

Washington Apple Health (Medicaid)

School-Based Health Care Services (SBHS) Billing Guide

October 1, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority rule arises, the rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2022**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by [chapter 182-537 WAC](#).

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

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.

Refer also to HCA's [ProviderOne billing and resource guide](#) for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

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

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

Confidentiality toolkit for providers

The [Washington State Confidentiality Toolkit for Providers](#) is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, [visit the HCA website](#).

* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's [Forms & Publications](#) webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Confidentiality toolkit for providers	Added new resource for health care providers required to comply with health care privacy laws	New resource
Definitions	Added a new definition for Health Insurance Portability and Accountability Act (HIPAA)	To complement the use of "HIPAA-compliant" in the guide's telemedicine section
Program Overview	Added two new sections	To provide guidance about which organizations should and should not use this guide
What is the SBHS program?	Rewrote section	To describe the program more thoroughly and clearly. Clarification, not a policy change.

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Subject	Change	Reason for Change
Procedure codes	Added detail regarding telemedicine	To complement HCA's recent implementation of new telemedicine policies
Telemedicine	Reformatted Telemedicine to its own, high-level section. Rewrote and reorganized existing sections. Added new sections	To complement HCA's recent implementation of new telemedicine policies and add information to this billing guide that had previously been contained in a separate <i>SBHS COVID-19 FAQ</i> document, which HCA is eliminating effective October 1
What is the reimbursement rate for services provided through telemedicine?	New section	Same explanation as above
Telemedicine place of service	New section	Same explanation as above
Which services can be provided through HIPAA-compliant audio/visual telemedicine?	New section	Same explanation as above
Which services can be provided through audio-only telemedicine?	New section	Same explanation as above
Are audio-only phone calls to parents billable?	New section	Same explanation as above
What is the provider revalidation process?	Added Trading Partner Agreement form and removed current liability insurance from the list of revalidation requirements	To update this section to reflect HCA's current provider revalidation process

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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?	Shanna Muirhead, SBHS Program Specialist 360-725-1153 Email Shanna Muirhead
Where can I find more information about the SBHS program and how do I enter into a contract with SBHS?	School-Based Health Care Services (SBHS) webpage SBHS Checklist for Interested/New School Districts SBHS 101 Training
I am a new SBHS coordinator. What resources are available to me?	Checklist for New SBHS Coordinators SBHS 101 Training Additional training is available on the SBHS webpage
Who do I contact if I need help enrolling providers in ProviderOne or to check on status of an application?	How to Enroll Servicing Providers training Provider Enrollment 800-562-3022 ext. 16137 Email Provider Enrollment
I am a newly contracted school district. Who do I contact if I need help setting up my ProviderOne account?	How to Enroll as a Billing Provider training Provider Enrollment 800-562-3022 ext. 16137 Email Provider Enrollment
Who do I contact to reset my ProviderOne password, or if I am locked out of ProviderOne?	ProviderOne Security 800-562-3022 ext. 19963 Email ProviderOne Security
Who do I contact if I have questions about denied claims?	A school district contracted with a Billing Agent should contact the Billing Agent Self-billing school districts should <ul style="list-style-type: none"> • Email Shanna Muirhead or • Email Provider Relations

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Topic	Resource Information
Who do I contact if I need a copy of my SBHS contract?	Email Contract Services
Who do I contact with questions about the provider revalidation process?	Provider Enrollment 800-562-3022 ext. 16137 Email Provider Enrollment
How do I sign up for SBHS GovDelivery messages?	GovDelivery subscription SBHS program and policy updates are sent via GovDelivery. At least one contact per district should subscribe to GovDelivery to receive these messages.

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 needs 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 Health Care Authority and Apple Health (Medicaid) providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, Health Care Authority rules and regulations, and Health Care Authority program policies, provider notices, and provider guides, including this guide. Providers must submit a claim according to Health Care Authority rules, policies, provider alerts, and provider billing guides in effect for the date of service.

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

- Audiology services
- Health services
- Mental health services
- Nursing services
- Occupational therapy
- Physical therapy
- 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 or 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 Health Care Authority 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.

Health care-related services or health-related services – For the purposes of this billing guide, means developmental, corrective, and other supportive services required to assist a student age three through twenty who is eligible for special education, and includes audiology, mental health services, nursing services, occupational therapy, physical therapy, and speech-language therapy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – A federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the CPT® codes and descriptions only are copyright 2021 American Medical Association.

HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule.

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 21.

Individualized Education Program (IEP) – A written educational program for a child, who is age 3 through 21 and eligible for special education. An IEP is developed, reviewed, and revised in accordance with [WAC 392-172A-03090](#) through [392-172A-03115](#). See [WAC 392-172A-01100](#).

Individualized Family Service Plan (IFSP) – A plan for providing early intervention services to a child, birth through age 2, 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.

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 34 C.F.R. [Sec. 303.342](#) through [Sec. 303.343](#).

