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SCHOOL-BASED HEALTH CARE SERVICES

Provider Guide

January 1, 2016

Washington State
Health Care Authority

About this guide*

This publication takes effect January 1, 2016, and supersedes earlier guides to this program.

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

What has changed?

Subject	Change	Reason for Change
Resources Available	Added table	Clarification
Definitions	Added definitions for CPT, evaluation report, FFS, handwritten signature, medically necessary, NPI, IDEA. Revised definition for HCPCS.	Clarification
Client Eligibility	Added new section called Which recipient aid category (RAC) codes are not eligible for reimbursement?	Clarification
Provider Qualifications	Added citations, and clarification about supervision	Clarification
Provider Taxonomy Codes	Moved and revised section	Clarification
Coverage	Revised section, added clarifying notes and comments, information about timed procedure codes, information about telemedicine	Clarification
Nursing Services; Timed and Untimed Codes	Removed table about billing for nursing services and added information about billing for timed and untimed procedure codes to Billing	Clarification
Third-Party Liability	Moved this section from Program Monitoring section to Billing	Clarification
Telemedicine	Added guidance for billing services provided via telemedicine	Clarification
Documentation	Revised list of treatment note requirements	Clarification
Billing and Claim Forms	Moved and revised section What documentation is due to the agency annually? Added sections: <ul style="list-style-type: none"> • What is the intergovernmental transfer process? • What is the National Correct Coding Initiative? • Procedure codes • Using timed and untimed procedure codes • How do I review my remittance advice and why is this important? • Fee schedule Revised section: <ul style="list-style-type: none"> • How do I complete the CMS-1500 claim form? 	Clarification

* This guide is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

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Table of Contents

Resources Available 6

Definitions..... 7

Program Overview..... 10

 What is the purpose of the school-based health care services (SBHS) program? 10

 Who pays for SBHS? 10

Client Eligibility 11

 How can I verify a child’s eligibility? 11

 Are clients enrolled in an agency-contracted managed care organization eligible? 12

 Which recipient aid category (RAC) codes are not eligible for reimbursement? 12

Provider Qualifications 13

 Who may provide school-based health care services? 13

 Licensing exemptions 14

 How do school districts enroll providers? 15

 Provider taxonomy codes 16

Coverage 17

 What is covered? 17

 Audiology services 17

 Counseling services 20

 Nursing services 20

 Psychological assessments 22

 Occupational therapy services 22

 Physical therapy services 24

 Speech-language therapy services 25

 What is telemedicine? 26

 When does the agency cover telemedicine? 26

 Originating site (location of client) 27

 Distant site (location of consultant) 27

 Billing for services provided via telemedicine 27

 What is not covered? 28

Payment 29

 What are the requirements for payment? 29

Documentation 30

 What documentation requirements are there for school districts? 30

 What documents are due to the SBHS program specialist annually? 31

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.



Program Monitoring..... 33
 What program monitoring and auditing does the agency conduct?..... 33

Billing and Claim Forms 34
 How does third-party liability affect claims submitted to the agency? 34
 What is the intergovernmental transfer process (IGT)?..... 35
 What is the National Correct Coding Initiative?..... 35
 Procedure codes 35
 Using untimed and timed procedure codes 36
 Untimed Codes..... 36
 Timed Codes 36
 How do I review my remittance advice (RA) and why is this important? 37
 How do I complete the CMS-1500 claim form?..... 37
 Fee Schedule 37



Resources Available

Topic	Resource Information
Who do I contact if I'm interested in contracting with the SBHS program or have questions regarding SBHS program policy?	SBHS Program Specialist 360-725-1153
Who do I contact if I need help enrolling providers or to check on status of an application?	Provider Enrollment 1-800-562-3022 ext. 16137 or Provider Relations ProviderRelations@hca.wa.gov
Who do I contact if I need help with ProviderOne?	ProviderOne Billing and Resource Guide Provider Relations ProviderRelations@hca.wa.gov ProviderOne Help Desk mmishelp@hca.wa.gov
Who do I contact if I have questions on denied claims or general questions regarding claims processing?	Medical Assistance Customer Service Center 1-800-562-3022
Who do I contact if I have questions on the IGT process or need copies of my invoices?	Accounting HCASchoolBased@hca.wa.gov
Who do I contact if I need a copy of my SBHS interagency agreement?	Contract Services Contracts@hca.wa.gov
How do I sign up for GovDelivery messages?	GovDelivery Subscription Select "School Based Health Care Services (SBHS)" as the subscription topic

