Washington State Health Care Authority

Medicaid Provider Guide

Outpatient Rehabilitation

WAC 182-545-200

January 1, 2014

A Billing Instruction

About this guide

This guide supersedes all previous *Outpatient Rehabilitation Program Medicaid Provider Guides* published by the Health Care Authority (the agency).

Services and equipment related to any of the following programs must be billed using their specific Medicaid Provider Guide:

- Home Health Services
- Neurodevelopmental Centers
- Wheelchairs, Durable Medical Equipment, and Supplies
- Prosthetic/Orthotic Devices and Supplies
- Outpatient Hospital Services
- Physician-Related Services/Healthcare Professional Services (includes Audiology)

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-101 Updated billing codes	**01/01/2014**	Housekeeping	Updated Table of Contents, fixed and added hyperlinks, and made stylistic changes to enhance clarity
		Coverage Table	Added evaluation CPT® code 97003
		Coverage Table	Replaced evaluation CPT code 92506 with CPT codes CPT code 92521, described as Evaluation of speech fluency CPT code 92522, described as Evaluation of speech sound production CPT code 92523, described as With the evaluation of language comprehension and expression CPT code 92524, described as Behavioral and quantitative analysis of voice and resonance
		Habilitative Services	Added language addressing habilitative services

How can I get agency provider documents?

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

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Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Resources Available

Topic	Resource
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 agency managed care organizations	
Electronic or paper billing	
Accessing agency documents, e.g., Medicaid Provider Guides, provider notices, fee schedules	
Private insurance or third-party liability	
How do I obtain prior authorization or a limitation extension?	Requests for prior authorization or limitation extensions must include: • A completed, typed General Information for Authorization form (HCA 13-835). This request form must be the first page when you submit your request. • A completed Outpatient Rehabilitation Authorization Request form (HCA 13-786) and all the documentation listed on that form and any other medical justification. Fax your request to: 866-668-1214.
General definitions	Medical Assistance Glossary.

Client Eligibility

(WAC 182-545-0200 (2))

How can I verify a patient's eligibility?

Clients may be eligible to receive the outpatient rehabilitation services described in this Medicaid provider guide, depending on their benefit package. Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

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

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

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

(WAC 182-538-060 and -095, or WAC 182-538-063 for Medical Care Services clients)

Yes. Clients enrolled in an agency-contracted managed care plan who are referred for outpatient rehabilitation services by their primary care provider are eligible to receive those services. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the Client Benefit Inquiry Screen.

All medical services covered under a managed care plan 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 with the plan to an outside provider.

Are clients enrolled in primary care case management (PCCM) eligible?

For the client who has obtained care with a PCCM, information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain, or be referred for, services provided at ambulatory surgery centers through their PCCM providers. 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 plan. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Provider Eligibility

(WAC 182-545-200)

Who may provide outpatient rehabilitation services?

The following licensed healthcare professionals may enroll with the agency to provide outpatient rehabilitation within their scope of practice:

- Occupational therapists
- Occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Physical therapists or physiatrists
- Physical therapist assistants supervised by a licensed physical therapist
- Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech, Hearing and Language Association
- Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate

Note: For other licensed professionals, such as physicians, podiatrists, PA-Cs, ARNPs, audiologists, and specialty wound centers, refer to the Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide and Outpatient Hospital Services Medicaid Provider Guide.

Coverage

(WAC 182-545-200(4))

When does the agency pay for outpatient rehabilitation?

The agency pays for outpatient rehabilitation when the services are:

- Covered.
- Medically necessary, as defined in WAC 182-500-0070.
- Within the scope of the eligible client's medical care program.
- Ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Authorized, as required in Chapter 182-545 WAC, Chapter 182-501 WAC, and Chapter 182-502 WAC, and Authorization.
- Begun within 30 days of the date ordered.
- Provided by an approved health professional (see Who Is Eligible to Provide Outpatient Rehabilitation?).
- Billed according to this Medicaid Provider Guide.
- Provided as part of an outpatient treatment program in:
  - ✓ An office or outpatient hospital setting.
  - ✓ The home, by a home health agency, as described in Chapter 182-551 WAC.
  - ✓ A neurodevelopmental center, as described in WAC 182-545-900.
  - ✓ In any natural setting, if the child is under three and has disabilities. Examples of natural settings include the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

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

Duplicate occupational, physical, and speech-therapy services are not allowed for the same client when both providers are performing the same or similar intervention(s).