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

School-Based Health Care Services (SBHS) 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 Health Care Authority to establish an Intergovernmental Transfer framework to reimburse the school district for providing Medicaid-covered services by or under the supervision of licensed health care providers that are included in a child's current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

School-Based Health Care Services Fee Schedule or SBHS Fee Schedule – A document providing information about billable procedure codes and the maximum allowable payment rate per unit.

School-Based Health Care Services Program (SBHS) – A Health Care Authority-administered program that pays contracted school districts, educational service districts, charter schools, and tribal schools for providing early intervention services or special education health-related services to students ages birth through 20 who have an IEP or IFSP. Services are paid on a fee-for-service basis per the SBHS Fee Schedule.

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School-Based Health Care Services Program Specialist or SBHS Specialist – A person identified by the Health Care Authority 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 to assist the supervisee in the administration of early intervention or health care-related services outlined in the IEP or IFSP.

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

Program Overview

Who should use this billing guide?

Public school districts, educational service districts (ESD), charter schools, and tribal schools who hold an active School-Based Health Care Services (SBHS) contract with the Health Care Authority (HCA).

Who should NOT use this billing guide?

- School-based health centers/clinics
- Private schools
- School districts, ESDs, charter schools, or tribal schools that want to receive Medicaid payment for services not included in an IEP/IFSP (e.g., behavioral health services, applied behavior analysis services, immunizations, annual vision/hearing exams, 504 services, etc.)

What is the SBHS program?

The School-Based Health Care Services (SBHS) program is a Medicaid program administered by the Health Care Authority. The SBHS program provides reimbursement to contracted school districts, educational service districts, charter schools, and tribal schools for Medicaid-covered services that are included in an eligible student's individualized education program (IEP) or individualized family service plan (IFSP).

Public schools are required per the federal Individuals with Disabilities Education Act (IDEA) to provide special education and related services to eligible students. Participation in the SBHS program is optional, but it allows school districts to recover a portion of the costs incurred for providing health-related services to Medicaid-eligible special education students age birth through 20.

The SBHS program is funded through federal and state funds and school districts are paid on a fee-for-service basis according to the [SBHS Fee Schedule](#).

To receive Medicaid reimbursement, services must:

- Identify, treat, and manage the disabilities of a child who requires early intervention or special education and related services
- Be medically necessary. For the purposes of this billing guide, the services school-based providers render via an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) because of special education eligibility are health care-related by definition. Services are recommended to manage and treat the disability of a child who requires early intervention or special education and related services and are recommended by a licensed health care provider (the school provider or other licensed Medicaid provider).
- Be included in a Title XIX Medicaid-eligible student's current IEP or IFSP

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- Be prescribed or recommended by a physician or other Department of Health (DOH)-licensed provider operating within the provider's scope of practice under state law. See [Referrals and prescriptions](#).
- Be provided by or under the supervision of DOH-licensed providers
- Be provided in a school setting, the natural environment, an alternate setting in accordance with IDEA, 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?

School districts interested in participating in the SBHS program may view the [SBHS 101 training](#) and may also download the [SBHS Checklist for New School Districts](#) for more information. All SBHS program information can be found in this billing guide and additional resources and trainings are available on the [SBHS webpage](#).

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 \(NPPES\)](#). **Each school district and each licensed provider participating in SBHS must obtain an NPI.**
- [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 licensed school district providers and contracted licensed providers who participate in SBHS as servicing providers under the school district's ProviderOne account.
 - See [Provider Qualifications](#) section for a list of eligible provider types.
 - See [How do I enroll providers in ProviderOne?](#) for assistance with enrolling licensed providers in ProviderOne.
- Decide whether the district will self-bill or contract with a billing agent for assistance with claim submission.
 - Self-billing districts can review the [How to Submit SBHS Claims](#) training for assistance with submitting claims.
 - Districts who contract with a billing agent must work with their billing agent on the claim submission process.

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- Bill according to this billing guide, [chapter 182-537 WAC](#) for SBHS, and the SBHS contract.
- Assign one or more school staff to be the SBHS coordinator(s). See [What is the role of the SBHS coordinator?](#)

SBHS Coordinator

School districts participating in the SBHS program must assign at least one staff member as the SBHS coordinator. New coordinators should read this billing guide and view the [SBHS 101 training video](#) for a high-level overview of the SBHS program. Additional trainings and resources are available on the [SBHS webpage](#).

What is the role of the SBHS coordinator?

The role of the SBHS coordinator may vary by school district. Tasks and activities will most likely include:

- Enrolling licensed providers under the school district's ProviderOne account.
 - See the [Provider Qualifications](#) section to review which providers are eligible to participate.
 - See [How do I enroll providers in ProviderOne?](#)
 - If the school district contracts with a billing agent, the SBHS coordinator must also enroll the providers in the billing agent's web-based IEP/IFSP documentation software. SBHS coordinators may contact the school district's billing agent for more information.
- Collecting treatment notes from providers and entering claims in ProviderOne (for self-billing school districts). **If the school district contracts with a billing agent, the billing agent submits the claims in ProviderOne.**
- Maintaining the Provider and Contact Update Form (HCA Form 12-325) and submitting it to HCA's SBHS program specialist annually and throughout the year as changes occur. See [What is the Provider and Contact Update Form?](#)
- Reviewing remittance advices to view denied and paid claims. See [Remittance Advice](#).
- Receiving [SBHS GovDelivery](#) messages and communicating program updates with providers and school district staff.
- Sharing [SBHS provider trainings](#) and this billing guide with servicing providers. All provider trainings and a link to this billing guide are available on the [SBHS webpage](#).
- 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?

