Washington State Health Care Authority

Washington Apple Health (Medicaid)

Neurodevelopmental Centers Billing Guide

January 1, 2019

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 January 1, 2019, and supersedes earlier 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.

> 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.

Services and equipment related to the programs listed below are not covered by this guide and must be billed using their specific provider guide:

- Hearing Hardware for Clients Age 20 and Younger
- Home Health Services
- Outpatient Hospital Services
- Outpatient Rehabilitation
- Physician-Related Services/Healthcare Professional Services

What has changed?

Subject	Change	Reason for Change
Client Eligibility: BHO, Changes for January 1, 2019, IMC, and Integrated Apple Health Foster Care	**Effective January 1, 2019,** some existing integrated managed care regions have new counties and many new regions and counties will be implemented.	Apple Health managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services.

How can I get agency provider documents?

To access Provider Alerts, go to the agency's Provider Alerts webpage.

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

* This publication is a billing instruction.

Copyright disclosure

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Resources

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources webpage.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Private insurance or third-party liability, other than agency managed care	
Obtaining prior authorization	
Definitions	Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.
Provider billing guides, fee schedules, and other agency documents	See the agency's online Rates Development Fee Schedules

About the Program

What do neurodevelopmental centers do?

Neurodevelopmental centers (NDCs) provide outpatient physical therapy, speech therapy, occupational therapy, and audiology services to children with neuromuscular or developmental disorders, such as cerebral palsy, Down's syndrome, autism, and pervasive developmental delay. NDCs serve clients age 20 and younger, although some NDCs further limit the age range they serve.

Who may provide services?

(WAC 182-545-200, WAC 182-531-0375)

After a client's primary care physician initiates NDC services by requesting an evaluation, the following health care professionals may provide services within their scope of practice to eligible clients in neurodevelopmental centers:

- Licensed occupational therapists
- Licensed occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Licensed physical therapists
- 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
- Audiologists who are licensed or registered to perform audiology services

Client Eligibility

How can I verify a patient's eligibility?

Clients age 20 and younger may be eligible to receive services in a neurodevelopmental center, 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 Program Benefit Packages and Scope of Services webpage.

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 (MCO) eligible?

(WAC 182-538-060 and 182-538-095)

Yes. Clients enrolled in an agency-contracted managed care plan who are referred for outpatient rehabilitation services (Physical Therapy, Occupational Therapy and Speech Therapy) by their primary care provider are eligible to receive those services in a neurodevelopmental center (NDC).

Effective July 1, 2018, payment for these services in the NDC setting are the responsibility of the client's agency-contracted managed care organization (MCO). When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted MCO, managed care enrollment will be displayed on the Client Benefit Inquiry Screen.

All medical services covered under a managed care plan must be received by the client through an enrolled MCO facility or provider and billed to the assigned MCO.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to 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 policies.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following four Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **North Sound:** Includes Island, San Juan, Skagit, Snohomish, and Whatcom counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage.

See the agency's Mental Health Services Billing Guide for details.

Apple Health – Changes for January 1, 2019

Effective January 1, 2019, agency-contracted managed care organizations (MCOs) in certain Regional Services Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated Managed Care Regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne Client Portal.

- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.

- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."

- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

> **American Indian/Alaska Native (AI/AN)** clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.
>
> For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Changes to Apple Health managed care webpage.

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Existing integrated managed care regions – Expanding January 1, 2019

- **North Central** (Chelan, Douglas, Grant, and Okanogan counties)
  The agency expanded this region to include Okanogan County.

- **Southwest Washington** (Clark, Klickitat, and Skamania counties)
  The agency expanded this region to include Klickitat County.

New integrated managed care regions – Effective January 1, 2019

The following new regions are implemented for integrated managed care:

- **Greater Columbia** (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman counties)
- **King** (King County)
- **Pierce (**Pierce County)
- **Spokane** (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

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

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

Fee-for-service Apple Health Foster Care

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

Coverage

What services are covered?