What outpatient rehabilitation does the agency cover for clients 20 years of age & younger?

(WAC 182-545-200(5))

For eligible clients 20 years of age and younger, the agency covers unlimited outpatient rehabilitation with the following exception: clients 19 to 20 years of age in Medical Care Services are eligible for limited outpatient rehabilitation. For these clients, see the *Clients 21 & Older and 19 – 20 in MCS* tables on the following pages.

When does the agency cover for the short term outpatient rehabilitation benefit?

(WAC 182-545-200(6))

The agency covers outpatient rehabilitation for the following clients as a *short-term benefit* to treat an acute medical condition, disease, or deficit resulting from a new injury or post-surgery:

- Clients 21 years of age and older
- Clients 19 through 20 years of age receiving MCS

What clinical criteria must be met for the short term outpatient rehabilitation benefit?

(WAC 182-545-200 (7))

Outpatient rehabilitation must:

- Meet reasonable medical expectation of significant functional improvement within 60 days of initial treatment.
- Restore or improve the client to a prior level of function that has been lost due to medically documented injury or illness.
- Meet currently accepted standards of medical practice and be specific and effective treatment for the client's existing condition.
- Include an on-going management plan for the client and/or the client's caregiver to support timely discharge and continued progress.

What are the short-term outpatient rehabilitation benefit limits?

The following are the short-term benefit limits for outpatient rehabilitation for adults. These benefit limits are per client, per calendar year regardless of setting. 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)

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 will cover outpatient physical, occupational, and speech therapy to treat one of the qualifying condition listed in the table below under the habilitative services benefit.

Note: The specific habilitation benefit is not available to clients enrolled in a classic Medicaid eligibility program (e.g., categorically needy (CN) and medically needy (MN)) or the medical care services (MCS) program. However, starting January 1, 2014, these services will be available to those clients eligible under expanded Medicaid (ABP).

Habilitative Services Qualifying Diagnoses	
ICD 9 code	**Qualifying Diagnosis**
137.0-137.4	Late effects of tuberculosis
138	Late effect acute polio
299.00-299.91	Autism spectrum disorder
315.0-315.9	Specific delays in development

Habilitative Services Qualifying Diagnoses	
ICD 9 code	**Qualifying Diagnosis**
331.3	Communicating hydrocephalus
331.4	Obstructive hydrocephalus
331.5	Idiopathic normal pressure hydrocephalus
331.7	Cerebral degeneration in diseases classified elsewhere
331.8	Other cerebral degeneration
333.7	Torsion dystonia
334.0-334.9	Spinocerebellar disease
335.0-335.9	Anterior horn disease
336.0	Syringomyelia
343.0-343.9	Infantile cerebral palsy
359.0-359.2	Congenital hereditary muscular dystrophy
7320	Juvenile osteochondrosis of spine
732.0-732.9	Osteochondropathies
737.0-737.9	Curvature of spine
740.0-740.2	Anencephalus
741.0-741.9	Spina bifida
742.0-742.9	Other congenital anomalies of nervous system
754.0-754.8	Certain congenital musculoskeletal disorders
755.0-755.9	Other congenital anomalies of limbs
756.0-756.9	Other congenital musculoskeletal anomalies
758.0-758.9	Chromosomal anomalies
759.0-759.9	Other and unspecified congenital anomalies

Billing for habilitative services

For information about how to bill, program requirements, and applicable procedure codes, refer to the agency's current Habilitative Services Medicaid Provider Guide.

