IDEA regulations).
- Follow the instructions found in the [How to Submit SBHS Claims training](#).

Which students are not eligible for reimbursement?

The agency pays school districts for SBHS provided to children ages birth through twenty with an IEP or IFSP who are receiving Title XIX Medicaid (see [How can I verify a student’s eligibility?](#)) Children not covered by Title XIX Medicaid are identified by their recipient aid category or RAC code. School districts cannot bill for SBHS provided to students with the following RAC codes assigned in ProviderOne:

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

Provider Qualifications

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

[WAC 182-537-0350](#)

The agency pays school districts for providing certain healthcare-related services under an IEP or IFSP (see [Covered Services](#)). These services must be delivered by a licensed health care provider who meets federal and state licensing requirements and who is enrolled with the agency under [Chapter 182-502 WAC](#). **All providers participating in the SBHS program must hold active and unrestricted licensure with the Washington State Department of Health (DOH).***

School districts are responsible for ensuring that health care providers meet the applicable DOH licensing requirements. Additionally, each provider must have their own individual national provider identifier (NPI) and be enrolled as a servicing provider under the school district's ProviderOne account.**

*Nonlicensed school staff who have been delegated certain health care tasks by a registered nurse (RN) are the only exception to this requirement.

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

How can I tell if a provider is eligible to participate in SBHS?

To be eligible to participate in the SBHS program, providers must:

- Be employed by the school district/ESD or be a sub-contractor
- Be listed on the SBHS [Eligible Provider Table](#) and hold active and unrestricted licensure with the Washington State Department of Health (DOH). Use the [DOH Provider Credential Search](#) to look up a provider's DOH license number
- Have a national provider identifier (NPI)
 - ✓ Look up a provider's NPI through the [NPI registry](#)
 - ✓ Providers who do not have an NPI can apply through the [National Plan and Provider Enumeration System](#) (NPPES)
- Be enrolled as a servicing/rendering provider under the school district's ProviderOne account (See [How do I enroll providers in ProviderOne?](#))

Eligible SBHS Provider Table

Services	Eligible Provider Types	DOH License Requirements
Audiology	<ul style="list-style-type: none"> Licensed audiologists 	Audiologist
Counseling	<ul style="list-style-type: none"> Licensed independent clinical social workers (LiCSW) Licensed advanced social workers (LiACSW) Licensed mental health counselors (LMHC) Licensed mental health counselor associates (LMHCA) under the direction and supervision of a qualified LMHC Licensed psychologist 	Licensed independent clinical social worker Licensed advanced social worker Licensed mental health counselor Licensed mental health counselor associate Psychologist
Nursing Services	<ul style="list-style-type: none"> Licensed registered nurses (RN) Licensed practical nurses (LPN) under the direction and supervision of a qualified RN Nonlicensed school staff who are delegated health care tasks by an RN and are supervised according to professional practice standards in RCW 18.79.260 	Registered Nurse Licensed Practical Nurse
Occupational Therapy	<ul style="list-style-type: none"> Licensed occupational therapists (OT) Licensed occupational therapy assistants (OTA) under the direction and supervision of a licensed OT 	Occupational Therapist Occupational Therapy Assistant

School-Based Health Care Services (SBHS)

Services	Eligible Provider Types	DOH License Requirements
Physical Therapy	<ul style="list-style-type: none"> • Licensed physical therapists (PT) • Licensed physical therapist assistants (PTA) under the direction and supervision of a licensed PT 	Physical Therapist Physical Therapist Assistant
Psychology	<ul style="list-style-type: none"> • Licensed psychologists 	Psychologist
Speech Therapy	<ul style="list-style-type: none"> • Licensed speech-language pathologists (SLP) • Licensed speech-language pathology assistants (SLPA) under the direction and supervision of a licensed SLP* <p>*A certificate of clinical competence (CCC) is not required in order to supervise or bill Medicaid. SLPs must provide supervision per their scope-of-practice requirements with the Department of Health.</p>	Speech-Language Pathologist Speech-Language Pathology Assistant

Which provider taxonomy codes are used for the SBHS program?