As the SBHS coordinator, you will need to be set up as a "System Administrator" and "Super User" in ProviderOne. To gain access to ProviderOne, new SBHS coordinators may contact HCA's [SBHS program specialist](#) for the name of the current ProviderOne System Administrator assigned to your district.

- If the current system administrator is still employed with the district, they must add you as a "System Administrator" and "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 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.
 - 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](#).
- Contact [Provider Relations](#) for assistance, if needed.

What is the Provider and Contact Update Form?

The Provider and Contact Update Form (HCA 12-325) (See [Where Can I Download HCA Forms?](#)) is a form that must be completed and submitted to HCA's SBHS program specialist at the beginning of each school year. By providing updated information to HCA, 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 update and submit the completed form to HCA's [SBHS program specialist](#) annually by October 31st and throughout the year as provider and staff changes occur.
- The "Contact Information" tab must include current school district contact information.

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- The “Provider Information” tab must include all licensed providers, licensed assistants, compact license holders, and interim permit holders who will be participating in the SBHS program for the current school year.
 - Nonlicensed school staff who provide services under the supervision of a licensed provider do not need to be listed on the form.
 - Enter a resignation date for any providers who have left the district within the past 3 months or who no longer participate in the SBHS program.
- Detailed instructions are included on the “Contact Instructions” and “Provider Instructions” tabs to assist school districts with completing the form.
- School districts should work from the same form each year. However, a blank form for newly SBHS-contracted school districts can be found on the [SBHS webpage](#).

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?](#) for more information.

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 HCA 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 HCA'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 HCA's [Program benefit packages and scope of services](#) webpage.

Note: People who are not Washington Apple Health clients may apply 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 HCA 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 HCA 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 HCA for SBHS. Federal law makes Medicaid the payer of last resort.

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

- Bill the student's private insurance carrier before billing HCA to receive a denial letter or Explanation of Benefits (EOB).

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- 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](#) or work with your billing agent on submitting claims for students who have private insurance.

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. 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 HCA 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 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](#).

Which students are not eligible for reimbursement?

HCA 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 (RAC) code, which is viewable in ProviderOne.

The following RAC codes are not eligible for reimbursement through the SBHS program. Claims submitted for students with the following RAC codes will be denied in ProviderOne:

Ineligible RAC codes			
1032	1033	1138-1142	1176
1179	1184	1185	1187
1189	1193-1195	1206	1207
1211-1213	1215	1216	1270
1272	1273		

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Provider Qualifications

Who may provide SBHS?

To receive Medicaid payment, SBHS must be delivered by or under the supervision of a Department of Health (DOH)-licensed provider. Licensed providers may be school district staff or contracted providers. School districts are responsible for ensuring providers meet the applicable DOH licensing requirements and are enrolled under the school district's ProviderOne account before submitting claims to HCA (See the [SBHS Eligible Provider Table](#) for a list of the providers who can participate in the SBHS program). Nonlicensed school staff do not need to be enrolled in ProviderOne. Any services provided by nonlicensed school staff must be billed under the supervising provider's NPI in ProviderOne.

Department of Health (DOH) license information

School districts may look up a licensed provider's DOH license information (i.e., license start date, last issue date, license number, license end date) on the [DOH Provider Credential Search tool](#).

DOH provider qualifications and continuing education requirements can be found on the [DOH Health Care Professional Credentialing Requirements webpage](#).

National Provider Identifier (NPI)

Licensed providers (including licensed assistants, compact license holders, and interim permit holders) participating in the SBHS program must have their own individual national provider identifier (NPI). Providers can apply for an NPI through the [National Plan and Provider Enumeration System \(NPPES\) webpage](#). School districts can look up a provider's NPI on the [NPI registry](#). Nonlicensed school staff providing services under the supervision of a licensed provider do not need an NPI.

Provider and Contact Update Form

School districts must use the Provider and Contact Update Form (HCA 12-325) to track all licensed providers (including licensed assistants, compact license holders, and interim permit holders) who participate in the SBHS program. School districts must record the provider's name, DOH license number, DOH license last issue date, DOH license end date, NPI, and the start date with the district. Nonlicensed school staff providing services under the supervision of a licensed provider do not need to be listed on this form. See [What is the Provider and Contact Update Form?](#) for more information on how to complete this form.