(WAC 182-545-900)

The Health Care Authority (agency) covers unlimited services in a neurodevelopmental center for clients age 20 and younger, with the following exception: clients age 19 through 20 in Medical Care Services (MCS) are eligible for **limited** outpatient rehabilitation. For these clients, the outpatient rehabilitation benefit applies. See the Outpatient Rehabilitation Billing Guide.

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.

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 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. To review the appropriate ICD diagnosis codes that are required in the primary diagnosis field on the claim, refer to Approved Diagnosis Codes by Program webpage for Habilitative Services.

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.

Procedure Code	Modifier	Short Description	Comments
Physical therapy			
64550		Apply neurostimulator	Not covered
95831	GP	Limb muscle testing, manual	Muscle testing procedures cannot be billed in combination with each other. They can be billed alone or with other PT/OT procedure codes.
95832	GP	Hand muscle testing, manual	
95833	GP	Body muscle testing, manual	
95834	GP	Body muscle testing, manual	
95851	GP	Range of motion measurements	Excluding hands
95852	GP	Range of motion measurements	Including hands
96125	GP	Cognitive test by hc pro	
97010	GP	Hot or cold packs therapy	Included in primary services. Bundled
97012	GP	Mechanical traction therapy	
97014	GP	Electric stimulation therapy	
97016	GP	Vasopneumatic device therapy	
97018	GP	Paraffin bath therapy	
97022	GP	Whirlpool therapy	
97024	GP	Diathermy treatment	
97026	GP	Infrared therapy	
97028	GP	Ultraviolet therapy	
Note: The following procedures codes require the therapy provider be in constant attendance.			
97161	GP	PT eval low complex 20 min	
97162		PT eval mod complex 30 min	
97163		PT eval high complex 45 min	
97164	GP	PT re-eval est plan care	
97005		Athletic train evaluation	Not covered
97006		Athletic train re-evaluation	Not covered
97032	GP	Electrical stimulation	Timed 15 min units
97033	GP	Electric current therapy	Timed 15 min units
97034	GP	Contrast bath therapy	Timed 15 min units

Procedure Code	Modifier	Short Description	Comments
97035	GP	Ultrasound therapy	Timed 15 min units
97036	GP	Hydrotherapy	Timed 15 min units
97039	GP	Physical therapy treatment	
97110	GP	Therapeutic exercises	Timed 15 min units
97112	GP	Neuromuscular reeducation	Timed 15 min units
97113	GP	Aquatic therapy/exercises	Times 15 min units
97116	GP	Gait training therapy	Timed 15 min units
97124	GP	Massage therapy	Timed 15 min units
97139	GP	Physical medicine procedure	
97140	GP	Manual therapy	Timed 15 min units
97150	GP	Group therapeutic procedures	
97530	GP	Therapeutic activities	Timed 15 min units
97532		Cognitive skills development	Not covered
97533		Sensory integration	Not covered
97535	GP	Self-care management training	Timed 15 min units
97537	GP	Community/work reintegration	Timed 15 min units
97542	GP	Wheelchair management training	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	Active wound care/20 cam or <	Do not use in combination with 11040-11044. Limit one per client per day.
97598	GP	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GP	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GP	Neg press wound tx, <50 cm	Included in primary services. Bundled
97606	GP	Neg press wound tx, >50 cm	Included in primary services. Bundled
97750	GP	Physical performance test	Do not use to bill for an evaluation
97755	GP	Assistive technology assess	Timed 15 min units
97760	GP	Orthotic mgmt and training	Can be billed alone or with other PT/OT procedure codes
97761	GP	Prosthetic training	Timed 15 min units

