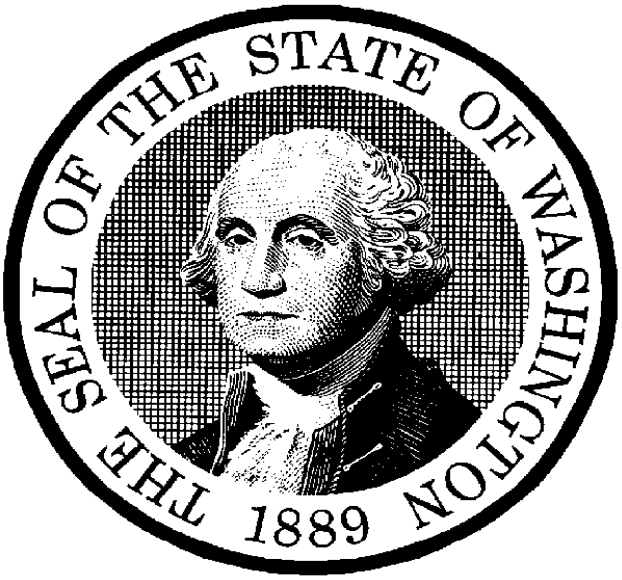
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration (HRSA)



Neurodevelopmental Centers

Billing Instructions

Copyright Disclosure

About this publication

This publication supersedes all previous billing instructions for Neurodevelopmental Centers. Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Physical Therapy
- Occupational Therapy
- Speech/Audiology Therapy
- School Medical Services

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. (WAC 388-502-0020(2)).

Applying for a provider #

Call:
Provider Enrollment
800.562.3022 (Select option #1)

or call one of the following numbers:

360.725.1026
360.725.1032
360.725.1033

Where do I send my claims?

Division of Medical Benefits and Care Management
PO Box 9248
Olympia WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://hrsa.dshs.wa.gov

Or write/call:
Provider Relations
PO Box 45505
Olympia WA 98504-5562
800.562.3022

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations
800.562.3022 (Select option #2)

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Eligibility and Service Delivery
Coordination of Benefits
PO Box 45561
Olympia, WA 98504-5565
800.562.6136

Electronic Billing?

http://maa.dshs.wa.gov/ecs

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Authorization – HRSA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Client - An applicant approved for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Current Procedural Terminology (CPT™) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Deductible-Medicare – An initial specified amount that is the responsibility of the client.

- **Part A of Medicare-Inpatient Hospital Deductible -** An initial amount of the medical care cost in each benefit period which Medicare does not pay.

- **Part B of Medicare-Physician Deductible** - An initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

[WAC 388-500-0005]

Expedited Prior Authorization (EPA) - The process of authorizing selected services in which providers use a set of numeric codes to indicate to HRSA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Identification (ID) card – Medical ID cards are the forms DSHS uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical Identification (ID) card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medically Necessary – A term for describing requested service which is reasonable calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.
[WAC 388-550-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
  [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Manager (PCCM) - A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly management fee.

Prior Authorization – Approval required from HRSA prior to providing services, for certain services, equipment, or supplies based on medical necessity.

Program Support, Division of (DPS) – The division within HRSA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

[WAC 388-500-0005]

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with HRSA.

Remittance And Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client.
[WAC 388-500-0005]

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Centers

What is the purpose of Neurodevelopmental Centers?

The purpose of Neurodevelopmental Centers is to provide therapy and related services to children with neuromuscular or developmental disorders. Neurodevelopmental Centers serve children from birth through adolescence, although some centers may limit the age groups served.

Examples of disorders affecting these children are:

- Cerebral palsy;
- Down syndrome;
- Autism;
- Pervasive developmental delay; and
- Other disorders involving neurodevelopmental function.

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Client Eligibility

Who is eligible?

Clients presenting Medical Identification (ID) cards with following identifiers are eligible for services provided in Neurodevelopmental Centers:

Medical ID card Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program-Emergency Only
LCP - MNP	Limited Casualty Program-Medically Needy Program – These clients are eligible for services provided by neurodevelopmental centers only when they are: • Twenty years of age or younger and referred by a screening provider under the EPSDT/Healthy Kids program; or • Receiving home health care services.

Who is not eligible?

Clients presenting Medical Identification (ID) cards with following identifiers are not eligible for services provided in Neurodevelopmental Centers:

Medical ID card Identifier	Medical Program
Detox Only	Detox
Family Planning Only	Family Planning
GA-U - No Out of State Care	General Assistance-Unemployable – No Out of State Care
General Assistance No Out of State Care	ADATSA, ADATSA Medical Only
QMB Medicare Only	Qualified Medicare Beneficiary-Medicare Only

Are neurodevelopmental services covered under Healthy Options managed care plans?

No. Neurodevelopmental services are not covered under HRSA's Healthy Options managed care plans. Managed care clients who meet the eligibility requirements may obtain neurodevelopmental services through fee-for-service.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their Medical Identification (ID) cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the 1500 Claim Form. (See *Billing* for further information.)

