Washington State Health Care Authority

Washington Apple Health (Medicaid)

Community Behavioral Health Support Services (CBHS) Billing Guide

January 1, 2026

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA 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, check the most recent version of the guide. If the broken link is in the most recent guide, please email us about the broken link.

About this guide*

This publication takes effect **January 1, 2026,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide are governed by the rules found in chapter 182-561 WAC.

HCA 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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

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.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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* 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: 13-0124).

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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
Early periodic screening, diagnosis, and treatment (EPSDT)	Added information regarding the services available through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit	To provide information about EPSDT services and accessibility
State hospitals and carceral settings	Deleted the struck through language: in an inpatient care setting at Eastern or Western State Hospitals~~, or placed in a community hospital, such as a community psychiatric setting or acute care hospital setting,~~ may be assessed	This language is not appropriate for this section. See instead, the section titled Other hospital settings.

Subject	Change	Reason for Change
What is the CBHS pathway to care?	Updated the table	To provide clarity regarding the steps HCA (for fee-for-service clients) and the MCO (for managed care clients) take to process a referral
Eligibility Start Dates New referrals	Changed the name of the section from "Authorization Start Dates" to "Eligibility Start Dates" Changed the cutoff date for referrals from the 27th to the 21st day of the month Clarified that, for clients transitioning into the community following an inpatient event, eligibility begins on the first day of the month the client transitions to a residential community setting	For administrative simplification, eligibility now begins the first of the month in which the referral is received for referrals received through the 20th day of the month. For referrals received on the 21st day or later, eligibility begins the first day of the following month. To clarify that, for clients transitioning into the community, eligibility begins on the first day of that month, not the day the client enters the community
Annual or significant change referrals	Added exception language: **Exception**: If CBHS eligibility ends before the first of the following month, the eligibility date will be the first of the month after CBHS eligibility ends. Added an explanation and examples for annual or significant change renewals that are being tiered lower	To add additional clarifying language regarding eligibility start dates
Supportive supervision re-tiering requests	Rewrote the section	To provide clearer instructions for initiating a tier level change

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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Contacting Provider Enrollment	See HCA's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Finding HCA documents (e.g., billing guides, fee schedules)	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's ProviderOne Resources webpage
Access E-learning tools	See HCA's ProviderOne Resources webpage
Community Behavioral Health Support Services general information	See HCA's CBHS webpage

Definitions

This list 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.

Adult family home (AFH)- A residential home licensed to care for up to six nonrelated residents. An AFH provides room, board, laundry, supervision, and help as needed with activities of daily living, personal care, and social services. See RCW 70.128.010.

Activities of daily living (ADL)- Certain self-care activities related to personal care. See RCW 18.20.310 and WAC 388-106-0010.

Adult residential care facility (ARC) – A licensed assisted living facility that has an adult residential care contract with the Department of Social and Health Services to provide a supervised living arrangement in a home-like environment for seven or more people. ARC services include housing, housekeeping services, meals, snacks, laundry, personal care, and activities.

Assisted living facility (ALF)- A facility in a community setting that is licensed to care for seven or more residents. An ALF provides room and board and helps with activities of daily living (ADL). Some ALFs provide limited nursing services; others may specialize in serving people with mental health problems, developmental disabilities, or dementia (Alzheimer's disease). See RCW 18.20.020(2).

Atypical provider identifier (API)- Atypical providers are providers that do not provide health care, as defined under HIPAA in Federal regulations at 45 CFR section 160.103. An API number is issued by HCA to use in the NPI field for providers unable to acquire an NPI.

Behavioral health agency (BHA)- An entity licensed by the Department of Health to provide behavioral health services under chapters 71.05, 71.24, or 71.34 RCW.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) - The manual published under this title by the American Psychiatric Association that provides a common language and standard criteria for the classification of mental disorders.

Enhanced adult residential care facility (EARC)-A licensed assisted living facility (ALF) with an enhanced adult residential care contract with the Department of Social and Health Services to provide adult residential care (ARC) services. In addition to the services provided under an ARC services contract, the EARC provides medication administration and intermittent nursing services if the client has an assessed need for those services.