School districts must ensure that all providers have the correct taxonomy code listed in ProviderOne. The taxonomy code listed on each claim must match the assigned provider’s taxonomy code. Providers can choose to have multiple taxonomy codes listed in ProviderOne based on their specialty. However, for the SBHS program, the following taxonomy codes must be used for each eligible provider type:

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

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

What are the provider supervision requirements?

Providers must provide supervision according to their scope-of-practice requirements with the Department of Health (DOH). For services provided under the supervision of a physical therapist, occupational therapist, speech-language pathologist, nurse, counselor, or social worker, the following requirements apply:

- The nature, frequency, and length of the supervision must be provided in accordance with professional practice standards, and be sufficient to ensure a child receives quality services.
- The supervising provider must see the child face-to-face when services begin and at least once more during the school year.
- Supervisors are responsible for approving and cosigning all treatment notes written by the supervisee before submitting claims for payment.

How do I enroll providers in ProviderOne?

School districts must enroll all licensed health care providers who participate in SBHS as servicing providers under the school district's ProviderOne account before submitting claims to the agency. Providers may be school district staff or subcontractors. The agency will deny claims for any licensed health care providers who are not enrolled with the agency.

For assistance in enrolling providers, school districts can:

- View the [How to Enroll Servicing Providers training](#) located on the [SBHS webpage](#).
- Schedule ProviderOne training with the agency's Provider Relations section by emailing them at ProviderRelations@hca.wa.gov.
- Contact Provider Enrollment for additional assistance with enrolling providers. (See [Resources Available](#)).

What do I do when a servicing provider no longer participates in SBHS?

Providers who are no longer employed by the school district, or who no longer participate in the SBHS program, will remain listed on the school district's ProviderOne account for historical purposes. School districts should end-date inactive providers in ProviderOne.

For assistance with end-dating providers, school districts can view the [How to end-date providers training](#) on the [SBHS webpage](#), or contact Provider Enrollment for assistance (See [Resources Available](#)).

Which providers cannot participate in the SBHS program?

Interim permit holders

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

Nonlicensed people

People including, but not limited to: nonlicensed school staff, interim permit holders, limited permit holders, and people completing schooling required for DOH licensure cannot participate in the SBHS program, even if they are providing services under the direction of a licensed provider. The only exception to this is nonlicensed school staff who are performing health/nursing tasks delegated by a registered nurse (RN).

If a school district is unsure of a provider's licensure status, it is the school district's responsibility to contact the agency's SBHS program specialist.

Licensing exemptions

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

- Counseling as found in [RCW 18.225.030](#)
- Psychology as found in [RCW 18.83.200](#)
- Social work as found in [RCW 18.320.010](#)
- Speech therapy as found in [RCW 18.35.195](#)

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

Covered Services

What is covered?

[WAC 182-537-0400](#)

The SBHS program pays school districts for:

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

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

Referrals and prescriptions

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

Some services do not require a physician’s referral or prescription. Providers participating in SBHS should review relevant sections of the Department of Health’s [Title 246 WAC](#) and [Title 18 RCW](#) specific to their provider type to confirm whether a physician’s referral or prescription is required.

Procedure codes

Providers must use the applicable procedure codes listed under the [Coverage Table](#) section when billing for services.

The agency's SBHS program specialist cannot tell providers which codes to use. Providers must use their professional judgement to determine which code(s) to use based on the service/procedure provided. The agency uses the following types of procedure codes within this billing guide:

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

All covered services in this billing guide may be provided through telemedicine (See [When does the agency cover telemedicine?](#))

Using untimed and timed procedure codes

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

Untimed procedure codes

If a procedure code's short description does not include time, the code is "untimed" and is billed as one unit regardless of how long the service takes, unless otherwise noted in the "comments" column of the covered services tables. Providers should consult a current CPT or HCPCS manual, or the CMS webpage for additional guidance. Providers can view the CMS MUE Edit Files to view the allowable number of units for each SBHS code (See [NCCI Resources](#)).

