Notice: **We launched a new web site. As a result, past versions of the billing guide, such as this one, have broken hyperlinks. Please review the current guide for the correct hyperlinks.**

Washington Apple Health

HOME HEALTH SERVICES
(Acute Care Services)
Provider Guide

October 1, 2015

Washington State Health Care Authority

About this guide*

This publication takes effect October 1, 2015, and supersedes earlier guides to this program.

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

What has changed?

Subject	Change	Reason for Change
How do I bill for Habilitative Services?	Added hyperlink to the Agency Approved Diagnosis Codes for Habilitative Services.	**Effective for claims with dates of service on and after October 1, 2015**, the agency requires the use of ICD-10 coding. ICD-9 codes may only be used for claims with dates of service before October 1, 2015.
ICD 9 Codes	Removed reference to ICD 9 codes.	**Effective for claims with dates of service on and after October 1, 2015**, the agency requires the use of ICD-10 coding. ICD-9 codes may only be used for claims with dates of service before October 1, 2015.

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's Provider Publications website.

* This publication is a billing instruction.

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page.
Finding out about payments, denials, claims processing, or Medicaid agency contracted managed care organizations	
Electronic or paper billing	
Finding Medicaid agency documents (e.g., provider guides, provider notices, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Sending medical verification of visits, plan of care, and change orders during focused review periods	Health Care Benefits and Utilization Management Home Health Program Manager PO Box 45506 Olympia WA98504-5506
Finding a list of interpreter agencies in my area	Visit the Medicaid agency's Medicaid Interpreter Services website.
Home health policy or medical review questions.	Home Health Program Coverage Home Health Program Manager Phone: 360-725-1611 FAX requests to: 866-668-1214
Long-term care (LTC) needs	LTC Exceptions FAX requests to: 866-668-1214
Home and Community Services (HCS)	Look at the front of the local telephone book **or call** the Aging and Long-Term Support Administration (ALTSA) State Reception Line 800-422-3263 and ask for the local HCS number.

Topic	Contact Information
Developmental Disabilities Administration (DDA) phone numbers	Region 1 800-462-0624 Region 2 800-822-7840 Region 3 800-788-2053 Region 4 800-314-3296 Region 5 800-248-0949 Region 6 800-339-8227
Pharmacy Authorization	See the Medicaid agency's Resources Available web page.
First Steps – Maternity Support Services (MSS)	HCA Family Services Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov Website: www.hca.wa.gov/medicaid/firststeps/pages/index.aspx
Contacting Aging and Long-Term Support Administration (ALTSA)	If you do not know the local telephone number, you may call: ALTSA State Reception Line: 800-422-3263
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extension, the following documentation is **required**: • A completed, TYPED *General Information for Authorization* form (HCA 13-835). This request form MUST be the initial page when you submit your request. • A completed *Home Health and Hospice (including PPC) Authorization Request* form (HCA 13-847), and all the documentation listed on this form and any other medical justification. Fax your request to: 866-668-1214
Contacting the Medicaid agency regarding requests for noncovered services	For all written requests, fax a completed, typed *General Information for Authorization* form (HCA 13-835), as well as a completed Home Health and Hospice (including PCC) Authorization Request form (HCA 13-847), to 866-668-1214.
Where do I find the Medicaid agency's maximum allowable fees for services?	See the Medicaid agency's online Rates Development Fee Schedules

Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the agency's Washington Apple Health Glossary for a more complete list of definitions.

Acute care – Care provided by a home health agency for clients who are not medically stable or who have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist. (**WAC 182-551-2010**)

Authorized practitioner – A person authorized to sign a home health plan of care.

Brief skilled nursing visit – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client for:

- An injection
- A blood draw
- A placement of medications in containers

(**WAC 182-551-2010**)

Case manager – A social worker or a nurse assigned by the Aging and Long-Term Care Administration (ALTSA) in the Department of Social and Health Services to manage and coordinate the client's case.

Case resource manager (CRM) – A person who meets with the family and assesses the client's developmental disability needs, develops a plan with the family, and helps connect to appropriate resources assigned by the Developmental Disabilities Administration (DDA).

Chronic care – Long-term care for medically stable clients. (**WAC 182-551-2010**)

Full skilled nursing services – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client for:

- Assessment
- Evaluation
- Management
- Observation
- Treatment
- Teaching
- Training

(**WAC 182-551-2010**)

Home health aide – A person registered or certified as a nursing assistance under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both. (WAC 182-551-2010)

Home health aide services – Services provided by a home health aide when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by, or under contract with, a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners, and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.
(**WAC 182-551-2010**)

Home health skilled services – Skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a Medicare certified home health agency with a current Core Provider Agreement. (**WAC 182-551-2010**)

Long-term care – A generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the Aging and Long-Term Support Administration (ALTSA) or Developmental Disabilities Administration (DDA) with the Department of Social and Health Services. (**WAC 182-551-2010**)

Plan of Care (POC) – (Also known as plan of treatment (POT)). A written document established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client's residence. (**WAC 182-551-2010**)

Residence - A client's home or private place of living. (**WAC 182-551-2010**)
(For information on clients in residential facilities whose home health services are not covered through the Medicaid agency's home health program see When does the Medicaid agency pay for covered home health services?)

Review period – The three-month period the Medicaid agency assigns to a home health agency, based on the address of the home health agency's main office, during which the Medicaid agency reviews all claims submitted by that home health agency. (**WAC 182-551-2010**)

Specialized therapy – Skilled therapy services provided to clients that include: physical, occupational, and speech/ Audiology services. (**WAC 182-551-2010**)

Supervision - Authoritative procedural guidance given by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides initial direction and periodic inspection of the actual act of accomplishing the function or activity.