Definitions

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

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

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

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

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

- Traumatic brain injury
- Visual impairment (including blindness) ([WAC 392-172A-01035](#))

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.

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

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

Evaluation Report – See [WAC 392-172A-03035](#).

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

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

Habilitation – Services that address cognitive, social, fine motor, gross motor, or other skills that contribute to mobility, communication, and performance of activities of daily living skills (ADLs) to enhance the quality of life.

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

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

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

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

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 statement of an educational program for a child eligible for special education that is developed, reviewed, and revised in accordance with [WAC 392-172A-03090](#) through [392-172A-03135](#). ([WAC 392-172A-01100](#)).

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

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

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

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

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

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

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

School-Based Health Care Services Program

(SBHS) – School-based health care services for children who require special education services that are diagnostic, evaluative, habilitative, or rehabilitative in nature; are based-on the child’s medical needs; and are included in the child’s IEP. The agency pays school districts for school-based health care services delivered to Medicaid-eligible children who require special education services under Section 1903 (c) of the Social Security Act, and Individuals with Disabilities Education Act (IDEA) Part B (age three through twenty years).

School-Based Health Care Services Program

Specialist or SBHS Specialist- An individual identified by the agency who is responsible for managing the SBHS program.

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

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

Program Overview

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

[WAC 182-537-0100](#)

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

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

Who pays for SBHS?

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

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

Client Eligibility

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

How can I verify a child's eligibility?

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

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

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

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

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

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

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

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

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

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

The agency reimburses school districts for medically necessary SBHS provided to children receiving Title XIX Medicaid. Districts are responsible for conducting monthly eligibility checks since student eligibility can change from one month to the next. The following RAC codes are not eligible for reimbursement through the SBHS Program:

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

Provider Qualifications

Who may provide school-based health care services?

[WAC 182-537-0350](#)

The agency pays school districts to provide certain healthcare-related services (see [Coverage](#)). These services must be delivered by a qualified health care provider who meets federal and state licensing and certification requirements and who is enrolled with the agency under [Chapter 182-502 WAC](#) and holds a current professional license.

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

Services	Provider Qualifications
Audiology	Audiologists who meet requirements of Chapter 246-828 WAC and Chapter 18.35 RCW
Counseling	<p>The following counseling professionals must meet requirements of Chapter 246-809 WAC and Chapter 18.225 RCW:</p> <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 LiCSW, LiACSW, or LMHC.
Nursing Services	<p>The following nursing professionals must meet requirements of Chapter 246-840 WAC and Chapter 18.79 RCW:</p> <ul style="list-style-type: none"> Licensed registered nurses (RN) Licensed practical nurses (LPN) under the direction and supervision of a qualified RN Exception: Non-credentialed school employees who are delegated certain limited health care tasks by an RN and are supervised according to professional practice standards in RCW 18.79.260

School-Based Health Care Services (SBHS)

Occupational Therapy	The following occupational therapy professionals who meet requirements of Chapter 246-847 WAC and Chapter 18.59 RCW : Licensed occupational therapists (OT) Licensed occupational therapist assistant (OTA) under the direction and supervision of a qualified OT
Physical Therapy	The following physical therapy professionals who meet requirements of Chapter 246-915 WAC and Chapter 18.74 RCW : Licensed physical therapists (PT) Licensed physical therapist assistants (PTA) under the direction and supervision of a licensed PT
Psychology	Psychologists who meet requirements of Chapter 246-924 WAC and Chapter 18.83 RCW
Speech Therapy	The following speech language pathology professionals who meet requirements of Chapter 246-828 WAC and Chapter 18.35 RCW : Licensed speech-language pathologists (SLP) Speech-language pathology assistants (SLPA) who: <ul style="list-style-type: none">• Have graduated from a speech-language pathology assistant program at a board-approved institution;• Are supervised by a speech-language pathologist with a current Certificate of Clinical Competence (CCC) and two years of work experience