Procedure Code	Modifier	Short Description	Comments
97762	GP	C/o for orthotic/prosth use	Use this code for DME assessment. Use modifier TS for follow up service. Can be billed alone or with other PT/OT procedure codes.
97799	GP	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.
Team conferences			
99367		Team conf w/o pat by phys	
Pediatric evaluations			
99201		Office/outpatient visit, new	
99202		Office/outpatient visit, new	
99203		Office/outpatient visit, new	
99204		Office/outpatient visit, new	
99205		Office/outpatient visit, new	
99211		Office/outpatient visit, est	
99212		Office/outpatient visit, est	
99213		Office/outpatient visit, est	
99214		Office/outpatient visit, est	
99215		Office/outpatient visit, est	
Speech-language pathologists			
92521	GN	Evaluation of speech fluency	
92522	GN	Evaluate speech production	
92523	GN	Speech sound lang comprehen	
92524	GN	Behavral qualit analys voice	
92507	GN	Speech/hearing therapy	
92508	GN	Speech/hearing therapy	
92526	GN	Oral function therapy	
92551	GN	Pure tone hearing test, air	
92597	GN	Oral speech device eval	
92605	GN	Evaluation for rx of nonspeech device 1 hr	Limit 1 hour Included in primary services. Bundled

Procedure Code	Modifier	Short Description	Comments
92618	GN	Eval for rx of nonspeech device addl	Add on to 92605 Each additional 30 minutes. Bundled
92606	GN	Non-speech device service	Included in Primary services. Bundled
92607	GN	Ex for speech device rx, 1hr	Limit 1 hour
92608	GN	Ex for speech device rx addl	Each additional 30 min
92609	GN	Use of speech device service	
92610	GN	Evaluate swallowing function	
92611	GN	Motion fluoroscopy/swallow	
92630	GN	Aud rehab pre-ling hear loss	
92633	GN	Aud rehab postling hear loss	
96125	GN	Cognitive test by hc pro	
97532	GN	Cognitive skills development	Timed 15 min units
97533	GN	Sensory integration	Timed 15 min units
S9152	GN	Speech therapy, re-eval	
Audiologists			
69210	AF	Remove impacted ear wax	
92521	AF	Evaluation of speech fluency	
92522	AF	Evaluate speech production	
92523	AF	Speech sound lang comprehen	
92524	AF	Behavral qualit analys voice	
92541	AF	Spontaneous nystagmus test	
92542	AF	Positional nystagmus test	
92543	AF	Caloric vestibular test	
92544	AF	Optokinetic nystagmus test	
92545	AF	Oscillating tracking test	
92546	AF	Sinusoidal rotational test	
92547	AF	Supplemental electrical test	
92550	AF	Tympanometry & reflex thresh	
92551	AF	Pure tone hearing test, air	
92552	AF	Pure tone audiometry, air	
92553	AF	Audiometry, air & bone	
92555	AF	Speech threshold audiometry	
92556	AF	Speech audiometry, complete	

Procedure Code	Modifier	Short Description	Comments
92557	AF	Comprehensive hearing test	
92558	AF	Evoked otoacoustic emissions screening- audiologists	
92567	AF	Tympanometry	
92568	AF	Acoustic reflex testing	
92570	AF	Acoustic immittance testing	
92579	AF	Visual audiometry (vra)	
92582	AF	Conditioning play audiometry	
92584	AF	Electrocochleography	
92585	AF	Auditor evoke potent, compre	
92586	AF	Auditor evoke potent, limit	
92587	AF	Evoked auditory test	
92588	AF	Evoked auditory test	
92601	AF	Cochlear implt f/up exam < 7	
92602	AF	Reprogram cochlear implt < 7	
92603	AF	Cochlear implt f/up exam 7 >	
92604	AF	Reprogram cochlear implt 7 >	
92611	AF	Motion fluoroscopy/swallow	
92620	AF	Auditory function, 60 min	
92621	AF	Auditory function, + 15 min	
92625	AF	Tinnitus assessment	
92626	AF	Oral function therapy	
92627	AF	Oral speech device eval	
92630	AF	Aud rehab pre-ling hear loss	
92633	AF	Aud rehab postling hear loss	
97532	AF	Cognitive skills development	One 15 minute increment equals one visit
97533	AF	Sensory integration	One 15 minute increment equals one visit
Occupational therapy			
64550		Apply neurostimulator	Not covered
92526	GO	Oral function therapy	
95831	GO	Limb muscle testing, manual	Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95832	GO	Hand muscle testing, manual	
95833	GO	Body muscle testing, manual	
95834	GO	Body muscle testing, manual	
95851	GO	Range of motion measurements	Excluding hands