Enhanced services facility (ESF)- A facility that provides support and services to persons for whom acute inpatient treatment is not medically necessary. See RCW 70.97.010.

Instrumental activities of daily living (iADL) – See WAC 388-106-0010.

Managed care organization (MCO) – See WAC 182-538-050.

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

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Program Overview

What is the Community Behavioral Health Support Services benefit?

Community behavioral health support services are individually tailored to help clients acquire, retain, restore, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community-based settings.

Supportive supervision providers furnish services to clients on a one-on-one basis to monitor, redirect, divert, and cue the client to prevent at-risk behavior that may result in harm to the client or to others. These interventions are not related to the provision of personal care.

These services assist clients in building skills and resiliency to support stabilized living and integration. Interventions are coordinated as appropriate with other support services, including behavioral health services.

Note: Supportive supervision does not cover environmental modifications, such as requests for individual rooms or other material goods or services.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

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

- **Online**: Go to Washington Healthplanfinder - select the "Let's get started" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".

- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the HCA-contracted MCO, if appropriate. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exception: Apple Health Expansion clients are enrolled in MC and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment or have the option to enroll in fee-for-service (FFS). These clients are eligible for physical health services under the fee-for-service program.

In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, with

the exception of American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement)
- Age 20 and younger who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAC) team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

Early periodic, screening, diagnosis, and treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide; see also the rules for the EPSDT program in **chapter 182-534 WAC.** Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165**.

Note: CBHS is not an EPSDT service.

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Eligibility for the CBHS benefit

Who may receive the CBHS benefit?

(WAC 182-561-0300)

To receive the CBHS benefit, a person must meet all the following:

- Be age 18 or older
- Be eligible for Apple Health
- Receive home and community services in a licensed residential facility
- Have a qualifying diagnosis as identified in WAC 182-561-0700. (Providers must use the most appropriate diagnosis code.)
- Meet the additional criteria described in WAC 182-561-0300

Qualifying behaviors

A qualifying behavior for supportive supervision must be related to and driven by a primary diagnosis of mental illness, as identified in WAC 182-561-0700.

A psychiatric symptom is not necessarily a qualifying behavior. To be a qualifying behavior for supportive supervision, the behavior must create a risk to safety and/or cause distress to and escalate the client or other residents to crisis if not monitored and redirected by staff.

Behaviors that result in a need for additional staff or additional staff time to attend to activities of daily living (ADL) or instrumental activities of daily living (iADL) needs are not considered qualifying behaviors for the purpose of supportive supervision tiering.

Provisional Approval

A provisional approval may aid the transition process and be granted for clients who are not currently active on Medicaid. A provisional approval does not guarantee services, but signifies the client is functionally eligible for CBHS services pending Medicaid eligibility.

State hospitals and carceral settings

Clients who are currently incarcerated or in an inpatient care setting at Eastern or Western State Hospitals may be assessed for functional eligibility for CBHS services. The managed care organization (MCO) must submit a CBHS referral to HCA to review for functional eligibility.

HCA reviews the CBHS referral and determines if the client meets functional eligibility criteria. HCA returns the referral to the MCO marked as a provisional approval.

Once the client transitions from the state hospital or carceral setting and their Medicaid coverage is activated, the MCO resubmits the referral form for HCA to determine financial eligibility.

Other hospital settings

Clients placed in a community hospital, such as a community psychiatric setting or acute care hospital setting, may also be assessed for functional eligibility for CBHS services. The Home and Community Services (HCS) case manager submits a CBHS referral to HCA to review for functional eligibility. HCA reviews the CBHS referral and determines if the client meets functional eligibility criteria. HCA returns the referral to the HCS case manager marked as a provisional approval.

Once the client transitions from the community hospital setting, the client's Medicaid coverage is activated and the client is enrolled with an MCO. At that time, the HCS case manager sends the provisionally approved referral to the newly assigned MCO to review. The MCO submits the referral to HCA to determine financial eligibility.

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Provider Requirements

Who may provide supportive supervision services?