Licensing exemptions

The following regulations describe exemptions to licensing requirements for providing the services. People providing services under the exemptions are not eligible for 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

How do school districts enroll providers?

School districts must enroll licensed health care providers as servicing providers under the school district's NPI number before submitting claims to the agency. Failure to enroll licensed health care providers will result in denied claims.

- Each provider must obtain an NPI number from National Plan and Provider Enumeration System ([NPPES](#)).
- The designated user of ProviderOne within the school district will enroll each provider in ProviderOne.
- An application ID will be provided for the school district to track the status of a provider's application.
- For assistance in enrolling providers, school districts can contact Provider Enrollment or Provider Relations (See [Resources Available](#)).

Provider supervision requirements

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

- The nature, frequency, and length of the supervision must be provided in accordance with professional practice standards, and be sufficient to ensure a child receives quality therapy services.
- The supervising therapist must see the child face-to-face at the beginning of each school year and at least once more during the school year.
- At a minimum, supervision must be face-to-face communication between the supervisor and the supervisee once per month. Supervisors are responsible for approving and cosigning all treatment notes written by the supervisee before submitting claims for payment.
- Documentation of supervisory activities must be recorded and available to the agency or its designee upon request.

Provider taxonomy codes

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

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

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

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

Coverage

What is covered?

[WAC 182-537-0400](#)

The agency covers:

- Evaluations when the child is determined to have a disability, and needs special education and health care-related services.
- Reevaluations to determine whether a child continues to need special education and health care-related services.
- Services included in the child's IEP, such as:
 - ✓ Audiology services
 - ✓ Counseling services
 - ✓ Nursing services
 - ✓ Occupational therapy services
 - ✓ Physical therapy services
 - ✓ Psychological assessments
 - ✓ Speech-language therapy services

All covered services under this section may be provided through telemedicine as described in [WAC 182-531-1730](#).

Audiology services

Audiology services include:

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

Listed below are the descriptions of covered audiology services with the corresponding CPT® codes.

Note: If no time is listed in the short description or comments column, the procedure code is untimed and can only be billed as one unit per day, per client, per provider, no matter how long the service takes. See [Using Timed and Untimed Procedure Codes](#).

School-Based Health Care Services (SBHS)

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

Procedure Code	Modifier	Short Description	Comments
92521	None	Evaluation of speech fluency	
92522	None	Evaluate speech production	
92523	None	Speech sound lang comprehen	
92524	None	Behavral qualit analys voice	
92507	None	Speech/hearing therapy	
92508	None	Speech/hearing therapy	
92551	None	Pure tone hearing test air	
92630	None	Audio rehab pre-ling hear loss	
92633	None	Audio rehab postling hear loss	
97532	None	Cognitive skills development	Timed 15 minutes
97533	None	Sensory integration	Timed 15 minutes
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Counseling services

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

Listed below are the descriptions of covered counseling services with the corresponding billing codes.

Procedure Code	Modifier	Short Description	Comments
S9445	None	Pt education noc individ	Review MUE guidelines for maximum allowable billable units
S9446	None	Pt education noc group	

Nursing services

Nursing services include:

- Medical and remedial services ordered by a physician or other licensed health care provider within the provider’s scope of practice.
- Assessments, reassessments, and treatment services, provided to do all of the following:
 - ✓ Prevent disease, disability, or the progression of other health conditions
 - ✓ Prolong life
 - ✓ Promote physical health, mental health, and efficiency

Procedure Code	Modifier	Short Description	Comments
T1001	None	Nursing assessment/evaluatn	Review MUE guidelines for maximum allowable billable units.
T1002**	None	RN services up to 15 minutes	Timed 15 minutes
T1003**	None	LPN/LVN services up to 15 minutes	Timed 15 minutes

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

School-Based Health Care Services (SBHS)

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

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

Psychological assessments

Psychological assessments include psychological and developmental testing and therapy.

