Social Services ProviderOne Billing Supplement for Providers of Physical, Occupational, or Speech Therapy

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

The purpose of this billing supplement is to assist ProviderOne social services providers to properly bill the Health Care Authority (agency) for services provided to eligible clients.
Services referred to in this guide are NOT payable in an outpatient setting.

What procedure codes may I bill the agency?

Home Health

Refer to the *Outpatient Rehabilitation Therapy Evaluation Codes Table* in the agency's Home Health Billing Guide for a complete listing of procedure codes to bill for services provided. When authorized for a blanket code:

- Code SA888 applies to the following PT procedure codes:
  - ✓ 97001
  - ✓ 97002
  - ✓ 97542
- Code SA889 applies to the following OT procedure codes:
  - ✓ 97003
  - ✓ 97004
  - ✓ 97542
- Code SA892 applies to the following ST procedure codes:
  - ✓ 92521
  - ✓ 92522
  - ✓ 92523
  - ✓ 92524

CPT® codes and descriptions only are copyright 2015 American Medical Association.

Note:

Even though your authorization may not include modifiers (GO, GN, etc.), when billing the agency, you must use the appropriate modifier from the *Modifier* column in the *Outpatient Rehabilitation Therapy Evaluation Codes Table*.

Any limits referenced on the coverage table apply to medical eligibility only. If the service authorized exceeds the duration or scope of the Medicaid State Plan, or if the client is not covered by the Medicaid State Plan, the services are limited to the authorization you received for the client.

Outpatient Rehabilitation and Neurodevelopmental Centers

Refer to the *Coverage Tables* in the agency's Outpatient Rehabilitation Billing Guide and Neurodevelopmental Centers Billing Guide for a complete listing of procedure codes to bill for services provided. When authorized for a blanket code[1]:

- Code SA888 applies to physical therapy current procedural terminology (CPT®) procedure codes.
- Code SA889 applies to the occupational therapy CPT procedure codes.
- Code SA892 applies to the following speech-language pathology CPT procedure codes:
  - ✓ 92521
  - ✓ 92522
  - ✓ 92523
  - ✓ 92524

Note:
Even though your authorization may not include modifiers (GO, GN, etc.), when billing the agency, you must use the appropriate modifier from the *Modifier* column in the *Coverage Table*.

Any limits referenced on the coverage table apply to medical eligibility only. If the service authorized exceeds the duration or scope of the Medicaid State Plan, or if the client is not covered by the Medicaid State Plan, the services are limited to the authorization you received for the client.

[1] A blanket code is a service code the DSHS worker authorizes that is connected to one or more CPT® or HCPCS procedure codes. Social service providers may bill the agency using any procedure code connected to the blanket code, up to the maximum amount authorized. Both the blanket code and the maximum amount appear on the authorization letter DSHS sends to the social service provider.

CPT® codes and descriptions only are copyright 2015 American Medical Association.

How do I bill for services?

- Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers web page, under Webinars.

- For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) web page.

- Also, see the agency's ProviderOne Billing and Resource Guide for general billing information.

Note: To prevent billing denials, check the client's eligibility for other coverage **before** scheduling services and at the **time of the service.** See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility and how to request a limitation extension or exception to rule. Providers must exhaust other coverage before submitting a request for payment to the agency under a social services authorization.

National correct coding initiative

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

- The American Medical Association's (AMA) 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 code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

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

CPT® codes and descriptions only are copyright 2015 American Medical Association.

Who do I contact if I have questions?

Visit the Washington Apple Health Contact Us page for further information about program coverage, how to bill, or who to contact with questions.

CPT® codes and descriptions only are copyright 2015 American Medical Association.