About the Program

(WAC 182-551-2000)

What is the purpose of the home health program?

The purpose of the Medicaid agency's home health program is to provide equally effective, less restrictive quality care to the client in the client's residence when the client is not able to access the medically necessary services in the community, or in lieu of hospitalization.

Home health skilled services are provided for **acute**, intermittent, short-term, and intensive courses of treatment.

> **Note:** See What home health services are not covered? for information on chronic, long-term maintenance care.

Who is an eligible home health provider?

(WAC 182-551-2200)

The following may contract with the Medicaid agency to provide health services through the home health program, subject to the restrictions or limitations in this provider guide and applicable published Washington Administrative Code (WAC):

- A home health agency that:
  - ✓ Is Title XVIII (Medicare)-certified
  - ✓ Is licensed by the Department of Health (DOH) as a home health agency
  - ✓ Continues to meet DOH requirements
  - ✓ Submits a completed, signed Core Provider Agreement to the Medicaid agency
  - ✓ Has a home health taxonomy on their provider file
- A registered nurse (RN) who:
  - ✓ Is prior authorized by the Medicaid agency to provide intermittent nursing services when a home health agency does not exist in the area a client resides
  - ✓ Is unable to contract with a Medicare-certified home health agency
  - ✓ Submits a completed, signed core provider agreement to the Medicaid agency
  - ✓ Has an RN home health taxonomy on their provider file

> **Important!** Notify the Medicaid agency **within ten days** of any changes in name, address, or telephone number (see Resources Available).

Client Eligibility

(WAC 182-551-2020(1))

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

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

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

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

What are the restrictions?

(WAC 182-551-2020(2))

The CNP–Emergency Medical Only program covers two skilled nursing home health visits for those covered under the cancer treatment program and hemodialysis program.

Are managed care clients covered?

(WAC 182-551-2020(1))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the client benefit inquiry screen. All services must be requested directly through the client's primary care provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

All medical services covered under a Medicaid agency-contracted MCO must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

> **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 plant. See the Medicaid agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Are Primary Care Case Management (PCCM) clients covered?

For the client who has chosen to obtain care with a PCCM provider, information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

> **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 PCCM provider. See the Medicaid agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Are dually-enrolled clients eligible?

Dually-enrolled (Medicare-Medicaid) clients and **Medicare only** clients may be eligible to receive certain home and community based services under the Community Options Program Entry System (COPES) or Title XIX Personal Care programs. These programs are administered under the Department of Social and Health Services' Aging and Long-Term Support Administration (ALTSA). Contact the local ALTSA field office for more information on these programs (see Resources Available).

Dually-enrolled clients who do NOT meet Home Bound status criteria per Medicare are eligible for Home Health through Medicaid. Providers must indicate NOT HOMEBOUND on the UB-04 box 80 REMARKS.

Coverage/Limits

(WAC 182-551-2030)

When does the Medicaid agency pay for covered home health services?

The Medicaid agency pays for covered home health services provided to eligible clients when all of the criteria listed in this section are met. Reimbursement is subject to the restrictions or limitations in this provider guide and other applicable published Washington Administrative Code (WAC).

For information about the Habilitative Services benefit available January 1, 2014, see What are habilitative services under this program?

Home health skilled services provided to eligible clients must:

- Meet the definition of acute care.
- Provide for the treatment of an illness, injury, or disability.
- Be medically necessary (see Washington Apple Health Glossary for definition).
- Be reasonable, based on the community standard of care, in amount, duration, and frequency.
- Be provided under a plan of care (POC). Any statement in the POC must be supported by documentation in the client's medical records.
- Be used to prevent placement in a more restrictive setting. **In addition**, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires. teaching that would be most effectively accomplished in the client's home on a short-term basis.
- Be provided in the client's residence. The Medicaid agency does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

    ✓ **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under the Medicaid agency's home health program.

- ✓ It is the home health agencies' responsibility to request coverage for a client when the services are not available to the client in the community or through LTC.

- ✓ If the client meets the criteria for therapy services in this provider guide, the Medicaid agency will evaluate the need after receiving the request.
- ✓ Refer to the Aging and Long-Term Support Administration's (ALTSA) Residential Care Services web page for more information.

- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed

WAC 182-551-2100(1)
The Medicaid agency covers home health acute care skilled nursing services when furnished by a qualified provider.

The Medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165.

Does the agency cover acute care services?
(WAC182-551-2100(2)(3))

The Medicaid agency covers the following home health acute care services:

- **Full skilled nursing services** that require the skills of a registered nurse (RN) **or** a licensed practical nurse (LPN) under the supervision of a RN, if the services involve **one or more** of the following:

  - ✓ Observation (approximately 3 weeks)
  - ✓ Assessment (approximately 3 weeks)
  - ✓ Treatment
  - ✓ Teaching (approximately 3 days)
  - ✓ Training (approximately 4 visits unless client remains unstable)
  - ✓ Management
  - ✓ Evaluation

- **Brief skilled nursing visit** if only one of the following activities is performed during the visit:

  ✓ An injection
  ✓ A blood draw
  ✓ The placement of medications in containers (e.g., envelopes, cups, medisets)

Note: Use revenue code 580 when billing for a brief skilled nursing visit.

The Medicaid agency limits skilled nursing visits provided to eligible clients to **two visits (whether they are brief or full) per day**.