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

Timed procedure codes

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

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

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

Examples:

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

What is the National Correct Coding Initiative?

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

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

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

Medically Unlikely Edits (MUEs) - Part of the NCCI policy are MUEs. MUEs are the maximum unit of service per HCPCS or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a “Medically Unlikely Edit.” Not all HCPCS or CPT codes are assigned an MUE. The SBHS program adheres to the CMS MUE edits for all codes in this billing guide.

The agency may perform a post-payment review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system.

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

NCCI Resources

To maximize reimbursement and avoid claim denials, school districts and providers participating in the SBHS program should review the [CMS Medicaid NCCI PTP and MUE Edit Files](#) available on the CMS webpage. The NCCI Edits Training Tool available on the [SBHS webpage](#) provides detailed instructions on how to view CMS Medicaid NCCI Edit files.

Telemedicine

[WAC 182-531-1730](#)

Under the SBHS program, the agency pays for services provided through telemedicine as outlined in this billing guide. Services provided through telemedicine to eligible students in the home setting are payable only when provided to children ages birth through two. This is due to IDEA’s requirement that early intervention services should be provided to the maximum extent appropriate in the “natural environment” (See [Billing for services provided via telemedicine](#)).

What is telemedicine?

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

The agency does not cover the following services provided through telemedicine:

- Email, audio only telephone, and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Purchase, rental, or repair of telemedicine equipment

When does the agency cover telemedicine?

The agency covers telemedicine when it is used to substitute for an in-person, face-to-face, hands-on encounter for only those services specifically listed in this billing guide. In order for a school district to receive reimbursement for telemedicine, the provider furnishing services through telemedicine must be enrolled as a servicing provider under the school district's ProviderOne account.

What are the documentation requirements?

The documentation requirements are the same as those listed in the documentation [section](#) of this billing guide, as well as the following:

- Documentation that the service was provided via telemedicine
- The location of the student
- The location of the provider

Originating site (location of student)

An originating site is the physical location of the student at the time the service is provided by a licensed provider through telemedicine. For the SBHS program, the approved originating site is:

- The school for students age three through 20 (Part B and C services)
- The home for students age birth through two (Part C services only)

Is the originating site paid for telemedicine?

Yes. When the originating site is the school, the school district will receive a telemedicine fee per completed telemedicine transmission.

Distant site (location of provider)

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

Billing for services provided via telemedicine

For services furnished on or after January 1, 2019, to indicate that the billed service was provided through telemedicine, school districts will submit claims for telemedicine services using place of service (POS) 02.

Also effective January 1, 2019, the GT modifier is no longer required on telemedicine claims. School districts must enter modifier 95 on any claims for services provided through telemedicine.

When billing for telemedicine through the SBHS program, the school district always submits a claim on behalf of both the originating and distant site.

- **Student at school and provider at distant site:** When the student is at the school and the provider is at a distant site, the school district:
 - ✓ Submits a claim for the corresponding procedure code with modifier 95 and place of service (POS) 02
 - ✓ Submits on the same claim, procedure code Q3014 (telemedicine fee) with POS 03
- **Student at home and provider at school or distant site:** When the student (ages birth through two) is at home and the provider is at the school or another distant site, the school district:
 - ✓ Submits a claim for the corresponding procedure code with modifier 95 and place of service (POS) 02
 - ✓ Does not bill for the procedure code Q3014 because the student is at home. The school district does not receive the telemedicine fee when the originating site is the home.

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

What is not covered?