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SBHS Eligible Provider Table

Services	Eligible Provider Types	DOH License Requirements
Audiology	Licensed audiologists	Audiologist
Audiology	Audiology interim permit holders practicing under the supervision of a licensed audiologist	Audiology Interim Permit Holder
Audiology	Nonlicensed school staff (e.g., paraeducators, aides) practicing under the supervision of a licensed audiologist	
Mental Health Services	Licensed social workers	Licensed Social Worker
Mental Health Services	Licensed mental health counselors (LMHC)	Licensed Mental Health Counselor
Mental Health Services	Licensed mental health counselor associates (LMHCA) practicing under the supervision of a licensed mental health provider	Licensed Mental Health Counselor Associate
Mental Health Services	Licensed psychologists	Psychologist
Mental Health Services	Nonlicensed school staff (e.g., school counselors, school psychologists, school social workers) practicing under the supervision of a licensed mental health provider	
Nursing Services	Advanced registered nurse practitioners (ARNP)	Advanced Registered Nurse Practitioner
Nursing Services	Licensed registered nurses (RN)	Registered Nurse

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Services	Eligible Provider Types	DOH License Requirements
Nursing Services	Licensed practical nurses (LPN) practicing under the direction and supervision of a licensed ARNP or RN	Licensed Practical Nurse
Nursing Services	Nonlicensed school staff (e.g., paraeducators, aides) who are delegated health care tasks by an ARNP or RN and are supervised according to professional practice standards	
Occupational Therapy	Licensed occupational therapists (OT)	Occupational Therapist
Occupational Therapy	Licensed occupational therapy assistants (OTA) practicing under the supervision of a licensed OT	Occupational Therapy Assistant
Occupational Therapy	Nonlicensed school staff (e.g., OT aides, paraeducators, OT students) practicing under the supervision of a licensed OT	
Physical Therapy	Licensed physical therapists (PT)	Physical Therapist
Physical Therapy	PT/PTA compact license holders	Physical Therapy Licensure Compact
Physical Therapy	Licensed physical therapist assistants (PTA) practicing under the supervision of a licensed PT	Physical Therapist Assistant

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Services	Eligible Provider Types	DOH License Requirements
Physical Therapy	Nonlicensed school staff (e.g., paraeducator, aides, PT students) practicing under the supervision of a licensed PT	
Speech Therapy	Licensed speech-language pathologists (SLP)	Speech-Language Pathologist
Speech Therapy	Licensed speech-language pathology assistants (SLPA) practicing under the supervision of a licensed SLP	Speech-Language Pathology Assistant
Speech Therapy	Interim permit holders practicing under the supervision of a licensed SLP	SLP Interim Permit Holder
Speech Therapy	Nonlicensed school staff (e.g., nonlicensed SLPs, paraeducators, aides) practicing under the supervision of a licensed SLP	

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
Advanced registered nurse practitioner	363LS0200X

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Service provider types	Servicing provider taxonomy codes
Audiologist (including audiology interim permit holders)	231H00000X
Licensed practical nurse	164W00000X
Mental health counselor	101YS0200X
Mental health counselor associate	101YS0200X
Occupational therapist	225X00000X
Occupational therapist assistant	224Z00000X
Physical therapist (including PT compact license holders)	225100000X
Physical therapist assistant (including PTA compact license holders)	225200000X
Psychologist	103TS0200X
Registered nurse	163WS0200X
Social worker	1041S0200X
Speech therapist (including SLP interim permit holders)	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). HCA 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) and the Office of Superintendent of Public Instruction (OSPI). For services provided under the supervision of a licensed provider, 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.
- Supervisors are responsible for reviewing and cosigning all treatment notes written by the supervisee before submitting claims for payment.

Note: A certificate of clinical competence (CCC) is not required to supervise or bill Medicaid. SLPs must provide supervision per their scope-of-practice requirements with the Department of Health and the Office of Superintendent of Public Instruction.

How do I enroll providers in ProviderOne?

School districts must enroll all licensed providers, licensed assistants, compact license holders, and interim permit holders who participate in SBHS as servicing providers under the school district's ProviderOne account before submitting claims to HCA. Providers may be school district staff or contracted providers. HCA will deny claims for any licensed providers who are not enrolled with HCA. Nonlicensed school staff providing services under the supervision of a licensed provider do not need to be enrolled in ProviderOne.

For assistance in enrolling providers, school districts can:

- View [How to Enroll Servicing Providers](#) for step-by-step directions on how to enroll servicing providers.
- Contact [Provider Relations](#) or [Provider Enrollment](#) for assistance with enrolling providers.
- When enrolling multiple providers at one time, school districts may use the [roster spreadsheet](#) to upload bulk enrollment applications to ProviderOne.
 - Please review the [roster instructions for HCA providers only](#). Follow the instructions to complete the roster spreadsheet.
 - Once the roster spreadsheet has been filled out, follow the [instructions for roster file upload and reviewing roster errors](#) to upload the roster and resolve errors. (Find help for [troubleshooting roster error messages](#)).

