Washington State Health Care Authority

Washington Apple Health (Medicaid)

Habilitative Services Program Billing Guide

July 1, 2017

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect July 1, 2017, and supersedes earlier billing guides to this program.

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

Neurodevelopmental Centers, Outpatient Hospital Services, Physician-Related Services/Healthcare Professional Services (which includes audiology), Home Health Services, and Outpatient Rehabilitation providers who provide physical therapy, occupational therapy, or speech language pathology to treat a condition that qualifies for habilitative services, in a client enrolled in the Alternative Benefit Plan, must bill for these therapies under this billing guide.

Services and equipment related to any of the following programs must be billed using their program-specific billing guide:

- Wheelchairs, Durable Medical Equipment, and Supplies
- Prosthetic/Orthotic Devices and Supplies
- Complex Rehabilitative Services

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

*This guide is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Client Eligibility	Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO Effective July 1, 2017, AI/AN clients living in the FIMC regions have a change to services available	Policy Update

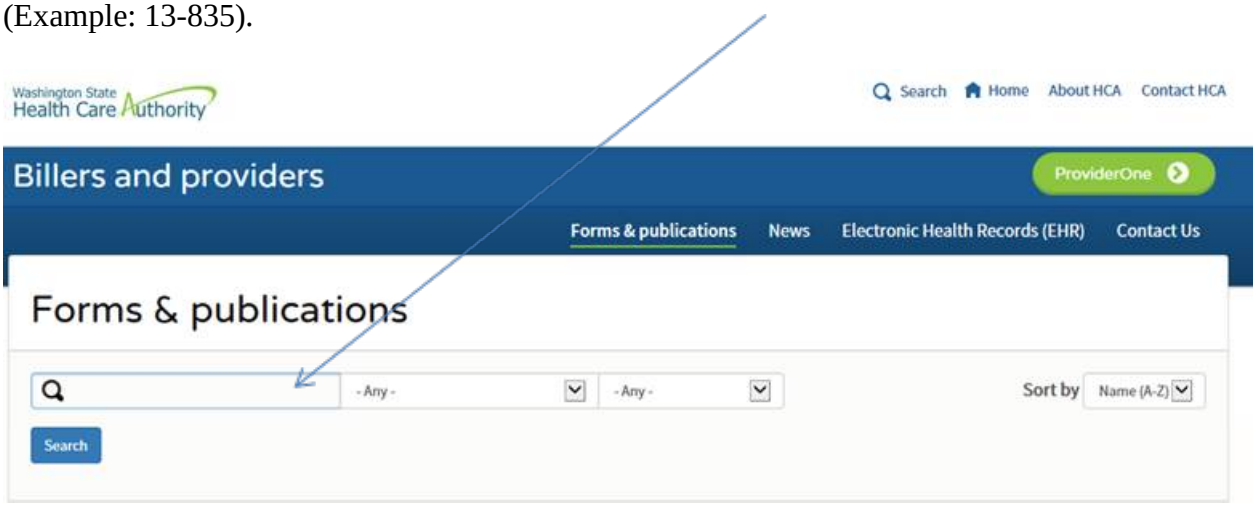
How can I get agency provider documents?

To access provider alerts, go to the agency's Provider Alerts web page.

To access provider documents, go to the agency's Provider billing guides and fee schedules web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's web page, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers web page.
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Accessing agency publications, including Medicaid Billing Guides, provider notices, and 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), which must be the first page of your request packet. • A completed *Habilitative Services Authorization Request* form HCA 13-842 and all the documentation listed on that form and any other medical justification. **Fax your request to: 866-668-1214** For information about downloading agency forms, see Where can I download agency forms?
General definitions	See Chapter 182-500 WAC.

Program Overview

(WAC 182-545-200)

What is the purpose of the habilitative services program?

The purpose of the habilitative services program is to provide medically necessary services that 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.

Client Eligibility

(WAC 182-545-400)

Who is eligible for habilitative services?

Eligibility for habilitative services is limited to clients who are enrolled in the Alternative Benefit Plan (ABP) defined in WAC 182-501-0060 and who have been diagnosed with one of the qualifying conditions listed below. ABP clients with diagnoses other than those listed in the following table may still qualify for outpatient rehabilitation under the outpatient rehabilitation benefit and billed according to the agency's current Outpatient Rehabilitation Billing Guide.