The following licensed, agency-contracted facilities may provide supportive supervision services. Providers must use the associated billing taxonomy when setting up a profile in ProviderOne.

Facility Type	Taxonomy
Adult family home (AFH)	311ZA0620X
Assisted Living Facilities (ALF), including the following subcontracted under an ALF: • **Enhanced Adult Residential Care Facility (EARC)** • **Adult Residential Care (ARC) Facility**	310400000X
Enhanced services facilities	3104A0625X

Additional requirements to provide supportive supervision

Supportive supervision providers must meet both of the following:

- Have a signed core provider agreement (CPA) with HCA
- Contract with Apple Health managed care organizations for residents receiving Medicaid through managed care.

See the Community Behavioral Health Support Services Program Guide on the CBHS webpage for more information.

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Accessing CBHS Services

What is the CBHS pathway to care?

To initiate community behavioral health support services, the Home and Community Living Administration (HCLA) of the Department of Social and Health Services completes a CARE assessment and submits the Community Behavioral Health Supports (CBHS) referral form (HCA 13-0124) to:

HCA	MCOs
For fee-for-service clients	For managed care clients
HCA: • Reviews the CARE assessment and clinical documentation • Confirms function and financial eligibility • Makes a tier determination and authorization • Coordinates services with residential providers	• The MCO reviews the CARE assessment and clinical documentation and makes an eligibility recommendation, with a tier recommendation if applicable, and submits to HCA • HCA confirms functional and financial eligibility and submits the eligibility determination back to the MCO for tier determination and authorization • The MCO coordinates services with residential providers

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Supportive Supervision Tier Levels

Payment for supportive supervision services is divided into six tiers. HCA and the managed care organizations use the information in the **tier guidance table** and the supporting documentation provided with the referral form to determine the appropriate level of care. The level of care is based on the frequency and intensity of **qualifying behaviors**.

To ensure the provider is furnishing the average number of hours for the authorized tier, the provider:

- Adds the total number of hours documented for provided services in a calendar week starting on Sunday at 12:01 a.m. and ending on Saturday at midnight; and
- Divides by seven.

Example: For a client who receives 42 hours of services in a calendar week, divide the total by seven to reach an average of six hours per day.

> **Note:** When the average weekly amount exceeds or falls below the approved number of hours for four consecutive weeks, a provider may request a reassessment of hours, or HCA and the MCO may reassess the hours needed.

At a minimum, all clients eligible for supportive supervision qualify for tier one. Payment for services provided is based on the authorized tier, which is determined by the client's acuity needs as described in the tier guidance table.

Tier guidance table

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 1: 0.5 – 2.0 hours per day	The client demonstrates a qualifying behavior(s) that requires daily intermittent monitoring, redirection, and cueing to promote community stability and to ensure the safety of the client and other residents. **OR** The client has a significant history of behaviors that are well-managed in a highly structured setting but are at risk of recurring in a community setting if not met with the appropriate level of supportive supervision. **OR** For renewal or re-assessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention. **Examples:** • Client's response to delusions and hallucinations require intermittent redirection at baseline • Mood swings and tearfulness that require additional reassurance • Repetitive complaints or requests that require additional staff time, but do not escalate • Irritability and agitation that can be mediated by taking a thoughtful approach and allowing additional time to complete tasks • Multiple prompts often required for tasks	S5126 Attendant care services, per diem	None

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 2: 2.1 – 6.0 hours per day	The client demonstrates current, qualifying behavior(s) at a frequency that requires an average of 2.1-6.0 hours per day of dedicated staff to redirect, deescalate, and cue to promote community stability and to ensure the safety of the client and other residents. **OR** The client has demonstrated multiple qualifying behaviors requiring an average of 2.1-6.0 hours per day of 1:1 staffing within the past month. Behaviors may be well-managed in a highly structured setting but are at risk of recurring in a community setting if not met with the appropriate level of supportive supervision. **OR** For renewal or reassessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention at this tier level. **Examples:** • May include behavioral examples from previous tier(s) and: • Client's response to delusions and hallucinations requires regular redirection or environmental modification at baseline to prevent escalation • Irritability and agitation sometimes expressed through yelling/screaming • Poor frustration tolerance can result in verbal abuse of staff or other residents • Sometimes intrusive to other residents' personal space or property, creating risk of harm if not deescalated promptly	S5126 Attendant care services, per diem	TF