Provider back-date process

After the school district enrolls servicing providers under the school district's ProviderOne account, HCA's Office of Provider Enrollment back-dates each provider to September 1 of the current school year. If the provider's DOH license was not active on September 1, Provider Enrollment will back-date the start date to the provider's license start date. This allows school districts to back-bill for services while waiting for Provider Enrollment to approve the provider's application in ProviderOne. If a provider's ProviderOne start date is not back-dated correctly, school districts may contact HCA's [SBHS program specialist](#).

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 may 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.

Coverage

What is covered?

The SBHS program pays school districts for:

- Evaluations provided by SBHS-eligible licensed providers within the provider's scope of practice when the child is determined to have a disability and needs early intervention services or special education and health care-related services.
- Reevaluations provided by SBHS-eligible licensed providers within the provider's scope of practice 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
 - Mental health services
 - Nursing/health services
 - Occupational therapy services
 - Physical therapy 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 and only when provided by DOH-licensed providers.

What is not covered?

It is the responsibility of the school district to contact HCA'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

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- 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

Referrals and prescriptions

To receive reimbursement for SBHS, services must be prescribed or referred by a physician or other Department of Health (DOH)-licensed provider within the provider's scope of practice under state law.

School providers who hold DOH licensure may be able to prescribe school-based services. Providers participating in the SBHS program 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 they can prescribe services or if a physician's referral or prescription is required.

Place of service (POS)

The SBHS program allows services to be provided in the school setting, in the natural setting, in the home, or in an alternate setting, in accordance with the Individuals with Disabilities Education Act (IDEA). Services may be provided in-person or through telemedicine. School districts and providers must ensure the appropriate POS is included on each claim submitted for reimbursement:

Place of Service (POS)	Place of Service Name	Place of Service Description	Note
02	Telehealth Provided Other than in Student's Home	The location where health services and health-related services are provided or received through telecommunication technology. Student is not located in their home when receiving health services or health-related services through telecommunication technology.	See Telemedicine section for additional information on when to use this POS
03	School	Education is the facility's primary purpose.	Used to denote in-person services or when billed with HCPCS code Q3014 (telehealth facility fee)
10	Telehealth Provided in Student's Home	The location where health services and health-related services are provided or received through telecommunication technology. Student is in their home (which is a location other than a hospital or other facility where the student receives care in a private residence) when receiving health services or health-related services through telecommunication technology.	See Telemedicine section for additional information on when to use this POS
12	Home	Location, other than a hospital or other facility, where the student receives care in a private residence.	Used to denote in-person services
99	Other Place of Service	Other place of service not identified above.	Used to denote in-person services

Procedure codes

Providers must use the applicable procedure codes listed under the [Coverage Table](#) section of this billing guide when billing for services. HCA'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. HCA 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 in person and through HIPAA-compliant audio/visual telemedicine. Audio-only service delivery is limited to certain codes. See [When does HCA cover telemedicine?](#) for more information on how to bill for services provided through HIPAA-compliant audio/visual and audio-only 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](#)).

HCA 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, $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, $68 \text{ total billable minutes} = 5 \text{ units of service}$.

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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?

HCA 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 HCA to control improper coding that may lead to inappropriate payment. HCA 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.

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

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

NCCI resources

For more information on NCCI edits, school districts and providers should review the [CMS Medicaid NCCI PTP and MUE Edit Files](#) available on the CMS webpage.

Diagnosis code

The SBHS program uses one diagnosis code, R69 (illness, unspecified). This diagnosis code must be entered on each claim to receive payment.

Directions on how to enter the diagnosis code on a claim in ProviderOne can be found in the resources below:

- Self-billing school districts: Review the [How to Submit SBHS Claims](#) training
- Billing agents/clearinghouses: Review HCA's [HIPAA Electronic Data Interchange \(EDI\) webpage](#)

Telemedicine

Under the SBHS program, HCA pays for services provided through telemedicine as outlined in this billing guide. Licensed providers, licensed assistants, compact license holders, interim permit holders, and nonlicensed school staff practicing under the supervision of a licensed provider may provide SBHS through telemedicine. Providers must use their professional judgement to determine if services can be provided safely and effectively through telemedicine. When providing services through telemedicine, providers must bill as outlined in the following section.

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 SBHS program also reimburses for some services when provided through audio-only telemedicine (i.e., telephone service delivery).

HCA does not cover the following services provided through telemedicine:

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

When does HCA cover telemedicine?

HCA 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. For a school district to receive reimbursement for telemedicine, the provider furnishing services must be enrolled as a servicing provider under the school district's ProviderOne account. Services provided by nonlicensed school staff must be billed under the supervising provider's NPI in ProviderOne.

What is the reimbursement rate for services provided through telemedicine?

School districts are reimbursed for services provided through telemedicine at the same rate as if the service was provided in person. Rates for all SBHS CPT/HCPCS codes are located in the current version of the [SBHS Fee Schedule](#).