Listed below is the description of the covered psychological service with the corresponding billing code.

Procedure Code	Modifier	Short Description	Comments
96101	None	Psycho testing by psych/psy	Review MUE guidelines for maximum allowable billable units.
S9445	None	Pt education noc individ	
S9446	None	Pt education noc group	
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Occupational therapy services

Occupational therapy services include:

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

Listed below are descriptions of covered occupational therapy services with the corresponding billing codes.

Procedure Code	Modifier	Short Description	Comments
95851	None	Range of motion measurements	Review MUE guidelines for maximum allowable billable units.
95852	None	Range of motion measurements	
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School-Based Health Care Services (SBHS)

Procedure Code	Modifier	Short Description	Comments
97003	None	Ot evaluation	
97004	None	Ot reevaluation	
97110	None	Therapeutic exercises	Timed 15 minutes
97112	None	Neuromuscular reeducation	Timed 15 minutes
97150	None	Group therapeutic procedures	
97530	None	Therapeutic activities	Timed 15 minutes
97532	None	Cognitive skills development	Timed 15 minutes
97533	None	Sensory integration	Timed 15 minutes
97535	None	Self-care management training	Timed 15 minutes
97537	None	Community/work reintegration	Timed 15 minutes
97542	None	Wheelchair management training.	Timed 15 minutes
97750	None	Physical performance test	Timed 15 minutes
97755	None	Assistive technology assess	Timed 15 minutes
97760	None	Orthotic management and training	Timed 15 minutes
97761	None	Prosthetic training	Timed 15 minutes
97762	None	C/o for orthotic/prosthesis use	Timed 15 minutes

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Physical therapy services

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

Listed below are descriptions of covered physical therapy services with the corresponding billing codes.

Procedure Code	Modifier	Short Description	Comments
95851	None	Range of motion measurements	Review MUE guidelines for maximum allowable billable units.
95852	None	Range of motion measurements	
97001	None	Pt evaluation	
97002	None	Pt re-evaluation	
97110	None	Therapeutic exercises	Timed 15 minutes
97112	None	Neuromuscular reeducation	Timed 15 minutes
97116	None	Gait training therapy	Timed 15 minutes
97124	None	Massage therapy	Timed 15 minutes
97139	None	Physical medicine procedure	Review MUE guidelines for maximum allowable billable units.
97150	None	Group therapeutic procedures	
97530	None	Therapeutic activities	Timed 15 minutes
97535	None	Self-care management training	Timed 15 minutes
97537	None	Community/work reintegration	Timed 15 minutes
97542	None	Wheelchair management training.	Timed 15 minutes
97750	None	Physical performance test	Timed 15 minutes

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School-Based Health Care Services (SBHS)

Procedure Code	Modifier	Short Description	Comments
97755	None	Assistive technology assess	Timed 15 minutes
97760	None	Orthotic management and training	Timed 15 minutes
97761	None	Prosthetic training	Timed 15 minutes
97762	None	C/o for orthotic/prosthesis use	Timed 15 minutes

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Speech-language therapy services

Speech-language therapy services include:

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

Listed below is the description of the covered speech-language pathology services with the corresponding billing code.