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 3: 6.1 – 10.0 hours per day	The client demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 6.1-10.0 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and to ensure the safety of the client and other residents. **OR** The client has demonstrated multiple qualifying behaviors requiring an average of 6.1-10.0 hours per day of 1:1 staffing within the past month. Behaviors may be well-managed in a highly structured setting but are at risk of recurring and/or increasing in frequency/severity in a community setting if not met with the appropriate level of supportive supervision. **OR** For renewal or reassessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention at this tier level. **Examples:** • May include behavioral examples from previous tier(s) and: • Irritability and agitation often expressed through intimidating behavior or posturing • Requires close monitoring to prevent intentional self-injury • Engages in wandering, but redirectable if closely monitored • Sexually inappropriate comments • If awakens during night to toilet, able to return to bed without excessive prompting	S5126 Attendant care services, per diem	HE

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 4: 10.1 – 15.0 hours per day	The client demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 10.1-15.0 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and ensure the safety of the client and other residents. **OR** The client has demonstrated multiple qualifying behaviors requiring an average of 10.1-15.0 hours per day of 1:1 staffing within the past month. Behaviors require at least 1:1 intervention, even in a structured setting, but may be at risk of increasing in frequency and/or severity in a community setting if not met with the appropriate level of supportive supervision. **OR** For renewal or reassessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention at this tier level. **Examples:** • May include behavioral examples from previous tier(s) and: • Assault on staff or other residents within the past 6 months • Requires close monitoring during most awake hours to prevent and redirect elopement attempts • Routinely engages in property damage, which may include breaking/throwing items • Engages in sexually inappropriate behavior (e.g., exposure, public masturbation, groping, etc.)	S5126 Attendant care services, per diem	TG

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 5: 15:1 – 20.0 hours per day	The client demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 15.1-20.0 hours per day of 1:1 staffing to redirect, engage, deescalate, and cue to promote community stability and ensure the safety of the client and other residents. **OR** Behaviors require daily 1:1 intervention even in the context of a structured setting and there would be an imminent risk of harm should the client not receive an average of 15.1-20.0 hours per day of at least 1:1 staffing in a community setting. **OR** For renewal or re-assessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention at this tier level. **Examples:** • May include behavioral examples from previous tier(s) and: • Regularly engages in assaultive behavior toward staff or other residents • Has an irregular sleep schedule or frequent awakenings and requires 1:1 staffing whenever awake to address disruption to other residents • Elopement attempts and/or wandering that place the client's safety at risk may occur multiple times per month • Safety concerns include recent or historical pattern of fire-setting behavior • Disorganized behavior places the client at risk of harm if unaccompanied in the community • There is a very recent or prolonged history of sexually aggressive behavior	S5126 Attendant care services, per diem	HK

Rate Tier	Tiering Guidance	HCPCS Code	Modifier
Tier 6 20.1 – 24 hours per day	The client demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 20.1-24 hours per day of 1:1 staffing and/or regular episodes that require multiple staff to redirect, engage, deescalate, and cue to promote community stability and ensure the safety of the client and other residents. **OR** Behaviors require constant 1:1 monitoring and intervention even in the context of a structured setting and there would be an imminent risk of harm should the client not receive an average of 20.1-24 hours per day of at least 1:1 staffing in a community setting. **OR** For renewal or reassessment, the client has a history of behavior(s) meeting the guidelines above, which are currently prevented only by additional skilled staff intervention at this tier level. **Examples:** • May include behavioral examples from previous tier(s) and: • Consistently engages in assaultive behavior toward staff or other residents at baseline • Demonstrates a consistent pattern of self-harming behavior that is prevented only with line-of-sight supervision • Is consistently awake at night engaging in behavior that causes a significant threat to safety, such as those that could lead to fire or predatory behavior toward other residents • Elopement attempts may occur multiple times per week *and* elopement could lead to an imminent threat to client or community safety • Demonstrates current sexually aggressive behavior that is directed toward a specific target	S5126 Attendant care services, per diem	HI

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Eligibility Start Dates

New referrals

For all referrals received by the 20th day of the month, the effective date is the first day of the month in which the referral was received.