[WAC 182-537-0500](#)

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

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

Coverage Tables

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

Audiology services

SBHS-covered audiology services include:

- Evaluations and reevaluations performed by a licensed audiologist to determine if the student is eligible for audiology/speech services per an IEP or IFSP
- IEP/IFSP audiology/speech services provided by a licensed audiologist

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

Procedure Code	Short Description	Comments
92552	Pure tone audiometry air	
92553	Audiometry air & bone	
92555	Speech threshold audiometry	
92556	Speech audiometry complete	
92557	Comprehensive hearing test	
92567	Tympanometry	
92568	Acoustic reflex testing, threshold	
92570	Acoustic immittance testing	
92579	Visual audiometry (vra)	
92582	Conditioning play audiometry	
92587	Evoked auditory test limited	

School-Based Health Care Services (SBHS)

Procedure Code	Short Description	Comments
92588	Evoked auditory tst complete	
92620	Auditory function 60 min	Timed 60 minutes
92621	Auditory function + 15 min	Each additional 15 minutes
92521	Evaluation of speech fluency	
92522	Evaluate speech production	
92523	Speech sound lang comprehen	
92524	Behavral qualit analys voice	
92507	Speech/hearing therapy	
92508	Speech/hearing therapy	
92551	Pure tone hearing test air	
92630	Audio rehab pre-ling hear loss	
92633	Audio rehab postling hear loss	
97127	Ther ivntj w/focus cog funcj	
97533	Sensory integration	Timed 15 minutes
S9152	Speech therapy re-eval	
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Counseling services

SBHS-covered counseling services assist a student with adjustment to the student’s disability and include:

- Evaluations and reevaluations performed by a licensed mental health provider to determine if a student requires counseling services per an IEP or IFSP
- IEP/IFSP counseling services provided by a licensed psychologist, licensed social worker, licensed mental health counselor or licensed mental health counselor associate under the direction of an LMHC

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

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

Covered nursing/health services include:

- Evaluations and reevaluations performed by a licensed RN to determine if a student requires nursing/health services per an IEP or IFSP
- IEP/IFSP nursing/health services provided by an RN, LPN, or nonlicensed school staff who has been delegated certain health related tasks by the licensed RN

All IEP/IFSP nursing/health services must be prescribed or referred by a licensed physician or other licensed health care provider within their scope of practice.

School-Based Health Care Services (SBHS)

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

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

Use procedure code T1001 when performing IEP or IFSP evaluations or reevaluations

Use procedure codes T1002 and T1003 when billing for IEP/IFSP nursing/health services. Examples of covered nursing/health services include, but are not limited to:

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

Psychological assessments and services

SBHS-covered psychological services include:

- Evaluations and reevaluations performed by a licensed psychologist to determine if a student requires psychological/counseling services per an IEP or IFSP
- IEP/IFSP psychological/counseling services provided by a licensed psychologist

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

Procedure Code	Short Description	Comments
96130	Psycl tst eval phys/qhp 1 st	Timed 60 minutes
96131	Psycl tst eval phys/qhp ea	Each additional hour
96136	Psycl/nrpsyc tst phy/qhp 1 st	Timed 30 minutes
96137	Psycl/nrpsyc tst phy/qhp ea	Each additional 30 minutes
90791	Psych diagnostic evaluation	
S9445	Pt education noc individ	Review MUE guidelines for maximum allowable billable units.
S9446	Pt education noc group	
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Occupational therapy services

SBHS-covered occupational therapy services include:

- Evaluations and reevaluations performed by a licensed occupational therapist to determine if a student requires occupational therapy services per an IEP or IFSP
- IEP/IFSP occupational therapy services provided by a licensed occupational therapist (OT) or licensed occupational therapy assistant (OTA) under the supervision of a licensed OT

The list on the following page are descriptions of covered occupational therapy services with the corresponding procedure codes. Licensed occupational therapists (OTs) and licensed occupational therapy assistants (OTAs) can provide these services within their scope of practice:

School-Based Health Care Services (SBHS)