- **Home infusion therapy** only if the client:

  ✓ Is willing and capable of learning and managing the client's infusion care
  ✓ Has a volunteer caregiver willing and capable of learning and managing the client's infusion care

Note: The Medicaid agency does not reimburse for any of the following services through the Home Health Program:

- Administration of IV therapy
- Teaching of IV therapy
- Skilled observation of the IV site

Note: All other infusion therapy related services must be billed on a CMS-1500 claim form using the Home Infusion Therapy/Parenteral Nutrition Program Provider Guide.

Note: Although Medicaid agency clients may have a paid caregiver who is willing and capable of performing the skilled task, a paid caregiver cannot bill for these services. The client may want to be involved in self-directed care.

- **Infant phototherapy** for an infant diagnosed with hyperbilirubinemia:

  ✓ When provided by a Medicaid agency-approved infant phototherapy agency
  ✓ For up to five skilled nursing visits per infant

Note: If the infant's mother is enrolled in a Medicaid agency-contracted managed care organization (MCO) at the time of the birth, approval must be received from the MCO listed on the mother's eligibility check. **Do not bill the Medicaid agency for these services.**

- **Limited high-risk obstetrical services for all of the following:**

  ✓ A medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn
  ✓ Up to three home health visits per pregnancy, if:

  - Enrollment in or referral to the following providers of First Steps has been verified:
    - Maternity Support Services (MSS)
    - Infant Case Management (ICM)
  - The visits are provided by a registered nurse who has either of the following:
    - National perinatal certification
    - A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years

Note: Use revenue code **0551** when billing for skilled high-risk obstetrical nursing care visits in the home setting.

Note: The Medicaid agency does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See Criteria for High-Risk Obstetrical.

Additional information required in the plan of care

(See Criteria for High-Risk Obstetrical)

1. Infant's name, mother's name, and ProviderOne Client ID(s)
2. Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy
3. Name of hospital where the infant was born and discharge date
4. Visit notes that include family teaching and interventions
5. Bilirubin levels

How do I become a Medicaid agency-approved infant phototherapy agency?

You must:

- Be a Medicaid- and Medicare- certified home health agency.
- Have an established phototherapy program.
- Submit to the Medicaid agency for review, all of the following:
  - ✓ Six months of documented phototherapy services delivered for infants
  - ✓ A written policy for home phototherapy submitted to the Medicaid agency for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health
  - ✓ Three letters of recommendation from pediatricians who have used your program

Note: The Medicaid agency will not cover infant phototherapy **unless** your agency has a pre-approval letter on file from the Medicaid agency noting that you are an approved infant phototherapy agency. See the Medicaid agency's current Wheelchairs, Durable Medical Equipment (DME), and Supplies Provider Guide for equipment component.

Does the agency cover specialized outpatient rehabilitative therapy for clients age 20 and younger?

(WAC 182-551-2110(1)(2))

For eligible clients age 20 and younger, the Medicaid agency covers s**pecialized therapy services which** include physical, occupational, or speech/audiology services:

The agency covers habilitative services for clients enrolled in the Alternative Benefit Plan (ABP). See the What are habilitative services under this program? for specialized therapy rendered under the habilitative services benefit (see WAC 182-545).

The Medicaid agency reimburses for specialized therapy services only when the client is **not able to access these services in the client's local community**. The Medicaid agency limits specialized therapy visits to one per client, per day, per type of specialized therapy. Documentation must justify the skilled need of the visit.

Under specialized therapy, a client's residence may include a residential care facility with skilled nursing services available.

> **Note: The maximum number of visits allowed is based on appropriate medical justification.** The Medicaid agency does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure (s). If the client requires more than one therapist in the residence on the same day, the Medicaid agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Does the agency cover skilled outpatient rehabilitative therapies for clients age 19 and 20 in MCS/ALTSA and clients age 21 and older?

Yes. The following are the short-term benefit limits for outpatient rehabilitation (occupational therapy [OT], physical therapy [PT] , and speech therapy [ST]) apply to clients age 19 through 20 in MCS/ALTSA and all clients age 21 and older. These benefit limits are **per client**, **per calendar year** regardless of setting (home health, outpatient hospital, and freestanding therapy clinics.) Authorization is not required.

- Physical therapy: 24 units (equals approximately 6 hours)
- Occupational therapy: 24 units (equals approximately 6 hours)
- Speech therapy: 6 units (equals a total of 6 untimed visits)

To ensure payment:

- Bill in a timely manner. Claims will pay in date of service order. If a claim comes in for a previous date of service, the system will automatically pay the earlier date and recoup or adjust the later date.

- Contact the Medicaid agency to check on the limits by submitting the information request form for providers on the Contact Us web page to the Medical Assistance Customer Service Center (MACSC).

- Consult the ProviderOne Billing and Resource Guide: Client Eligibility, Benefit Packages, and Coverage Limits sections.

See expedited prior authorization (EPA) to obtain additional visits for qualifying conditions. If the client does not have a qualifying condition as outlined in the EPA section, the Medicaid agency requires the home health agency to request a limitation extension (LE) from the Medicaid agency.

For Department of Social and Health Services occupational therapy (OT) assessments, see the Outpatient Rehabilitative Therapy Evaluation Codes Table.

How are timed/untimed CPT® codes billed?

For specialized therapies:

- Each 15 minutes of timed CPT® codes equals one unit
- Each non-timed CPT® code equals one unit, regardless of how long the procedure takes

Therapy codes, including evaluations, must be billed as described in this provider guide. Failure to bill correctly will result in denials or recoupment.