> **Note:** This benefit is available only to clients enrolled in ABP. These services may be available to other Washington Apple Health clients under the Outpatient Rehabilitation benefit. Outpatient Rehabilitation benefits must be billed using the agency's current Outpatient Rehabilitation Billing Guide.

Use the appropriate ICD diagnosis code. See the agency's Program Policy Approved Diagnosis Codes for Habilitative Services.

How can I verify a patient's eligibility?

Providers must verify that a patient has Medicaid or other coverage under Washington Apple Health 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 Program Benefit Packages and Scope of Services web page.

Note: Patients who wish to apply for Washington Apple Health can do so 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 with 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 with an agency-contracted managed care organization (MCO) referred for habilitative services by their primary care provider are eligible to receive those services.

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.

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.

Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients will not be enrolled in a BHO/FIMC/BHSO program. For these clients, SUD services are covered under the fee-for-service (FFS) program.

Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients must choose to enroll in one of the managed care plans, either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW) under the FIMC model receiving all physical health services, all levels of mental health services and drug and alcohol treatment coordinated by one managed care plan; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose, they will be auto-enrolled into Apple Health FFS for all their health care services.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care web site, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Regional Resources web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women

- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

	Molina Healthcare of Washington, Inc. 1-800-869-7165

	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Provider Eligibility

(WAC 182-545-400)

Who may provide habilitative services?

The following licensed health care professionals may enroll with the agency to provide habilitative services within their scope of practice to eligible clients:

- Physiatrists
- Occupational therapists
- Occupational therapy assistants supervised by a licensed occupational therapist
- Physical therapists
- 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: Other licensed professionals, such as physicians, podiatrists, PA-Cs, ARNPs, audiologists, and specialty wound centers, refer to the agency's Physician-Related Services/Healthcare Professional Services Billing Guide and Outpatient Hospital Services Billing Guide.

Coverage

(WAC 182-545-400)

What habilitative services does the agency cover for clients age 20 and younger?

The agency covers unlimited outpatient habilitative services for eligible clients age 20 and younger.

What habilitative services does the agency cover for clients age 21 and older?

The agency covers limited outpatient habilitative services for eligible clients age 21 and older, which includes an on-going management plan for the client or the client's caregiver to support continued client progress. See the following tables for an explanation of limitations for clients age 21 and older. The agency allows service beyond the limitations described below if authorization is obtained. See Authorization for additional information.

Occupational therapy

CLIENTS 21 & Older Without Prior Authorization	
Description	**Limit**
Occupational therapy evaluation	One per client, per calendar year
Occupational therapy re-evaluation at time of discharge	One per client, per calendar year
Occupational therapy	24 units (approximately 6 hours), per client, per calendar year

CLIENTS 21 & Older: Additional Benefit Limits with Expedited Prior Authorization		
When the clinical situation is:	**Limit**	**EPA#**
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency.	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.	870001329

Physical therapy

CLIENTS 21 & Older Without Prior Authorization	
Description	**Limit**
Physical therapy evaluation	One per client, per calendar year
Physical therapy re-evaluation at time of discharge	One per client, per calendar year
Physical therapy	24 units (approximately 6 hours), per client, per calendar year

CLIENTS 21 & Older: Additional Benefit Limits with Expedited Prior Authorization		
When the clinical situation is:	**Limit**	**EPA#**
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency.	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.	870001329

Speech therapy

CLIENTS 21 & Older 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 evaluation code, per calendar year	No
Speech therapy	6 units (approximately 6 hours), per client, per calendar year	No

CLIENTS 21 & Older: Additional Benefit Limits with Expedited Prior Authorization		
When the clinical situation is:	**Limit**	**EPA#**
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency.	Six additional units, per client, per calendar year See Requesting a Limitation Extension for requesting units beyond the additional benefit limits.	870001328

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 billing 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.

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.