Procedure Code	Short Description	Comments
95851	Range of motion measurements	Review MUE guidelines for maximum allowable billable units.
95852	Range of motion measurements	
97110	Therapeutic exercises	Timed 15 minutes
97112	Neuromuscular reeducation	Timed 15 minutes
97127	Ther ivntj w/focus cog funcj	
97150	Group therapeutic procedures	
97165	OT eval low complex, 30 min	
97166	OT eval mod complex, 45 min	
97167	OT eval high complex, 60 min	
97168	OT re-eval est plan care	
97530	Therapeutic activities	Timed 15 minutes
97533	Sensory integration	Timed 15 minutes
97535	Self-care management training	Timed 15 minutes
97537	Community/work reintegration	Timed 15 minutes
97542	Wheelchair management training	Timed 15 minutes
97750	Physical performance test	Timed 15 minutes
97755	Assistive technology assess	Timed 15 minutes
97760	Orthotic management and training	Timed 15 minutes
97761	Prosthetic training	Timed 15 minutes
97763	Orthc/prostc mgmt sbsq enc	Timed 15 minutes

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Physical therapy services

SBHS-covered physical therapy services include:

- Evaluations and reevaluations performed by a licensed physical therapist to determine if a student requires physical therapy services per an IEP or IFSP
- IEP/IFSP physical therapy services provided by a licensed physical therapist (PT) or licensed physical therapist assistant (PTA) under the supervision of a licensed PT

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

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

School-Based Health Care Services (SBHS)

Procedure Code	Short Description	Comments
97542	Wheelchair management training	Timed 15 minutes
97750	Physical performance test	Timed 15 minutes
97755	Assistive technology assess	Timed 15 minutes
97760	Orthotic management and training	Timed 15 minutes
97761	Prosthetic training	Timed 15 minutes
97763	Orthc/prostc mgmt sbsq enc	Timed 15 minutes
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Speech-language therapy services

SBHS-covered speech-language therapy services include:

- Evaluations and reevaluations performed by a licensed speech-language pathologist to determine if a student requires speech-language therapy services per an IEP or IFSP
- IEP/IFSP speech-language therapy services provided by a licensed speech-language therapist (SLP) or licensed speech language pathologist assistant (SLPA) under the supervision of a licensed SLP

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

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

School-Based Health Care Services (SBHS)

Procedure Code	Short Description	Comments
92568	Acoustic reflex testing, threshold	
92570	Acoustic immittance testing	
92607	Ex for speech device rx 1 hr	Timed 60 minutes
92608	Ex for speech device rx addl	Timed additional 30 minutes
92609	Use of speech device service	
92610	Evaluate swallowing function	
92630	Aud rehab pre-ling hear loss	
92633	Aud rehab postling hear loss	
97127	Ther ivntj w/focus cog funcj	
97533	Sensory integration	Timed 15 minutes
S9152	Speech therapy re-eval	
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Documentation

What documentation requirements are there for school districts?

[WAC 182-537-0700](#) and [182-502-0020](#)

For each student who receives SBHS, school districts must maintain proper documentation to fully justify the services and billing. Maintaining records in an electronic format is acceptable. Each school district is responsible for determining what standards are consistent with state and federal electronic record requirements.

School districts must maintain the following records for each student for at least six years from the date of service:

- A referral or prescription for services by a physician or other licensed health care provider within their scope of practice (See [Referrals and prescriptions](#))
- Professional assessment reports completed by a licensed provider
- Evaluation and reevaluation reports completed as part of the IEP/IFSP evaluation and reevaluation processes
- Current and previous individualized education program (IEP) or individualized family service plan (IFSP)
- Attendance records for each student receiving services
- Treatment notes to justify billed claims

Treatment notes

Providers must document all school-based health care services as specified in this billing guide. School districts must maintain treatment notes to justify billed claims for a minimum of six years from the date of service. Treatment notes must contain the:

- Child's name
- Child's date of birth
- Child's ProviderOne client ID
- Date of service, and for each date of service:
 - ✓ Time-in
 - ✓ Time-out
 - ✓ A corresponding procedure code(s)
 - ✓ A description of each service provided
 - ✓ The child's progress related to each service
 - ✓ Whether the treatment described in the note was individual or group therapy (for OT, PT, SLP, audiology, and counseling services)
- All treatment notes require the licensed provider's printed name, handwritten or electronic signature, and title.
- Assistants, as defined in the Provider Qualifications section of this billing guide, who provide health care-related services, must have the supervising provider cosign all documentation in accordance with the supervisory requirements for the provider type.
- As described in [WAC 182-502-0020](#), all records must be easily and readily available to the agency upon request.