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Short Description	Modifiers
PT	0421	G0151	Services performed by a qualified physical therapist in the home health or hospice setting each 15 minutes	GP
OT	0431	G0152	Services performed by a qualified occupational therapist in the home health or hospice setting each 15 minutes	GO
ST	0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder individual	GN

If the client's outpatient rehabilitation services maximum benefit limit has been reached (initial units and any additional EPA units, when appropriate), a provider may request authorization for a limitation extension from the Medicaid agency.

Does the Medicaid agency pay for outpatient rehabilitative therapy evaluations for clients age 21 and older?

Yes. The Medicaid agency pays for therapy evaluations for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Evaluations do not count toward the limit, but are subject to annual limits. See the following Outpatient Therapy Evaluation Codes Table. Providers bill with revenue code, the CPT code, and the appropriate modifier. Providers must request authorization for a limitation extension (LE) if additional evaluations are needed.

Outpatient Rehabilitative Therapy Evaluation Codes Table

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations
PT	0424	97001	Physical therapy evaluation	GP	One per client, per calendar year
		97002	Physical therapy re-evaluation at time of discharge	GP	One per client, per calendar year
		97542	Wheelchair management	GP	One per client, per calendar year Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment.

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations
OT	0434	97003	Occupational therapy evaluation	GO	1 per client, per calendar year
			Occupational therapy evaluation personal care for children	GO	EPA required. One per client, unless change of residence or condition
			Occupational therapy evaluation (bed rail assessment)	GO	EPA required. One per client, unless change of residence or condition
		97004	Occupational therapy re-evaluation at time of discharge	GO	One per client, per calendar year
		97542	Wheelchair management	GO	One per client, per calendar year Assessment is limited to four 15-minute units per assessment. Indicate on claim wheelchair assessment.
ST	0444	92521	Evaluation of speech fluency	GN	One per client, per calendar year unless change of condition
		92522	Evaluation of speech sound production	GN	One per client, per calendar year unless change of condition
		92523	With evaluation of language comprehension and expression	GN	One per client, per calendar year unless change of condition
		92524	Behavioral and quantitative analysis of voice and resonance	GN	One per client, per calendar year unless change of condition
		S9152	Speech language pathology re-evaluation at time of discharge	GN	One per client, per calendar year

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Short Description	Modifiers	Limitations
ST	0444	92610	Evaluate swallowing function (this one would not have any limits)	GN	No limit

What is the expedited prior authorization (EPA) for additional units of outpatient rehabilitative services for clients age 21 and older?

When a client meets the EPA criteria listed in Authorization for additional benefit units of outpatient rehabilitation, providers must use the expedited prior authorization (EPA) process. When a client's situation does not meet the conditions for EPA, a provider must request prior authorization.

Note: EPA may be requested once, per client, per calendar year, per each therapy type.

What are habilitative services under this program?

Habilitative services are those medically necessary services provided to help a client partially or fully attain or maintain developmental age-appropriate skills that were not fully acquired due to a congenital, genetic, or early-acquired health condition. Such services are required to maximize the client's ability to function in his or her environment.

Effective January 1, 2014, and applicable to those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, the agency covers outpatient physical, occupational, and speech therapy to treat one of the qualifying conditions listed in the agency's Habilitative Services Provider Guide, under *Client Eligibility.*

How do I bill for habilitative services?

See the Habilitative Services Provider Guide for details on billing habilitative services provided in the home health setting. To review the appropriate ICD 10 diagnosis codes that are required in

the primary diagnosis field on the claim form, refer to Program Policy Approved Diagnosis Codes for Habilitative Services.

What are the limits for home health aide services?

(WAC 182-551-2120(1)(2)(3))

- The Medicaid agency limits home health aide visits to **one per day**.
- The Medicaid agency reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:
  - ✓ Skilled nursing services.
  - ✓ Specialized therapy services.
- The Medicaid agency covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every 14 days to monitor or supervise home health aide services, with or without the presence of the home health aide. The Medicaid agency does not reimburse for services covered by another state administration such as LTC services, Community Options Program Entry System (COPES), CHORE, or CAP services.
- Documentation in the client's file must justify the need for the home health aide visits.

Note: Contact the client's case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

Does the agency cover home health services through telemedicine?

(WAC 182-551-2125)

The Medicaid agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis or diagnoses where there is a high risk of sudden change in medical condition which could compromise health outcomes.

When billing the Medicaid agency for home health services delivered through telemedicine, use the following codes:

Revenue Code	HCPCS Code	Short Description	Limitation
0780	T1030	RN home care per diem	One per client per day
0780	T1031	LPN home care per diem	One per client per day

Payment

The Medicaid agency pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner's home health plan of care.

Payment requirements

To receive payment for the delivery of home health services through telemedicine, the services must involve:

- A documented assessment, identified problem, and evaluation which includes:
  - ✓ Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care.
  - ✓ Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care
- Implementation of a documented management plan through one or more of the following:
  - ✓ Education regarding medication management as appropriate, based on the findings from the telemedicine encounter
  - ✓ Education regarding other interventions as appropriate to both the patient and the caregiver
  - ✓ Management and evaluation of the plan of care including changes in visit frequency or the addition of other skilled services
  - ✓ Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter

- ✓ Coordination and referral to other medical providers as needed
- ✓ Referral to the emergency room as needed

Telemedicine-related costs

The Medicaid agency does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.