Occupational therapy

CLIENTS 21 & Older & 19-20 in MCS benefit limits without prior authorization		
Description	**Limit**	**PA?**
Occupational Therapy Evaluation	One per client, per calendar year	No
Occupational Therapy Re-evaluation at time of discharge	One per client, per calendar year	No
Occupational Therapy	24 Units (approximately 6 hours), per client, per calendar year	No

CLIENTS 21 & Older & 19-20 in MCS additional benefit limits with expedited prior authorization		
When client's diagnosis is:	**Limit**	**EPA#**
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year. See Requesting a Limitation Extension for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months		870000009
Burns – 2nd or 3rd degree only		870000015
Cerebral vascular accident with residual functional deficits within the past 24 months		870000009
Lymphedema		870000008
Major joint surgery – partial or total replacement only		870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)		870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)		870000016
Reflex sympathetic dystrophy		870000016
Swallowing deficits due to injury or surgery to face, head, or neck		870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months		870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency		870000011

Physical therapy

CLIENTS 21 & Older & 19-20 in MCS benefit limits without prior authorization		
Description	**Limit**	**PA?**
Physical Therapy Evaluation	One per client, per calendar year	No
Physical Therapy Re-evaluation at time of discharge	One per client, per calendar year	No
Physical Therapy	24 Units (approximately 6 hours), per client, per calendar year	No

CLIENTS 21 & Older & 19-20 in MCS additional benefit limits with expedited prior authorization		
When client's diagnosis is:	**Limit**	**EPA#**
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year. See Requesting a Limitation Extension for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months		870000009
Burns – 2nd or 3rd degree only		870000015
Cerebral vascular accident with residual functional deficits within the past 24 months		870000009
Lymphedema		870000008
Major joint surgery – partial or total replacement only		870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)		870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)		870000016
Reflex sympathetic dystrophy		870000016
Swallowing deficits due to injury or surgery to face, head, or neck		870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months		870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency		870000011

Speech therapy

CLIENTS 21 & Older & 19-20 in MCS benefit limits without prior authorization		
Description	**Limit**	**PA?**
Speech Language Pathology Evaluation	One per client, per code, per calendar year	No
Speech Language Pathology Re-evaluation at time of discharge	One per client, per calendar year	No
Speech Therapy	6 Units (approximately 6 hours), per client, per calendar year	No

CLIENTS 21 & Older & 19-20 in MCS additional benefit limits with expedited prior authorization		
When client's diagnosis is:	**Limit**	**EPA#**
Brain injury with residual functional deficits within the past 24 months	Six additional units, per client, per calendar year See Requesting a Limitation Extension for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns of internal organs such as nasal oral mucosa or upper airway		870000015
Burns of the face, head, and neck – 2nd or 3rd degree only		870000015
Cerebral vascular accident with residual functional deficits within the past 24 months		870000009
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea		870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)		870000016
Speech deficit due to injury or surgery to face, head, or neck		870000017
Speech deficit which requires a speech generating device		870000007
Swallowing deficit due to injury or surgery to face, head, or neck;		870000010
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency		870000011

Swallowing evaluations

Swallowing (dysphagia) evaluations must be performed by a speech-language pathologist who:

- Holds a master's degree in speech-language pathology.
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing.
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques.
- May include video fluoroscopy for further evaluation of swallowing status and aspiration risks.

Using timed and untimed procedure codes

For the purposes of this Medicaid Provider Guide:

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

If time is included in the CPT code description, the beginning and ending times of each therapy modality must be documented in the client’s medical record.

What are the benefit limits?

The following limits for therapies are per client, per calendar year.

- Bill timely. 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 agency to check on limits, by submitting a service limit request to the agency's Medical Assistance Customer Service Center (MACSC) by using the Contact Us On-line Request Form.

- Consult *Client Eligibility, Benefit Packages, and Coverage Limits* in the agency's ProviderOne Billing and Resource Guide.

Coverage Table

Note: Due to its licensing agreement with the American Medical Association, the agency publishes only the official, short CPT® code descriptions. To view the full descriptions, refer to a current CPT book.