Procedure Code	Modifier	Short Description	Comments
92521	None	Evaluation of speech fluency	
92522	None	Evaluate speech production	
92523	None	Speech sound lang comprehen	
92524	None	Behavral qualit analys voice	
92507	None	Speech/hearing therapy	
92508	None	Speech/hearing therapy	

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School-Based Health Care Services (SBHS)

Procedure Code	Modifier	Short Description	Comments
92551	None	Pure tone hearing test air	
92568	None	Acoustic reflex testing, threshold	
92570	None	Acoustic immittance testing	
92607	None	Ex for speech device rx 1 hr	Timed 60 minutes
92608	None	Ex for speech device rx addl	Timed additional 30 minutes
92609	None	Use of speech device service	
92610	None	Evaluate swallowing function	
92630	None	Aud rehab pre-ling hear loss	
92633	None	Aud rehab postling hear loss	
97532	None	Cognitive skills development	Timed 15 minutes
97533	None	Sensory integration	Timed 15 minutes
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What is telemedicine?

WAC [182-531-1730](#)

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

When does the agency cover telemedicine?

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

Originating site (location of client)

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

Distant site (location of consultant)

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

Billing for services provided via telemedicine

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

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

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

What is not covered?

[WAC 182-537-0500](#)

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

- Applied behavioral analysis therapy*
- Attending meetings*
- Charting*
- Equipment preparation*
- Instructional assistant contact*
- Parent consultation*
- Parent contact*
- Planning*
- Preparing and sending correspondence to parents or other professionals*
- Professional consultation*
- Report writing*
- Review of records*
- School district staff accompanying a child who requires special education services to and from school on the bus
- Set-up (except for pump feeding)
- Teacher contact
- Test interpretation
- Travel and transporting
- Continuous observation of a child when direct school-based health care services are not actively provided.

The agency pays for the act of watching carefully and attentively only if it involves actual interventions. The School-Based Health Care Services (SBHS) 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 SBHS Program Specialist for questions regarding covered and noncovered services.

Payment

What are the requirements for payment?

[WAC 182-537-0600](#)

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

- Have a current, signed core provider agreement (CPA) with the agency. A copy of the CPA must be on-site within the school district.
- Have a current, signed, and executed interagency agreement with the agency. A copy of the agreement must be on-site within the school district for review as requested.
- Meet and comply with the applicable requirements in [Chapter 182-502 WAC](#).
- Enroll providers as a servicing provider under the district's billing NPI 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 Provider Guide, the [SBHS 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 qualified health care professionals, as described in this guide, who are acting within the scope of their license or certification according to [Provider Qualifications](#).
- Meet the documentation requirements in this guide (see [Documentation](#)).

Documentation

What documentation requirements are there for school districts?

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

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

- Professional assessment reports completed by a licensed professional.
- Evaluation and reevaluation reports by the individualized education program (IEP) team members.
- A comprehensive IEP.
- Attendance records for each student receiving services.
- Treatment notes. Treatment notes must include the:
 - ✓ Child's name
 - ✓ Child's date of birth
 - ✓ Child's ProviderOne client ID
 - ✓ Date of service, and for each date of service:
 - Time-in
 - Time-out
 - A corresponding procedure code(s) and number of billed units for each service provided
 - A description of each service provided
 - The child's progress related to each service
 - Whether the treatment described in the note was individual or group therapy

School-Based Health Care Services (SBHS)

- All required documentation and treatment notes for each date of service require the licensed provider's printed name, handwritten signature, and title.
- Assistants, as defined in the Provider Qualifications section of this guide, who provide health care-related services, must have their supervisor cosign all documentation in accordance with the supervisory requirements for the provider type.
- As described in [WAC 182-502-0020](#), all records must be easily and readily available to the agency upon request.

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

What documents are due to the SBHS program specialist annually?

School districts must submit the following documentation to the [SBHS program specialist](#) by October 31st of each year.

- **Provider Update Form (PUF)** [HCA 12-325](#) – School districts may fax or e-mail this form to the SBHS program specialist. The PUF must meet all of the following:
 - ✓ List all current providers and providers who resigned within the last year and include each provider's license number and national provider identifier (NPI)
 - ✓ List all license start dates for providers who will be providing services through the SBHS program
 - ✓ Include the special education director or superintendent's signature

Note: The agency does not require schools to submit copies of licensure, NPI verification, and transcripts with the PUF, but these documents must be current and on file with the school district and available for review upon request.