Prior authorization

The Medicaid agency does not require prior authorization for the delivery of home health services through telemedicine.

What home health services are not covered?

(WAC 182-551-2130)

The Medicaid agency does not cover the following home health services under the Home Health program, unless otherwise specified:

- Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the Department of Social and Health Services Aging and Long-Term Support Administration (ALTSA) or Developmental Disabilities Administration (DDA).
  - ✓ **The Medicaid agency may consider requests** for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ALTSA or DDA to implement a long-term care skilled nursing plan or specialized therapy plan.
  - ✓ On a case-by-case basis, the Medicaid agency may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an ALTSA or DDA long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this provider guide and other published WACs.

Home Health Agencies

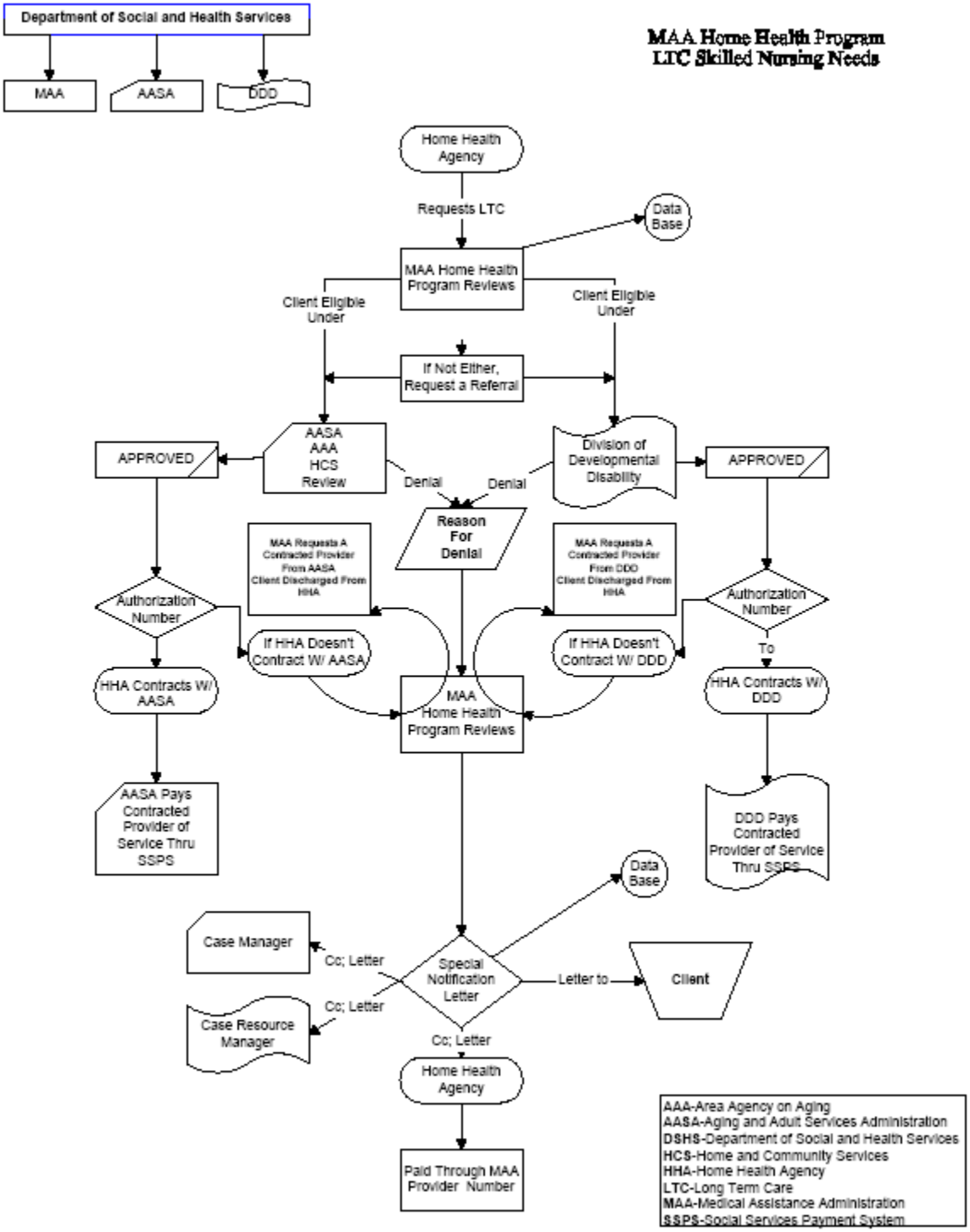
- The client must have a stable, chronic skilled nursing need.
- The client's skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community).
- The home health provider must **contact the Medicaid agency and request coverage** through the home health program.

The Medicaid agency will first contact the client's ALTSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through ALTSA or DDD.

If there are no other options, the Medicaid agency will send a notification letter to the client, home health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through the Medicaid agency for a limited time until a long-term care plan is in place.

See LTC Skilled Nursing Needs flow chart on the next page

Long Term Care Skilled Nursing Needs Flow Chart



What home health services are not covered? (continued)

- Social work services
- Psychiatric skilled nursing services
- Pre and postnatal skilled nursing services, except those listed under Covered – Acute Nursing Services
- Well-baby follow-up care
- Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available
- Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services
- Home health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change, unless the client meets the applicable criteria in this guide)
- Skilled nursing visits for a client when a home health agency cannot **safely** meet the medical needs of that client within home health services program limitations

  Examples:

  - ✓ The client or caregiver is not willing and/or capable of managing the client's infusion therapy care.
  - ✓ A client requires daily visits in excess of program limitations.