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 through telemedicine

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- Provider must indicate whether the service was delivered through audio/visual or audio-only 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
- The home, daycare, or any location determined appropriate by the student or parents

Is the originating site paid for telemedicine?

Yes. When the originating site is the school (i.e., the student is at school) and the provider is at a distant site, the school district may submit a claim for the telemedicine facility fee (HCPCS code Q3014) when services are provided through HIPAA-compliant audio/visual telemedicine. See [Billing for services provided through audio/visual telemedicine](#) for more information.

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

Telemedicine place of service (POS)

To indicate a service was provided through telemedicine, either POS 02 or POS 10 must be included on the claim. The POS is based on the student's location:

Place of Service (POS)	Place of Service Name	Place of Service Description
02	Telehealth Provided Other than in Student's Home	The location where health services and health-related services are provided or received through telecommunication technology. Student is not located in their home when receiving health services or health-related services through telecommunication technology.

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Place of Service (POS)	Place of Service Name	Place of Service Description
10	Telehealth Provided in Student's Home	The location where health services and health-related services are provided or received through telecommunication technology. Student is in their home (which is a location other than a hospital or other facility where the student receives care in a private residence) when receiving health services or health-related services through telecommunication technology.

Telemedicine modifiers

The SBHS program uses two telemedicine modifiers (93 or 95). Telemedicine claims must include one of the following modifiers based on the platform used to deliver the service. For services that are partially audio/visual and partially audio-only, a service is considered audio-only if 50 percent or more of the service was provided via audio-only telemedicine.

Telemedicine Modifiers	Description	Comments
93	Synchronous Telemedicine Service Rendered through Telephone or Other Real-Time Interactive Audio-Only Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional.	Use only when providing services through audio-only telehealth (i.e., telephone with no visual component). Use with either POS 02 or POS 10.
95	Synchronous Telemedicine Service Rendered through Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.	Use only when providing services through HIPAA-compliant audio/visual telehealth. Use with either POS 02 or POS 10.

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Billing for telemedicine

Billing for services provided through audio/visual telemedicine

To indicate that the service was provided through HIPAA-compliant audio/visual telemedicine, school districts must submit a claim using either place of service (POS) 02 or POS 10, depending on the student's location, and must add modifier 95 to indicate the service was provided through HIPAA-compliant audio/visual telemedicine.

- **Student at school, daycare, or alternate setting and provider at distant site.** The school district:
 - Submits a claim for the CPT or HCPCS procedure code (as you would if the encounter was in person) with modifier 95 and place of service (POS) 02; and
 - If the student is located at the school, the school district submits an additional claim for procedure code Q3014 (telemedicine facility fee) with POS 03
- **Student at home and provider at school or distant site.** The school district:
 - Submits a claim for the CPT or HCPCS procedure code (as you would if the encounter was in person) with modifier 95 and place of service (POS) 10
 - Does not submit an additional claim for procedure code Q3014 because the student is not at school. The school district does not receive the telemedicine fee when the originating site is somewhere other than the school.

Note: To receive payment for the telemedicine fee (HCPCS code Q3014), the student must be located at the school and a corresponding CPT or HCPCS procedure code must be billed for the same date of service. Treatment notes must clearly reflect when services were provided through telemedicine.

Which services can be provided through HIPAA-compliant audio/visual telemedicine

Providers must use their professional judgment to determine if services can be provided effectively and safely through telemedicine. HCA provides reimbursement for all CPT/HCPCS procedure codes listed in this billing guide when provided through HIPAA-compliant audio/visual telemedicine platforms.

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Billing for services provided through audio-only telemedicine

To indicate that the service was provided through audio-only telemedicine (i.e., telephone service delivery with no visual component), school districts must submit a claim using either place of service (POS) 02 or POS 10, depending on the student's location, and must add modifier 93 to indicate the service was provided through audio-only telemedicine.

- **Student at school, daycare, or alternate setting and provider at distant site.** The school district:
 - Submits a claim for the CPT or HCPCS procedure code (as you would if the encounter was in person) with place of service (POS) 02 and modifier 93 (**DO NOT** add modifier 95)
 - Does not submit an additional claim for procedure code Q3014. HCA does not reimburse for the telemedicine facility fee for audio-only services.
- **Student at home and provider at school or distant site.** The school district:
 - Submits a claim for the CPT or HCPCS procedure code (as you would if the encounter was in person) with place of service (POS) 10 and modifier 93 (**DO NOT** add modifier 95)
 - Does not submit an additional claim for procedure code Q3014. HCA does not reimburse for the telemedicine facility fee for audio-only services.

Which services can be provided through audio-only telemedicine?

For the SBHS program, reimbursement for audio-only service delivery is limited to the following codes:

CPT®/HCPCS Procedure Code	Short Description
92507	Speech/hearing therapy
92521	Evaluation of speech fluency
92522	Evaluation of speech production
92523	Speech sound lang comprehen
97535	Self-care management training
S9445	Pt education noc individ

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Are audio-only phone calls with parents billable?