- **Annual contact information** – School districts must submit the name, title, address, phone and fax numbers, and email address of all of the following:
 - ✓ Person responsible for receiving invoices from the agency and transmitting local funds
 - ✓ Person responsible for signing contracts with the agency

School-Based Health Care Services (SBHS)

- ✓ Person who receives agency contracts
- ✓ Billing agent or other contact who submits claims to the agency

Program Monitoring

What program monitoring and auditing does the agency conduct?

[WAC 182-537-0800](#)

- School districts must participate in all agency monitoring and auditing activities.
- School districts are responsible for the accuracy, compliance, and completeness of all claims submitted for Medicaid reimbursement.
- The agency conducts monitoring activities annually according to Chapter [182-502A](#) WAC.
- The School-Based Health Care Services Program Specialist conducts a minimum of 10 school-based Medicaid program reviews annually. During this time frame, the agency:
 - ✓ Completes a minimum of 5 record reviews as a desk review.
 - ✓ Conducts a minimum of 5 record reviews on-site.
- The agency conducts audits and recovers overpayments if a school district is found not in compliance with agency requirements according to RCWs [74.09.200](#), [74.09.220](#), and [74.09.290](#), which concern audits and investigations of providers.

Billing and Claim Forms

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

[WAC 182-501-0200](#)

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

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

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

- Receiving a denial letter or Explanation of Benefits (EOB) from the child's primary insurance carrier
- Attaching the written denial to the claim before submitting it to the agency

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

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

When the agency is being billed, follow the instructions found in the agency's [ProviderOne Billing and Resource Guide](#).

What is the intergovernmental transfer process (IGT)?

Schools are reimbursed for SBHS through an intergovernmental transfer process (IGT). IGT is the transfer of public funds between governmental entities. Public funds must be made up of state and local tax-based dollars. The SBHS program is funded by a 50/50 federal and nonfederal split. School districts must provide 60% (local match) of the nonfederal split. Once the local match is received from the school district, the agency releases claims for payment. The reimbursement includes the return local match along with the state matching funds (40%) and the federal funds. Schools must submit their local match within 120 days of receiving their A-19 invoice via email from the agency.

What is the National Correct Coding Initiative?

The agency follows 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 purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The purpose of the NCCI Medically Unlikely Edits (MUE) program is to prevent improper payments when services are reported with incorrect units of service.

NCCI rules are enforced by the ProviderOne payment system. More information on NCCI can be found on the [CMS website](#).

Procedure codes

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

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

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

Using untimed and timed procedure codes

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

Untimed Codes

If a code’s description does not include time, the code is billed as one unit regardless of how long the service takes.

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

Timed Codes

For any code reimbursed based on time, each measure of time as defined by the code description equals one unit. 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, 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, $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, $68 \text{ total billable minutes} = 5 \text{ units of service}$.

Examples:

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

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

The remittance advice (RA) provides needed information for school districts to check the status of claims. It is important for school districts to review their RAs weekly to determine if claims were paid, determine if any claims were denied and review the explanation for the denial. School districts should contact the agency’s customer service center at 1-800-562-3022 with questions on denied claims. Instructions on how to review the RA are available in the [ProviderOne Billing and Resource Guide](#).

How do I complete the CMS-1500 claim form?

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

- [DDE Professional claim](#)
- [DDE Professional with Primary Insurance](#)
- [DDE Medicare Crossover Claim](#)

Also, see Appendix I of the agency’s [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 claim form.

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

Field No.	Name	Action
24b	Place of Service	Enter 03 School
24e	Diagnosis Code	Enter R69 (Illness, unspecified)
24f	Charges	If billing for more than one unit, enter the total charge of the units being billed.

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

Fee Schedule

The [SBHS Fee Schedule](#) provides information about procedure codes and the maximum allowable payment rate per unit. The agency updates the fee schedule as the national codes are updated. School districts are expected to check the agency’s website for the current program fee schedule.