- More than one of the same type of specialized therapy and/or home health aide visit per day. The Medicaid agency does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).
- Any home health services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.
- Home health visits made without a written physician order, unless the verbal order is:

  - ✓ Documented prior to the visit
  - ✓ The document is signed by the physician within 45 days of the order being given

- Additional administrative costs billed above the visit (these costs are included in the visit rate and will not be paid separately)

The Medicaid agency evaluates a request for any service that is listed as noncovered under the provisions of WAC 182-501-0165.

Requests must include the following:

1. Name of agency and NPI
2. Client's name and ProviderOne Client ID
3. Copy of the plan of care
4. Explanation of client-specific medical necessity

Send requests for noncovered services to the Medicaid agency (see Resources Available). See Authorization for information regarding Limitation Extensions.

Authorization

The Medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services **beyond** those limitations or restrictions when medically necessary, under the standard for covered services in **WAC 182-501-0165**.

> **Note:** A provider may request an exception to rule (ETR) for a noncovered service as described in **WAC 182-501-0160**.

What is a limitation extension (LE)?

A limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide **more units of service** than allowed in the Medicaid agency's Washington Administrative Code (WAC) and Medicaid provider guides.

How is LE or ETR authorization obtained?

LE or ETR authorization may be obtained by using the written/fax authorization process.

Your request must include the following:

- Name of agency and NPI
- Client's name and ProviderOne Client ID
- Copy of the plan of care
- Explanation of client-specific medical necessity to exceed limitation or why it is an exception to rule

Clients who have Medicare as their primary insurance must meet Medicare's definition of homebound for Home Health services.

> **Note:** Indicate on your request if the client does not meet Medicare's definition of home bound when submitting the ETR request.

Clients who do not meet Medicare's definition of homebound may be eligible for Medicaid to cover home health services as an ETR. These clients must still meet Medicaid's home health coverage requirements. See Coverage/Limits.

What forms are required for LE or ETR authorization?

The Medicaid agency requires both of the following forms to request LE or ETR authorization:

- Home Health & Hospice Authorization Request form, 13-847
- General Information for Authorization form, 13-835

Send or fax your completed forms to the Medicaid agency (see Resources Available).

> **Note:** See the Medicaid agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

What does expedited prior authorization (EPA) do?

EPA is designed to eliminate the need for written authorization from the Medicaid agency. The Medicaid agency establishes clinical criteria for the provider to apply and determine if the client's condition is medically necessary and qualifies for additional services. The Medicaid agency assigns each criteria-set a specific numeric code.

Enter the appropriate 9-digit EPA code on the billing form in the authorization number field, or in the **Authorization or Comments** field when billing electronically.

EPA numbers and/or limitation extensions (LE) do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

> **Note:** The Medicaid agency denies claims submitted without a required EPA number.

The Medicaid agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how EPA criteria were met and make this information available to the Medicaid agency upon request. If the Medicaid agency determines the documentation does not meet the criteria, the claim will be denied.

What are the EPA guidelines for documentation?

The provider must verify medical necessity for the services billed using the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the Medicaid agency request. If the Medicaid agency determines the documentation does not meet EPA criteria, the claim will be denied**.**

Note: When medical necessity for the service cannot be established using the EPA clinical criteria, prior authorization is required.

Which services require EPA?

EPA #	EPA	Description	Billing Code(s)	Modifier
870000008	**Lymphedema Therapy**	Lymphedema management	0421- G0151 0431 - G0152	GO, GP
870000009	**CNS Injury (Brain Injury - Traumatic and non-Traumatic, CVA - new onset)**	Cerebral vascular accident with residual functional deficits within the past twenty-four months	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000010	**Swallowing**	Swallowing deficits due to injury or surgery to face, head, or neck	0431 - G0152, 0441 - 92507	GN, GO
870000011	**Botox**	As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency	0421- G0151 0431 - G0152	GP & GO

EPA #	EPA	Description	Billing Code(s)	Modifier
870000012	**Spinal Injury/Surgery (para, quad& spinal surgery-new onset)**	Spinal cord injury resulting in paraplegia or quadriplegia within the past twenty-four months	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000013	**Major Joint Surgery**	Major joint surgery - partial or total replacement only	0421- G0151 0431 - G0152	GP & GO
870000014	**Muscular/ skeletal, other (open fractures, ORIF)**	New onset muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg foot, knee, or hip), Reflex sympathetic dystrophy	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000015	**Burns/Wounds (complex)**	Acute, open, or chronic non-healing wounds Burns - second or third degree only	0421- G0151 0431 - G0152 0441 - 92507	GN, GP & GO
870000016	**Neurological Disorders - Adult Onset**	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre)	0421-G0151 0431-G0152 0441-92507	GN, GP & GO
870000017	**Speech deficit**	Due to injury or surgery to face, head, or neck	0441-92507	GN
870001326	**Bed Rails**	Assess for bed rails and bed rail safety	0434-97003	GO

EPA #	EPA	Description	Billing Code(s)	Modifier
870001343	**Personal Care for Children**	Hours required for in-home care	0434-97003	GO

Provider Requirements

What are the Medicaid agency's documentation requirements?

The Medicaid agency requires home health providers to keep individual medical records for each client and report to Medicare's Outcome and Assessment Information Set (OASIS).