A phone call between a provider and a parent when the student is not present is not billable. If the student is present and the provider is speaking with the parent while the parent assists the child with performing the activities as part of the service delivery, this is billable.

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 or under the supervision of a licensed audiologist

The following are descriptions of SBHS-covered audiology services with the corresponding procedure codes. Providers can view the Billing for Audiology Services training available on the [SBHS webpage](#) for additional guidance on how to bill for audiology services.

CPT®/HCPCS 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	

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CPT®/HCPCS Procedure Code		
Procedure Code	Short Description	Comments
92587	Evoked auditory test limited	
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	
97533	Sensory integration	Timed 15 minutes
S9152	Speech therapy re-eval	

Mental Health services

SBHS-covered mental health services are diagnostic and treatment services involving mental, emotional, or behavioral problems or dysfunctions and include:

- Evaluations and reevaluations performed by a licensed mental health provider to determine if a student requires mental health services per an IEP or IFSP
- IEP/IFSP mental health services provided by or under the supervision of a licensed mental health provider

The following are descriptions of SBHS-covered mental health services with the corresponding procedure codes. Providers can view the Billing for Mental Health

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Services training available on the [SBHS webpage](#) for additional guidance on how to bill for mental health services.

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

Nursing/health services

SBHS-covered nursing/health services include:

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

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

The following are descriptions of SBHS-covered nursing/health services with the corresponding procedure codes. Providers can view the Billing for Nursing Services training available on the [SBHS webpage](#) for additional guidance on how to bill for nursing services.

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HCPCS Procedure Code	Short Description	Comments
T1001	Nursing assessment/evaluation	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

ARNPs and RNs must use procedure code T1001 when performing IEP or IFSP evaluations or reevaluations.

Code T1002 must be used for IEP/IFSP nursing/health services provided by or under the supervision of an ARNP or RN. Code T1003 must be used for IEP/IFSP nursing/health services provided by LPNs.

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

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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 or under the supervision of a licensed occupational therapist (OT)

The following are descriptions of SBHS-covered occupational therapy services with the corresponding procedure codes. Providers may view the Billing for Occupational Therapy Services training available on the [SBHS webpage](#) for additional guidance on how to bill for occupational therapy services.

CPT® 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
97150	Group therapeutic procedures	
97165	OT eval low complex, 30 min	Review MUE guidelines for maximum allowable units.
97166	OT eval mod complex, 45 min	Review MUE guidelines for maximum allowable units.
97167	OT eval high complex, 60 min	Review MUE guidelines for maximum allowable units.
97168	OT re-eval est plan care	
97530	Therapeutic activities	Timed 15 minutes
97533	Sensory integration	Timed 15 minutes

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CPT® Procedure Code	Short Description	Comments
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

Physical therapy services

SBHS-covered physical therapy services include:

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

The following are descriptions of SBHS-covered physical therapy services with the corresponding billing codes. Providers may view the Billing for Physical Therapy Services training available on the [SBHS webpage](#) for additional guidance on how to bill for physical therapy services.

CPT® Procedure Code	Short Description	Comments
95851	Range of motion measurements	Review MUE guidelines for maximum allowable units.
95852	Range of motion measurements	
97110	Therapeutic exercises	Timed 15 minutes

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CPT® Procedure Code	Short Description	Comments
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	Review MUE guidelines for maximum allowable units.
97162	PT eval mod complex, 30 min	Review MUE guidelines for maximum allowable units.
97163	PT eval high complex, 45 min	Review MUE guidelines for maximum allowable units.
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
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

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CPT® Procedure Code	Short Description	Comments
97761	Prosthetic training	Timed 15 minutes
97763	Orthc/prostc mgmt sbsq enc	Timed 15 minutes

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 or under the supervision of a licensed speech-language pathologist (SLP)

The following are descriptions of SBHS-covered speech-language therapy services with the corresponding procedure codes. Providers may view the Billing for Speech-Language Therapy Services training available on the [SBHS webpage](#) for additional guidance on how to bill for speech-language therapy services.

CPT®/HCPCS 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	
92568	Acoustic reflex testing, threshold	
92570	Acoustic immittance testing	
92607	Ex for speech device rx 1 hr	Timed 60 minutes

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CPT®/HCPCS Procedure Code		
Short Description	Comments	
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	
97533	Sensory integration	Timed 15 minutes
S9152	Speech therapy re-eval	

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Documentation

What are the documentation requirements for school districts?

School districts must maintain proper documentation to fully justify the services and billing for each student who receives SBHS. 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 6 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 6 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)

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- If services are provided through telemedicine, see the [Telemedicine](#) Section for additional documentation requirements
- All treatment notes require the licensed provider's printed name, handwritten or electronic signature, and title.
- Assistants, interim permit holders, and nonlicensed school staff, as defined in the Provider Qualifications section of this billing guide, who provide health care-related services, must have the supervising provider review and cosign all treatment notes prior to submitting claims to HCA for reimbursement.
- As described in [WAC 182-502-0020](#), all records must be easily and readily available to HCA upon request.