Example: If HCA receives a referral for a new client on March 15, eligibility begins March 1.

For referrals received on the 21st day of the month or later, eligibility begins the first day of the following month.

Example: If HCA receives a new client referral on March 27, eligibility begins April 1.

For clients transitioning into the community following an inpatient event, eligibility begins on the first day of the month the client is transitioned to a residential community setting and continues through the end of the client's current CBHS eligibility period.

Annual or significant change referrals

Annual referrals or referrals for a client with a significant change have an eligibility start date effective the first day of the following month.

Exception: If CBHS eligibility ends before the first of the following month, the eligibility date will be the first of the month after CBHS eligibility ends.

Example: If HCA receives a referral for a client before their annual assessment date on March 12, a new year of eligibility begins April 1.

For annual or significant change renewals that are being tiered lower, the plan will give at least 10 calendar days' notice prior to implementing any reduction in service.

Once a verbal notice is given to the residential provider, the plan will implement the lower tier effective the first of the following month. If the 10 calendar days extend after the first of the month, the first day of the lower tier will begin the next month.

Example #1: A client renewal is reviewed and completed November 15. The plan contacts the residential provider on November 18. Counting from November 19, 10 calendar days would be November 28. The new tier begins December 1.

Example #2: A client renewal is reviewed and completed November 22. The plan contacts the residential facility on November 23. Counting from November 23, 10 calendar days would be December 3. The new tier begins January 1.

To document this change on the referral form, the managed care reviewer will:

- Select the new tier with a start date to correspond with the renewal start date; and
- Document the date they verbally contacted the home in the "Date of Adverse Benefit Determination" field. If the 10 calendar days exceeds the first of the month (Example #2), the MCO will include in the comments that the home may bill one more month at the current tier.

Washington State Health Care Authority

Documentation

Supportive supervision documentation

The provider must document the services provided and be able to submit this documentation upon request.

The daily documentation must include basic client information, such as name and date of birth and service information, such as:

- Date of service
- Approximate time/duration of services
- A summary of services

The summary of services must include:

- The name(s) of the staff who provided the services throughout the day.
- A description of behaviors exhibited or prevented for which intervention was needed
- The intervention(s) provided by the staff (e.g., monitoring, redirection, diversion, and/or cueing)

The summary of services provided must be signed (either on paper or electronically) by at least one provider each day.

HCA developed the CBHS *Supportive supervision attestation form* (HCA 13-0126) as an optional resource for documenting daily services provided.

Recordkeeping requirements

CBHS providers must retain the following records for clients receiving CBHS supportive supervision:

- CARE assessment
- Billing spreadsheets
- Daily supportive supervision documentation
- Other records required by contract

Supportive supervision re-tiering requests

Providers or clients can use the **Supportive supervision re-tiering request form** (HCA 13-0126) to request an increase or decrease in the client's CBHS Supportive Supervision tiering. To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box.

To initiate a tier level change request, the provider or client must submit a *Supportive Supervision re-tiering request* form with supporting documentation to the client's MCO or HCA for FFS.

The requestor must support, with data, any increase or decrease in the client's behaviors that result in the need for a change in the client's one-on-one support, including:

- Information about the behavior
- Interventions
- The time needed for the interventions
- Any documentation that supports the request, including:
  - Daily logs,
  - Care assessments,
  - Behavioral support plans, or,
  - Any other supporting documents demonstrating the client's needs are not met by the current tier.

The CBHS payor must review the request and make a determination within five days of receiving the request.

Washington State Health Care Authority

Billing

What are the general billing requirements?

Providers must follow the billing requirements listed in HCA's ProviderOne Billing and Resource Guide. The guide explains how to complete electronic claims.