Documentation to keep in the client's medical record in case the Medicaid agency requests

The individual client medical record must comply with community standards of practice, and must include documentation of:

- Visit notes for every billed visit.
- Supervisory visits for home health aide services as described in Coverage/Limits.
- All medications administered and treatments provided.
- All physician orders, new orders, and change orders, with notation that the order was received prior to treatment.
- Signed physician new orders and change orders.
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan.
- Interdisciplinary and multidisciplinary team communications.
- Inter-agency and intra-agency referrals.
- Medical tests and results.
- Pertinent medical history.
- Notations and charting with signature and title of writer.

Visit notes

At a minimum, the provider must document:

- Skilled interventions per the POC.
- Client response to POC.
- Any clinical change in the client status.
- Follow-up interventions specific to a change in status with significant clinical findings.
- Any communications with the attending physician.

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, client compliance, and client response
- **Weekly** documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided
- If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered and if possible, the client has been referred to a wound care specialist
- The client's physical system assessment as identified in the POC

Will insufficiently documented home health care service cause a denial of claims?

(WAC 182-551-2220(6))

The Medicaid agency may take back or deny payment for any insufficiently documented home health care service when the Medicaid agency determines that:

- The service did not meet the conditions listed in Coverage/Limits.
- The service was not in compliance with program policy.

What are the plan of care (POC) requirements?

For any delivered home health service to be payable, the Medicaid agency requires home health providers to develop and implement an individualized POC for the client.

> **Note:** Home health providers are required to comply with audits and/or site visits to ensure quality of care and compliance with state rule. All documentation in the client record, including the signed Plan of Care, must be made available to the Medicaid agency upon request. (See WAC 182-502-0020)

General requirements

The POC must:

- Be documented in writing and be located in the client's home health medical record.
- Be developed, supervised, and signed by a licensed registered nurse or licensed therapist.
- Reflect the physician's orders and client's **current** health status.
- Contain specific goals and treatment plans.
- Be reviewed and revised by the licensed registered nurse or licensed therapist and the client's physician at least every 60 calendar days.
- Signed by the physician within 45 days of the verbal order.
- Returned to the home health agency's file.
- Be available to the Medicaid agency staff or its designated contractor(s) on request.

Information that must be in the POC

The POC must include:

- The client's name and date of birth.
- The start of care.
- The date(s) of service.
- The primary diagnosis (the diagnosis that is **most related to the reason** the client qualifies for home health services, and the reason for the visit frequency).

- All secondary medical diagnosis including date(s) of onset **(O)** or exacerbation **(E).**
- The prognosis.
- The type(s) of equipment required.

> **Note:** Durable Medical Supplies & Equipment (DME) must be billed on a separate CMS-1500 claim form using an NPI and taxonomy for which DME/MSE services are allowed. Do not bill DMEs on a Home Health claim.

- A description of each planned service and goals related to the services provided.
- Specific procedures and modalities.
- A description of the client's mental status.
- A description of the client's rehabilitation potential.
- A list of permitted activities.
- A list of safety measures taken on behalf of the client.
- A list of medications which indicates:
  - ✓ Any new (N) prescription.
  - ✓ Which medications are changed (C) for dosage or route of administration.

The following important information must be included in or attached to the POC:

- The client's address, including the name of the residential care facility where the client is residing (if applicable)
- A description of the client's functional limits and the effects
- Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting
- Significant clinical findings
- The dates of recent hospitalization
- Notification to the home health agency's designated case manager of admittance

- A discharge plan, including notification to the home health agency's designated case manager of the planned discharge date and client disposition at time of discharge
- A short summary of:
  - ✓ What is happening with the client

    -OR-

  - ✓ What has happened since last review

Is it required that clients be notified of their rights (Advance Directives)?

(42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment.
- Make decisions concerning their own medical care.
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions. Keep a copy of the written information in the client's record.

Clients have the right to:

- Accept or refuse medical treatment.
- Make decisions concerning their own medical care.
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Criteria for High-Risk Obstetrical

When is home care for hyperemesis gravidarum (HG) initiated?

Home care for the client with HG may be initiated when weight loss and significant metabolic changes require fluid and nutritional replacement therapy that can be managed in the home setting. The client or caregiver must be willing and capable of learning and managing the client's intravenous therapy.

Goals:

- Assess the client's condition
- Teach the client to help maintain the pregnancy to term
- Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances

Therapeutic Skilled Nursing Services may be initiated with the obstetrical provider's request for care. These services are designed to reinforce the clinic, hospital and/or provider's teaching. The nursing services assist the client and family in managing the client's care in the home and may include:

- Education about the factors that may contribute to HG, such as stress and coping with pregnancy.
- Education on the symptoms related to dehydration and electrolyte disturbances and their effects on the mother and fetus (e.g., parenteral fluids and nutritional supplements).
- Assurance that the client is able to follow the treatment regimen (parenteral fluids and nutritional supplements) and comply with medications (antiemetics).
- Reinforcement of the obstetrical provider's plan of care, including the plan for resuming oral intake.
- Demonstration of the ability to manage and administer the infusion treatment ordered by the obstetrical provider (hydration or total parenteral nutrition).
- Education concerning when to notify the obstetrical provider.

Documentation in the client record is not limited to, but must include:

- An estimated date of confinement.
- The gravidity/parity.
- A history of symptoms of hyperemesis gravidarum (HG).
- An evaluation of clinical status of mother and fetus, including maternal weight and vital signs.
- An evaluation of the obstetrical provider's plan of care.
- A referral to a maternity support services (MSS) provider.
- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy.

When are skilled nursing services used for clients with gestational diabetes?