- To check on limits, submit a service limit request to the agency's Medical Assistance Customer Service Center (MACSC), 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 abbreviations used in the modifier column in the table below mean the following: **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 age 21 and older.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92521	GN	Evaluation of speech fluency			X	1 per client, per calendar year
92522	GN	Evaluate speech production			X	1 per client, per calendar year
92523	GN	Speech sound lang comprehen			X	1 per client, per calendar year
92524	GN	Behavral qualit analys voice			X	1 per client, per calendar year
S9152	GN	Speech therapy re-eval			X	1 per client, per code: 92521, 92522, 92523, 92524, per calendar year
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.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92618	GN	Eval for rx of nonspeech device addl			X	Add on to 92605 Each additional 30 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
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.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
95832*	GP, GO	Hand 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.
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
97005		Athletic train eval				NC
97006		Athletic train re-eval				NC
97110*	GP, GO	Therapeutic exercises	X	X		Timed 15 min units
97112*	GP, GO	Neuromuscular re-education	X	X		Timed 15 min units
97113*	GP, GO	Aquatic therapy/exercises	X	X		Timed 15 min units

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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		
97161	GP	PT eval low complex 20 min	X			Only one of these codes is allowed per client, per calendar year.
97162		PT eval mod complex 30 min	X			
97163		PT eval high complex 45 min	X			
97164	GP	PT re-eval est plan care	X			One per client, per calendar year
97165	GO	OT eval low complex 30 min		X		Only one of these codes allowed, per client, per calendar year
97166		OT eval mod complex 45 min		X		
97167		OT eval high complex 60 min		X		
97168	GO	OT re-eval est plan care		X		One per client, per calendar year
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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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
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				NC
97546		Work hardening add-on				NC
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.
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.

Note: In addition to standard billing modifiers, use the informational SZ modifier to denote habilitative services provided on or after July 1, 2014.

The agency does not pay:

- Separately for habilitative services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

- A health care professional for habilitative services performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.

Payment

When does the agency pay for outpatient habilitative services?

The agency pays for outpatient habilitative services that are:

- Covered within the scope of the client's alternative benefit plan under WAC 182-501-0060.
- Medically necessary.
- Related to a qualifying diagnosis.
- Within currently accepted standards of evidence-based medical practice.
- Ordered by a physician, physician assistant, or an advanced registered nurse practitioner.
- Begun within thirty calendar days of the date ordered.
- Provided by one of the health professionals listed in subsection (3) of this section.
- Authorized under chapters 182-501, 182-502, and section 182-545-400 WAC, and the agency's published Medicaid billing guides and published provider notices.
- Billed under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published Medicaid billing guides and published provider notices.
- Provided as part of a habilitative treatment program in one of the following locations:
    - ✓ 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

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

Fee schedule

Habilitative services are paid according to the agency's 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 billing 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 or limitation extension (LE).
- 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).

When is the expedited prior authorization (EPA) process used?

When a client meets the criteria for additional benefit units of habilitative services, 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).

For EPA, 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.

When is a limitation extension (LE) required?

If a client's benefit limit of habilitative services 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 habilitative services that exceed limitations in this billing 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 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); see Where can I download agency forms?
- A completed Habilitative Services Authorization Request form, HCA 13-842**,** and all the documentation listed on this form and any other medical justification
- Fax LE requests to: 866-668-1214

Billing

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

Are referring and provider NPIs required on all claims?

Yes. Providers must use the referring provider's national provider identifier (NPI) on *all* claims in order to be paid. If the referring provider's NPI is not listed on the claim, the claim may be denied. Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide.

How do I bill claims electronically?

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

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

Habilitative services must be billed using one of the diagnosis codes listed in the Qualifying Diagnoses table in the primary diagnosis field on the claim.

These habilitative services benefit limits for clients age 21 and older 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. For example, use the billing and servicing taxonomy for physical therapy when billing physical therapy services. Do not bill occupational therapy or speech therapy on the same claim as physical therapy services.

Are servicing provider NPIs required on all claims?

Yes. The servicing provider's national provider identifier (NPI) must be included on all claims in order to be paid. If the servicing provider's NPI is not listed on the claim, the claim may be denied.

Home health agencies

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

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

See the agency's Home Health Billing Guide for further details.

Outpatient hospital or hospital-based clinic setting

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

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

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

Note: In addition to standard billing modifiers, use the informational SZ modifier to denote habilitative services provided on or after July 1, 2014.