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

Signature requirements

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

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

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

Signature log

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

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

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

School districts must obtain a one-time signature from each servicing provider and must update the signature log as new providers are hired. School districts are responsible for the accuracy of the signature log. This log does not need to be provided to the agency, but must be kept on file at the school and made available for all monitoring activities.

A sample signature log is available on the [SBHS webpage](#).

Electronic Signatures

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

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

Billing and Payment

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the requirements for payment?

[WAC 182-537-0600](#)

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

- Have a ProviderOne account and a current, signed core provider agreement (CPA) with the agency
- Have a current, signed and executed contract with the SBHS program
- Meet and comply with the applicable requirements in [Chapter 182-502 WAC](#) which includes
 - ✓ Submitting the initial claim to the agency and having a transaction control number (TCN) assigned within three hundred sixty-five calendar days from the date the provider furnishes the service to the eligible client; and
 - ✓ Resubmitting, modifying, or adjusting an initial claim within 24 months from the date of service
- Enroll each provider as a servicing provider under the district's ProviderOne account and ensure providers have their own National Provider Identifier (NPI)
- Comply with the agency's current [ProviderOne Billing and Resource Guide](#)
- Bill according to the SBHS Billing Guide and the SBHS Fee Schedule
- Comply with the intergovernmental transfer (IGT) process
- Meet and comply with the applicable requirements in [Chapter 182-537 WAC](#)
- Provide only health care-related services identified in a current individualized education program (IEP) or individualized family service plan (IFSP)
- Use only licensed health care providers, as described in this billing guide, who are acting within the scope of their license according to [Provider Qualifications](#)
- Meet the documentation requirements in this billing guide (See [Documentation](#))
- Participate in all Provider Revalidation activities (See [What is the Provider Revalidation Process?](#))

What is the intergovernmental transfer (IGT) process?

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

- The SBHS program is funded by a 50/50 federal and nonfederal split. School districts are required to submit 60% (local match) of the nonfederal split, and the agency is responsible for providing 40% of the nonfederal split.
- After the school district submits claims in ProviderOne, the agency's accounting office emails an invoice to the SBHS coordinator and the school district business manager within 30-60 days.
- The SBHS coordinator and school district business manager are responsible for forwarding the invoice to the appropriate school district staff member who will process the invoice and submit local match to the agency.
- School districts have 120 days from the invoice date to provide local match. Once the local match is received from the school district, the agency releases claims for payment.
- The reimbursement, or total computable, provided to the school district includes the return of the local match, the state matching funds, and the federal funds.
- School districts may review the [IGT flow chart](#) for additional clarification on how the IGT process works.
- Any invoice/IGT questions should be directed to the agency's accounting office (See [Resources Available](#)).

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

How do I submit local match to the agency?

School districts may submit local match via paper check or electronically. For directions on how to submit local match to the agency, school districts may contact the agency's accounting office (See [Resources Available](#)).

How are school districts paid?

After the agency receives local match from the school district, claims are released for payment. School districts receive the total computable, which includes the return of their local match, state matching funds, and federal funds.

The agency pays school districts by paper check or electronic funds transfer (EFT).

- The agency mails checks to the mailing address on file. School districts may update their address and contact information with the agency's accounting office (See [Resources Available](#)).
- The agency submits payment through EFT to the bank account listed in ProviderOne. To update bank information listed in ProviderOne or to sign up to receive payment through EFT, school districts must complete the Electronic Funds Transfer Form (HCA 12-002) (See [Where Can I Download Agency Forms?](#)).