Therapeutic Skilled Nursing Services may be initiated when there is a documented reason for teaching gestational diabetes management in the home. It should reinforce the obstetrical provider's or clinic's teaching.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client reduce symptoms of gestational diabetes
- Maintain the pregnancy to planned delivery

Whenever possible, education should be given at suitable diabetes teaching centers. A more complete and comprehensive training is available at these sites. A few cases may merit skilled nursing services. For example, skilled nursing may be provided to a client who is unable to get to a diabetes educational center or to a client who has special learning needs.

Therapeutic skilled nursing services may include:

- Assuring the client understands the plan of care.
- Managing insulin injections.
- Diet and exercise.
- Demonstrating and teaching the blood glucose monitoring techniques, and the necessary times to test and documentation of testing results.
- Explaining the differences between normal and abnormal blood glucose test results.
- Explaining protocols for results of abnormal blood glucose, ketones and protein in the urine.
- Planning with the client for emergency treatment of hyper/hypoglycemia.
- Explaining when to notify the obstetrical provider about symptoms.

Documentation in the client record is not limited to, but must include:

- The estimated date of confinement.
- The gravidity/parity.
- A history of symptoms of gestational diabetes.
- An evaluation of clinical status of mother and fetus.
- An evaluation of obstetrical provider's Plan of Care.
- Rationale for in-home gestational diabetes education.
- A referral to a maternity support services (MSS) provider.
- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

When is home care for clients in preterm labor initiated?

Home care for preterm labor (PTL) symptoms may be initiated with the obstetrical provider's prescription for care and when there is an assurance of a viable newborn.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client maintain the pregnancy to term

Preventive Services may be initiated between 20-25 weeks when an eligible client has a history of preterm births and/or has a multiple gestation and has been started on oral tocolytics.

Therapeutic Skilled Nursing Services may be initiated between 25-36 weeks gestation or birth (whichever comes first) or until the tocolytics are discontinued. Cervical changes should be documented at the start of care.

Skilled nursing care reinforces the medical protocol and assures that:

- The client comprehends and is compliant with the medication.
- The client can manage the restricted activity plan.
- The plan of care is coordinated with maternity support services (MSS) so that childcare and transportation services are readily available, if needed.
- The client education includes fetal movement count, signs and symptoms of preterm labor and when to notify the obstetrical provider.

Documentation in the client record is not limited to, but must include:

- The estimated date of confinement.
- The gravidity/parity.
- A history of pre-term labor (PTL).
- Documentation of cervical change.
- The obstetrical provider's plan of care.
- An assessment of maternal and fetal clinical status.

- A list of medications.
- A referral to an MSS provider.
- Education of the client and family in management of the prescribed care for a high-risk pregnancy.

When is home care used for clients with pregnancy-induced hypertension?

Home care for Pregnancy-Induced Hypertension (PIH) may be initiated after 20 weeks gestation when:

- Blood pressure readings have increased by 30 mm Hg (systolic pressure) /15 mm Hg (diastolic pressure) over the baseline
- The client has accompanying symptoms (e.g., lab changes, proteinuria, and a weight gain greater than two lbs. / week). Late signs/symptoms may include hyperreflexia, epigastric pain, and/or visual changes.

Goals:

- Assess the client's condition
- Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension
- Maintain the pregnancy to term

Therapeutic skilled nursing services may be initiated at the prescribing medical provider's request and when documented signs and symptoms indicate the PIH may be safely managed in the home setting, **and** the:

- Client requires bed rest with bathroom privileges.
- Client understands and is able to comply with bed rest or reduced activities in the home.
- Assessment includes vital signs, fetal heart tones, fundal height, deep tendon reflexes, and a check for proteinuria, edema and signs and symptoms of PIH.

- Client and family members receive education on:

  - ✓ How to monitor blood pressure.
  - ✓ How to evaluate urine for protein.
  - ✓ When to notify the obstetrical provider.

- Skilled nursing service provider reinforces education that the client received from her obstetrical provider's office. This may include:

  - ✓ Etiology and diagnosis of PIH.
  - ✓ Treatment and rationale.
  - ✓ Nutrition needs.
  - ✓ Need for rest.
  - ✓ Client monitoring of uterine and fetal activity.
  - ✓ The role of medication in reducing symptoms (if provided).

- Plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

Documentation in the client record is not limited to, but must include:

- The gravidity/parity.
- A history of symptoms of PIH.
- An evaluation of clinical status of mother and fetus.
- An obstetrical provider's plan of care.
- Frequency of clinic visits.
- Activity level.
- List of medication, if prescribed.
- A referral to a maternity support services (MSS) provider.
- Education of the client and family on management of the prescribed care.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Note: When billing on the UB-04 claim form, services provided on different days are required to be listed separately along with revenue code, procedure code, modifier, dates of service, and units.

Medical review rebilling: Prior to rebilling, cross off all lines on the claim form that have already been paid by the Medicaid agency.

ATTN: Special Handling
Home Health Services Program Manager
PO Box 45506
Olympia, WA98504-5506

Where is the Home Health Services fee schedule?

See the Medicaid agency's Home Health Services Fee Schedule web page.

How do I complete the UB-04 claim form?

Providers may access online webinars demonstrating how to submit institutional fee-for-service claims using direct data entry and how to upload a HIPAA batch file.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee.

Electronic submitters: External cause codes (V00-Y99) are required to be submitted in groups of three in order for a claim to be processed. This does not apply to paper claim submissions. For questions, email: HIPAA-Help@hca.wa.gov.