Procedure Code	Modifier	Short Description	Comments
95852	GO	Range of motion measurements	Including hands
96125	GO	Cognitive test by hc pro	
97165	GO	OT eval low complex 30 min	
97166		OT eval mod comple 45 min	
97167		OT eval high complex 60 min	
97168	GO	OT re-eval est plan care	
97010	GO	Hot or cold packs therapy	Included in Primary services. Bundled
97014	GO	Electric stimulation therapy	
97018	GO	Paraffin bath therapy	
97032	GO	Electrical stimulation	Timed 15 min units
97034	GO	Contrast bath therapy	Timed 15 min units
97110	GO	Therapeutic exercises	Timed 15 min units
97112	GO	Neuromuscular reeducation	Timed 15 min units
97113	GO	Aquatic therapy/exercises	Timed 15 min units
97124	GO	Massage therapy	Timed 15 min units
97140	GO	Manual therapy	Timed 15 min units
97150	GO	Group therapeutic procedures	
97530	GO	Therapeutic activities	Timed 15 min units
97532	GO	Cognitive skills development	Timed 15 min units
97533	GO	Sensory integration	Timed 15 min units
97535	GO	Self-care management training	Timed 15 min units
97537	GO	Community/work reintegration	Timed 15 min units
97542	GO	Wheelchair management training	Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97597	GO	Active wound care/20 cm or <	Do not use in combination with 11040-11044. Limit one per client per day
97598	GO	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GO	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GO	Neg press wound tx, <50 cm	Included in Primary services. Bundled
97606	GO	Neg press wound tx, >50 cm	Included in Primary services. Bundled
97750	GO	Physical performance test	Do not use to bill for an evaluation

Procedure Code	Modifier	Short Description	Comments
97755	GO	Assistive technology assess	Timed 15 min units
97760	GO	Orthotic management and training	Can be billed alone or with other PT/OT procedure codes
97761	GO	Prosthetic training	Timed 15 min units
97762	GO, TS	C/o for orthotic/prosth use	Use this code for DME assessment. Use modifier TS for follow up service. Can be billed alone or with other PT/OT procedure codes
97799	GO & RT or LT	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.

Payment

What must an NDC do to be reimbursed by the agency?

To be reimbursed for the services listed in the coverage section, an NDC must:

- Contract with the Department of Health (DOH) as a neurodevelopmental center.
- Provide documentation of its DOH contract to the agency.
- Have an approved core-provider agreement with the agency.

To be reimbursed for the services listed in the coverage section, each service must be:

- Covered by the client's benefit package.
- 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 assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Begun within 30 days of the date ordered.
- Provided by an approved health professional.
- Billed according to this guide.
- Provided as part of an outpatient treatment program in a neurodevelopmental center, as described in WAC 182-545-900.

What services does the agency not pay for?

The agency does not pay for:

- Duplicate services for the same client when two or more providers are performing the same or similar intervention on the same date.

- Services included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services (see WAC 182-545-900).

Billing

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 servicing provider national provider identifiers (NPIs) required on all claims?

Yes. Neurodevelopmental centers (NDCs) must use the servicing provider's national provider identifier (NPI) 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. 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 webpage, 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) webpage.

Are modifiers required for billing?

Yes. Neurodevelopmental centers must use the appropriate modifier when billing the agency:

MODALITY	MODIFIERS
Physical Therapy	GP
Occupational Therapy	GO
Speech Therapy	GN
Audiology and Specialty Physician	AF

What are the general billing requirements?

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

- 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