Coverage

DSHS pays only for covered services listed in this section when they are:

- Within the scope of an eligible client's medical care program; and
- Medically necessary and prescribed by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP).

DSHS recommends that services:

- Begin within 30 days of the date prescribed; and
- Are for conditions resulting from injuries and/or medically recognized diseases and defects.

What is covered?

DSHS covers unlimited physical therapy, speech/audiology, and occupational therapy services for clients 20 years of age and younger.

DSHS covers specific evaluation and management procedures (CPT code 99201-99215 and 99367).

Limitations

DSHS does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar service(s).

Are school medical services covered?

DSHS covers physical therapy, speech/audiology, and occupational therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to the DSHS/HRSA *School-based Healthcare Services for Special Education Students Billing Instructions*. (See *Important Contacts*.)

What is not covered?

DSHS does not cover services (physical therapy, speech/audiology, and occupational therapy) included as part of the reimbursement for other treatment programs. This includes, but is not limited to hospital inpatient and nursing facility services.

Neurodevelopmental Centers Coverage Table

Note: Due to its licensing agreement with the American Medical Association, DSHS publishes only the official, brief CPT™ code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Physical Therapy				
64550		Apply neurostimulator		
95831		Limb muscle testing, manual		
95832		Hand muscle testing, manual		
95833		Body muscle testing, manual		
95834		Body muscle testing, manual		
95851		Range of motion measurements		
95852		Range of motion measurements		
96125		Cognitive test by hc pro.		
97001		PT evaluation		
97002		PT re-evaluation		
97005		Athletic train eval		Not covered service
97006		Athletic train re-eval		Not covered service
97010		Hot or cold packs therapy		Bundled service
97012		Mechanical traction therapy		
97014		Electric stimulation therapy		
97016		Vasopneumatic device therapy		
97018		Paraffin bath therapy		
97022		Whirlpool therapy		
97024		Diathermy treatment		
97026		Infrared therapy		
97028		Ultraviolet therapy		
Note: The following procedures codes require the therapy provider be in constant attendance.				
97032		Electrical stimulation		
97033		Electric current therapy		
97034		Contrast bath therapy		
97035		Ultrasound therapy		
97036		Hydrotherapy		
97039		Physical therapy treatment		
97110		Therapeutic exercises		
97112		Neuromuscular reeducation		
97113		Aquatic therapy/exercises		

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Physical Therapy Continued				
Note: The following procedures codes require the therapy provider be in constant attendance.				
97116		Gait training therapy		
97124		Massage therapy		
97139		Physical medicine procedure		
97140		Manual therapy		
97150		Group therapeutic procedures		
97530		Therapeutic activities		
97532		Cognitive skills development		Not covered service
97533		Sensory integration		Not covered service
97535		Self care mngment training		
97537		Community/work reintegration		
97542		Wheelchair mngment training		
97545		Work hardening		Not covered service
97546		Work hardening add-on		Not covered service
97597		Active wound care/20 cam or <		DSHS reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes. Providers may not bill CPT codes 97597, 97598, or 97602 in conjunction with one another. Providers must not bill procedure codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.
97598		Active wound care > 20 cm		
97602		Wound(s) care non-selective		
97605		Neg press wound tx, <50 cm		Bundled service
97606		Neg press wound tx, >50 cm		Bundled service
97750		Physical performance test		
97755		Assistive technology assess		
97760		Orthotic mgmt and training		
97761		Prosthetic training		
97762		C/o for orthotic/prosth use		
97799		Physical medicine procedure		

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
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 Therapy Audiologists and Speech-Language Pathologists				
92506		Speech/hearing evaluation		
92507		Speech/hearing therapy		
92508		Speech/hearing therapy		
92540		Basic vestibular evaluation		Added January 1, 2010
92540	26	Basic vestibular evaluation		Added January 1, 2010
92540	TC	Basic vestibular evaluation		Added January 1, 2010
92526		Oral function therapy		
92551		Pure tone hearing test, air		
~~92569~~		~~Acoustic reflex decay test~~		Discontinued January 1, 2010
92630		Aud rehab pre-ling hear loss		
92633		Aud rehab postling hear loss		
97532		Cognitive skills development		One 15 minute visit equals one increment
97533		Sensory integration		One 15 minute visit equals one increment
Audiologists Only				
69210		Remove impacted ear wax		
92541	26	Spontaneous nystagmus test		
92541	TC	Spontaneous nystagmus test		
92541		Spontaneous nystagmus test		
92542	26	Positional nystagmus test		
92542	TC	Positional nystagmus test		
92542		Positional nystagmus test		
92543	26	Caloric vestibular test		
92543	TC	Caloric vestibular test		
92543		Caloric vestibular test		
92544	26	Optokinetic nystagmus test		