Time limits for billing the agency

School districts must submit initial claims to the agency and have a transaction control number (TCN) assigned by the agency within 365 calendar days from the date the provider furnishes the service to the eligible student.

Providers must resubmit, modify, or adjust an initial claim within 24 months from the date of service.

If your school district contracts with an outside billing agent, your district may have stricter time limits to ensure claims are submitted to the agency on time.

How do I submit claims for a student who has private insurance?

[WAC 182-501-0200](#)

If a school district decides to bill the agency for SBHS provided to students who are covered by a primary insurance, school districts must bill the child's primary insurance first in order to receive a denial letter. This means that knowing a child's eligibility status prior to billing is very important.

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

School districts may choose not to bill the agency for services provided to special education students who have third-party insurance. However, if the school district decides to bill for these students, the school district must comply with all of the following in order to receive payment from the agency:

- 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 (per IDEA requirements).
- Follow the instructions found in the [How to Submit SBHS Claims](#) training.

I am a self-billing school district. How do I submit claims in ProviderOne?

School districts may schedule training with the agency’s Provider Relations team for assistance with submitting Direct Data Entry (DDE) claims (See [Resources Available](#)). Additional information on how to submit claims can be found in the [How to Submit SBHS Claims](#) training available on the SBHS webpage.

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

Name	Action
Place of Service (POS)	Enter 03 School (school) or 02 when billing for telemedicine
Diagnosis Code	Enter R69 (Illness, unspecified)
Charges	If billing for more than one unit, enter the total charge of the units being billed. (See SBHS Fee Schedule)

Note: Using a POS code other than 02 or 03 will result in denied claims.

Fee Schedule

The [SBHS Fee Schedule](#) provides information about procedure codes and the maximum allowable payment rate per unit. The agency updates the fee schedule as the national codes and rates are updated by the federal Centers for Medicare and Medicaid Services (CMS).

The School-Based Health Care Services (SBHS) rates are based on Resource-Based Relative Value Scale (RBRVS) methodology under [WAC 182-531-1850](#), in which Washington uses CMS-established relative value units multiplied by one of the conversion factors specific to

Washington and these services. SBHS rates (and all other professional rates) are based on values established by CMS and the State's conversion factor that is annually adjusted based on utilization and budget neutrality. The rates paid for SBHS are no different than rates paid to similar providers within the community outside of the school setting.

School districts may need to know the rates associated with each SBHS procedure code for claim submission if they are a self-billing school or for completing safety net applications for the Office of Superintendent of Public Instruction (OSPI).

Do I need to report SBHS payments on the SEFA?

School districts do not need to report SBHS payments received for health care services provided to Medicaid-eligible special education students on the Schedule of Expenditures of Federal Awards (SEFA). These are patient-care services and are not subject to audit under Uniform Guidance at [29 CFR 99.205](#) and Chapter XI: Schedule of Expenditures of Federal Awards (SEFA) Contents.

Remittance advice

- The Remittance Advice (RA) provides detail about paid, denied, adjusted, and in-process claims submitted to ProviderOne.
- The RA is accessible in ProviderOne.
- If your district contracts with a billing agent, your billing agent may email you a copy of the RA weekly or monthly.
- School districts are encouraged to review their RAs weekly or monthly to determine if claims were paid, determine if any claims were denied, and review the explanation for the denial.
- School districts may contact the SBHS program specialist, the Office of Provider Relations, or their billing agent with questions about denied claims (See [Resources Available](#)).
- Instructions on how to review the RA are available in the [ProviderOne Billing and Resource Guide](#).

Program Integrity

What program integrity activities does the agency conduct?

[WAC 182-537-0800](#)

To ensure compliance with program rules, the agency conducts program integrity activities under [Chapter 182-502A WAC](#) and [Chapter 182-502 WAC](#).

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