The following abbreviations are used in the table below: GP = Physical Therapy; GO = Occupational Therapy; GN = Speech Therapy; TS = Follow-up service; RT = Right; LT = Left. An asterisk indicates that a procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92521	GN	Evaluation of speech fluency			X	1 per client, per code, per calendar year
92522	GN	Evaluate speech production			X	1 per client, per code, per calendar year
92523	GN	Speech sound lang comprehen			X	1 per client, per code, per calendar year
92524	GN	Behavral qualit analys voice			X	1 per client, per code, per calendar year
92507*	GN	Speech/hearing therapy			X	
92508*	GN	Speech/ hearing therapy			X	
92526*	GO, GN	Oral function therapy		X	X	
92551*	GN	Pure tone hearing test air			X	
92597*	GN	Oral speech device eval			X	
92605	GN	Eval for rx of nonspeech device 1 hr			X	Limit 1 hour Included in the primary services. Bundled.
92618	GN	Eval for rx of nonspeech device addl			X	Add on to 92605 Each additional 30

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
						minutes. Bundled.
92606	GN	Nonspeech device service			X	Included in the primary services. Bundled.
92607	GN	Ex for speech device rx 1 hr			X	Limit 1 hour

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92608	GN	Ex for speech device rx addl			X	Each additional 30 min. Add on to 92607
92609*	GN	Use of speech device service			X	
92610	GN	Evaluate swallowing function			X	No limit
92611	GN	Motion fluoroscopy/swallow			X	No longer limited
92630*	GN	Aud rehab pre-ling hear loss			X	
92633*	GN	Aud rehab post-ling hear loss			X	
95831*	GP, GO	Limb muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95832*	GP, GO	Hand muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
						combination with each other. Can be billed alone or with other PT/OT procedure codes.
95833*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95834*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97001	GP	Pt evaluation	X			1 per client, per calendar year
97002	GP	Pt re-evaluation	X			1 per client, per calendar year
97003	GO	Ot evaluation		X		1 per client, per calendar year. Use EPA# 870001326 with

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
						billing code 0434-97003, assess for bedrails and bedrail safety.
97004	GO	OT re-evaluation		X		1 per client, per calendar year
97005		Athletic train eval				Not covered
97006		Athletic train re-eval				Not covered
97010	GP, GO	Hot or cold packs therapy	X	X		Bundled
97012*	GP	Mechanical traction therapy	X			
97014*	GP, GO	Electric stimulation therapy	X	X		
97016*	GP	Vasopneumatic device therapy	X			
97018*	GP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units
97035*	GP	Ultrasound therapy	X			Timed 15 min units
97036*	GP	Hydrotherapy	X			Timed 15 min units
97039*	GP	Physical therapy treatment	X			
97110*	GP, GO	Therapeutic exercises	X	X		Timed 15 min units
97112*	GP, GO	Neuromuscular re-education	X	X		Timed 15 min units

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97113*	GP, GO	Aquatic therapy/exercises	X	X		Timed 15 min units
97116*	GP	Gait training therapy	X			Timed 15 min units
97124*	GP, GO	Massage therapy	X	X		Timed 15 min units
97139*	GP	Physical medicine procedure	X			
97140*	GP, GO	Manual therapy	X	X		Timed 15 min units
97150*	GP, GO	Group therapeutic procedures	X	X		
97530*	GP, GO	Therapeutic activities	X	X		Timed 15 min units
97532*	GO, GN	Cognitive skills development		X	X	Timed 15 min units
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units
97535*	GP, GO	Self care mngment training	X	X		Timed 15 min units
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97542	GP, GO	Wheelchair mngment training	X	X		1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97545		Work hardening				Not covered
97546		Work hardening add-on				Not covered
97597*	GP, GO	Rmvl devital tis 20 cm/<	X	X		Do not use in combination with

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
						11042-11047. Limit one per client, per day.
97598*	GP, GO	Rmvl devital tis addl 20 cm<	X	X		1 per client, per day. Do not use in combination with 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		1 per client, per day. Do not use in combination with 11042-11047.
97605	GP, GO	Neg press wound tx < 50 cm	X	X		Bundled
97606	GP, GO	Neg press wound tx > 50 cm	X	X		Bundled
97750*	GP, GO	Physical performance test	X	X		Do not use to bill for an evaluation (97001) or re-eval (97002)
97755	GP, GO	Assistive technology assess	X	X		Timed 15 min units
97760*	GP, GO	Orthotic mgmt and training	X	X		Two 15-minute units, per client, per day. Can be billed alone or with other PT/OT procedure codes.
97761*	GP, GO	Prosthetic training	X	X		Timed 15 min units
97762	GP, GO -or- GP,GO & TS	C/o for orthotic/prosth use	X	X		Use this code for DME assessment. 1 per client, per calendar year. Use with two 15-min units per session. Use modifier TS for follow up service. Can be billed alone or with other PT/OT procedure codes.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97799*	GP, GO & RT or LT	Physical medicine procedure	X	X		Use this code for custom hand splints. 1 per hand, per calendar year. Use modifier to indicate right or left hand. Documentation must be attached to claim.
S9152	GN	Speech therapy re-eval			X	1 per client, per calendar year