- The MCOs must provide the authorization number on the professional claim (837P format).
- To be paid, the dates of service, procedure code, modifier(s) when above tier one, and units of service must match those authorized on the authorization record.
- The provider must add the taxonomy used on the claim submitted to HCA or the MCO to the provider's profile in ProviderOne. (For more information, see Completing the Core Provider Agreement.)

For current rates, see HCA's **provider billing guides and fee schedule webpage**.

> **Note:** All claims must be submitted electronically to HCA, except under limited circumstances.
>
> For more information about this policy, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

Fee-for-service providers

Providers must use the approved procedure codes for all service units, include the dates of service for the approved tier (see the Tier guidance table) and bill on a single service line on the claim.

Each span of dates may be billed as a separate claim. For example

- If the provider supported the same client from 8:00 a.m. to 10:00 a.m. and again from 3:00 p.m. to 5:00 p.m. on the same day, this is one day of service.
  - Separating the diagnosis codes into two service lines of eight units for the same date of service will generate a denial for duplication.
- If the provider furnishes services daily for multiple dates of service, the provider can bill the time span of dates (e.g., the 1st through the 15th for 15 days of service) and 15 units.
- If a provider furnished services from 8:00 a.m. to 10:00 a.m. on Monday and again from 1:00 p.m. to 5:00 p.m. on Tuesday, the provider may bill the approved tier diagnosis code on:
  - Two separate claims as one unit each day; or
  - One line for both days as two units.

Managed care providers

Providers must use the approved procedure codes for all service units. Include the dates of service for the approved tier (see the **Tier guidance table**), and bill on a single service line on the claim.

Each date span may be billed as a separate claim. For example:

- If the provider supported the same client from 8:00 a.m. to 10:00 a.m. and again from 3:00 p.m. to 5:00 p.m. on the same day, this is one day of service.
    - Separating the diagnosis codes into two service lines of eight units each will generate a denial for duplication.
- If the provider furnishes services daily for multiple dates of service, the provider can bill the time span of dates (e.g. the 1st through the 15th for 15 days of service) and 15 units.
- If a provider furnished services from 8:00 a.m. to 10:00 a.m. on Monday and again from 1:00 p.m. to 5:00 p.m. on Tuesday, the provider may bill the approved tier diagnosis code on:
    - Two separate claims as one unit each day; or
    - One line for both days as two units.

All encounters must include the approved servicing provider's national provider identifier (NPI) and taxonomy.

HCA follows the guidelines in the Encounter Data Reporting Guide to generate service based enhancements.

How to bill for supportive supervision?

Managed care clients

Adult Family Homes

Adult family home providers must submit the Supportive Supervision Reporting Spreadsheet (located on the **CBHS webpage**) to the client's respective managed care organization (MCO). The spreadsheet is divided by tiers, and the adult family home adds clients to the appropriate tier level tab.

> **Note:** If an adult family home serves more than one client enrolled with the same MCO, the adult family home must submit a different spreadsheet for each client.

Providers must submit the spreadsheet to HCA and the MCO using the approved billing template. Providers must also:

- Submit the form in an excel format with HIPAA-compliant encryption or through a secure file transfer.
- Complete all fields.

Other community residential settings

Other community residential settings, such as assisted living facilities, must follow the MCO billing process.

Fee-for-service clients

Adult Family Homes, Assisted Living Facilities, and Other Community Residential Settings

CBHS providers must submit the Supportive Supervision Reporting Spreadsheet (located on the CBHS webpage) to HCA for clients not enrolled in a managed care plan. The spreadsheet is divided by tiers, and the provider adds clients to the appropriate tier level tab. Submit the Supportive Supervision Reporting Spreadsheet to: hca1915iservices@hca.wa.gov for payment.

Referral turnaround times

Organization	Claim Turn Around Time	Referral Turnaround Time Upon Receipt
MCO partners	30 days for MCO clients	Submit complete authorizations within 7 business days for inpatient clients For all others, submit within 14 business days
HCA	30 days	Two business days for a complete authorization