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 licensed provider, compact license holder, licensed assistant, and interim permit holder 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 HCA, but it must be kept on file at the school and made available for CPT® codes and descriptions only are copyright 2021 American Medical Association.

all monitoring activities. Nonlicensed school staff providing services under the supervision of a licensed provider do not need to sign the signature log.

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

Electronic signatures

The SBHS program accepts electronic signatures on treatment notes and other documents. 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 must develop policies and procedures to ensure complete, accurate, and authentic records. These policies and procedures may 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 HCA, except under limited circumstances.
- For more information, see [Paperless Billing at HCA](#).
- For providers approved to bill paper claims, see HCA's [Paper Claim Billing Resource](#).

What are the requirements for payment?

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

- Have a current, signed and executed SBHS contract with HCA
- Have an active ProviderOne account and a current, signed core provider agreement (CPA) with HCA
- Meet and comply with the applicable requirements in [chapter 182-502 WAC](#), which includes the following:
 - Submitting the initial claim to HCA and having a transaction control number (TCN) assigned within 365 calendar days from the date the provider furnishes the service to the eligible client
 - Resubmitting, modifying, or adjusting an initial claim within 24 months from the date of service
- Ensure licensed providers, compact license holders, licensed assistants, and interim permit holders have their own National Provider Identifier (NPI)
 - Enroll these licensed providers as servicing providers under the school district's ProviderOne account
 - Only bill for services provided by or under the direction of licensed providers
- Comply with the applicable sections in HCA's current [ProviderOne Billing and Resource Guide](#)
- Bill according to the SBHS Billing Guide and the [SBHS Fee Schedule](#)
- Meet and comply with the applicable requirements in [chapter 182-537 WAC](#)
- Only bill for health care-related services identified in a current individualized education program (IEP) or individualized family service plan (IFSP) and ensure services are prescribed or recommended by a licensed provider

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- Meet the documentation requirements in this billing guide (See [Documentation](#))
- Participate in all Provider Revalidation activities (See [What is the Provider Revalidation Process?](#))

How often are school districts paid?

After claims are submitted in ProviderOne by the SBHS coordinator (self-billing districts) or the district's contracted billing agent, the school district receives payment from HCA via electronic funds transfer or paper check.

ProviderOne makes weekly payments, typically every Thursday. Claim submission cutoff in the payment system is Tuesday at 5 p.m. Pacific Time to make payment on Thursday of the same week for a "clean" claim. Clean claims submitted after cutoff will be paid the following payment cycle on the following Thursday. Clean claims are claims that have all the required data elements and do not conflict with SBHS program policies.

Claims may arrive in the payment system before 5:00 p.m. on Tuesday but may not process until after the cutoff time. These claims will miss the Thursday payment and will be paid the following payment cycle on the following Thursday.

How are school districts paid?

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

- For districts that have chosen to receive payment by paper check, HCA mails checks to the mailing address listed in ProviderOne.
- For districts that have chosen to receive payment through EFT, HCA submits payment to the bank account listed in ProviderOne.

To update the mailing address or bank information listed in ProviderOne or to sign up to receive payment through EFT, school districts may contact Provider Enrollment:

800-562-3022 ext. 16137

Email ProviderEnrollment@hca.wa.gov

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. New RAs are available in ProviderOne every Friday.
- School districts may view the [Reading the Remittance Advice Training](#) for directions on how to view the remittance advices in ProviderOne.
- If your district contracts with a billing agent, your billing agent may email you a copy of the RA weekly or monthly.

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- 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](#)).

Time limits for billing HCA

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

School districts 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 HCA on time.

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

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

If HCA 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 HCA 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 the following to receive payment from HCA:

- Bill third-party carriers before billing HCA
- 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 HCA'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.

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Fee schedule

The [SBHS Fee Schedule](#) provides a list of billable procedure codes for the SBHS program and the maximum allowable payment rate per unit. HCA updates the SBHS Fee Schedule as the national codes and rates are updated by the federal Centers for Medicare and Medicaid Services (CMS). Updates typically occur on July 1 of each year.

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. In addition, HCA does not regulate how school districts spend their Medicaid payments. Most school districts put the Medicaid funding back into their Special Education budget, but it is up to each school district how they spend their Medicaid dollars.

Program Integrity

What program integrity activities does HCA conduct?

To ensure compliance with program rules, HCA 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.
- HCA conducts reviews and recovers overpayments if a school district is found not in compliance with HCA requirements according to HCA rules.

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 5 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, HCA'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](#).
- 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 HCA. 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 a Trading Partner Agreement (form 18-0009). See [Where can I download HCA forms?](#)

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- A current [Internal Revenue Service \(IRS\) W-9 form](#).
- All required forms must be uploaded to the school district's ProviderOne account. Download the instructions for [how to upload attachments in ProviderOne](#)
- Additional information about the provider revalidation process can be found on [HCA's Billers, providers, and partners webpage](#).
- Questions about the revalidation process must be directed to [Provider Enrollment](#).