The agency does not pay:

- Separately for outpatient rehabilitation that is included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.
- A healthcare professional for outpatient rehabilitation performed in an outpatient hospital setting when the healthcare professional is not employed by the hospital. The hospital must bill the agency for the services.

Where can I find the fee schedule?

- Rehabilitation services provided in an office setting are paid according to the agency's Outpatient Rehabilitation Fee Schedule.
- Rehabilitation services provided in hospital and hospital-based clinic settings are subject to the agency's Outpatient Prospective Payment System (OPPS) Fee Schedule and Outpatient Hospitals Fee Schedule.

Authorization

What are the general guidelines for authorization?

- When a service requires authorization, the provider must properly request written authorization in accordance with the agency's rules, this Medicaid provider guide, and applicable provider notices.
- When the provider does not properly request authorization, the agency returns the request to the provider for proper completion and resubmission. The agency does not consider the returned request to be a denial of service.
- Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for using the expedited prior authorization (EPA) code and/or limitation extension.
- The agency's authorization of service(s) does not guarantee payment.
- The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100(1)(c) and WAC 182-544-0560(7).

EPA – what are the additional units for clients 21 and older and clients 19 through 20 years of age in MCS?

When a client meets the criteria for additional benefit units of outpatient rehabilitation, providers must use the EPA process. The EPA units may be used once per client, per calendar year for each therapy type. When a client's situation does not meet the conditions for EPA, a provider must request a limitation extension (LE).

Expedited Prior Authorization
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 codes are designed to eliminate the need for written authorization.

EPA numbers and LEs do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

How can I request an LE?

When clients reach their benefit limit of outpatient rehabilitation has been reached (the initial units and any additional EPA units, if appropriate), a provider may request authorization for an LE from the agency.

The agency evaluates requests for authorization of covered outpatient rehabilitation that exceed limitations in this Medicaid Provider Guide on a case-by-case basis in accordance with WAC 182-501-0169. The provider must justify that the request is medically necessary (as defined in WAC 182-500-0070) for that client.

> **Note:** Requests for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility programs cover all services.

The following documentation is required for all requests for LE:

- A completed General Information for Authorization form**,** HCA 13-835 (this request form MUST be the first page when you submit your request)
- A completed Outpatient Rehabilitation Authorization Request form, HCA 13-786**,** and all the documentation listed on this form and any other medical justification
- Fax LE requests to: 866-668-1214

Billing and Claim Forms

What are the billing requirements?

Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide. The guide explains how to complete the CMS-1500 Claim Form.

These outpatient rehabilitation benefit limits for clients 21 years of age and older and clients 19 through 20 years of age in MCS apply to the skilled therapy services provided through a Medicare-certified Home Health agency as well as therapy provided by physical, occupational, and speech therapists in outpatient hospital clinics and free-standing therapy clinics.

Use billing and servicing taxonomy specific to the service being billed. Do not mix modalities on the same claim form. For example, use the billing and servicing taxonomy specific to physical therapy for billing physical therapy services. Do not bill occupational therapy services on the same claim form as physical therapy services.

Home health agencies

Home Health Agencies must use the following procedure codes and modifiers when billing the agency:

Modality	Home Health Revenue Codes	New Home Health Procedure Codes	Modifiers
Physical Therapy	0421	G0151 = 15 min units	GP
Occupational Therapy	0431	G0152 = 15 min units	GO
Speech Therapy	0441	92507 = 1 unit	GN

Outpatient hospital or hospital-based clinic setting

Hospitals must use the appropriate revenue code, CPT code, and modifier when billing the agency:

Modality	Revenue Code	Modifiers
Physical Therapy	042X	GP
Occupational Therapy	043X	GO
Speech Therapy	044X	GN

See the agency's Outpatient Hospital Medicaid Provider Guide for further details.