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists Only Continued				
92544	TC	Optokinetic nystagmus test		
92544		Optokinetic nystagmus test		
92545	26	Oscillating tracking test		
92545	TC	Oscillating tracking test		
92545		Oscillating tracking test		
92546	26	Sinusoidal rotational test		
92546	TC	Sinusoidal rotational test		
92546		Sinusoidal rotational test		
92547		Supplemental electrical test		
92552		Pure tone audiometry, air		
92553		Audiometry, air & bone		
92555		Speech threshold audiometry		
92556		Speech audiometry, complete		
92557		Comprehensive hearing test		
92567		Tympanometry		
92568		Acoustic reflex testing		
~~92569~~		~~Acoustic reflex decay test~~		Discontinued January 1, 2010
92570		Acoustic immittance testing		Added January 1, 2010
92579		Visual audiometry (vra)		
92582		Conditioning play audiometry		
92584		Electrocochleography		
92585		Auditor evoke potent, compre		
92585	26	Auditor evoke potent, compre		
92585	TC	Auditor evoke potent, compre		
92586		Auditor evoke potent, limit		
92587		Evoked auditory test		
92587	26	Evoked auditory test		
92587	TC	Evoked auditory test		
92588		Evoked auditory test		
92588	26	Evoked auditory test		
92588	TC	Evoked auditory test		
92601		Cochlear implt f/up exam < 7		
92602		Reprogram cochlear implt < 7		
92603		Cochlear implt f/up exam 7 >		
92604		Reprogram cochlear implt 7 >		
92620		Auditory function, 60 min		
92621		Auditory function, + 15 min		
92625		Tinnitus assessment		
92626		Oral function therapy		
92627		Oral speech device eval		

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Speech-Language Pathologists Only				
S9152		Speech Therapy Re-eval		
92605		Eval for nonspeech device rx		Included in the primary services Bundled service
92606		Non-speech device service		
92607		Ex for speech device rx, 1hr		
92608		Ex for speech device rx addl		
92609		Use of speech device service		
92610		Evaluate swallowing function		
96125		Cognitive test by hc pro.		
Occupational Therapy				
64550		Apply neurostimulator		
95831		Limb muscle testing, manual		
95832		Hand muscle testing, manual		
95833		Body muscle testing, manual		
95834		Body muscle testing, manual		
95851		Range of motion measurements		
95852		Range of motion measurements		
96125		Cognitive test by hc pro.		
97003		OT evaluation		
97004		OT re-evaluation		
97010		Hot or cold packs therapy		Bundled service
97014		Electric stimulation therapy		
97018		Paraffin bath therapy		
97032		Electrical stimulation		
97034		Contrast bath therapy		
97110		Therapeutic exercises		
97112		Neuromuscular reeducation		
97113		Aquatic therapy/exercises		
97140		Manual therapy		
97150		Group therapeutic procedures		
97530		Therapeutic activities		
97532		Cognitive skills development		
97533		Sensory integration		
97535		Self care mngment training		
97537		Community/work reintegration		
97542		Wheelchair mngment training		
97597		Active wound care/20 cm or <		Do not bill with 97598 or 97602 for same wound. Do not use in combination with 11040-11044.

Occupational Therapy Continued				
97598		Active wound care > 20 cm		Do not bill with 97597 or 97602 for same wound. Do not use in combination with 11040-11044.
97602		Wound(s) care non-selective		Do not bill with 97597 or 97598 for same wound. Do not use in combination with 11040-11044.
97750		Physical performance test		
97755		Assistive technology assess		
97760		Orthotic mgmt and training		
97761		Prosthetic training		
97762		C/o for orthotic/prosth use		Use this code for DME assessments.
97799	RT LT	Physical medicine procedure		Use this code for custom hand splints. Use modifier to indicate right or left hand.

Neurodevelopmental Centers

Note: The client's attending physician must initiate all Neurodevelopmental Center services by requesting an evaluation.

Physical Therapy

Who is eligible to provide physical therapy? [Refer toWAC 388-545-500(1)]

- A licensed physical therapist or physiatrist; or
- A physical therapist assistant supervised by a licensed physical therapist.

Speech Language Pathology

Who is eligible to provide speech-language therapy?

[Refer to WAC 388-545-0700 (1)(a)(b)]

A speech-language pathologist who has:

- Been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; or
- Completed the equivalent educational and work experience necessary for such a certificate.

Swallowing Evaluations

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

- Holds a master's degree in speech-language pathology; and
- 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; and
- (May include) A videofluoroscopy for further evaluation of swallowing status and aspiration risks.

Audiology

Who is eligible to perform audiology services? [WAC 388-545-0700 (1)(c)]

An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence.

What type of equipment must be used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

Occupational Therapy

Who is eligible to provide occupational therapy? [Refer to WAC 388-545-0300(1)]

- A licensed occupational therapist;
- A licensed occupational therapy assistant supervised by a licensed occupational therapist; or
- An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  - ✓ HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that impacts the particular claim;
    - The date a court orders HRSA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note: If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the time limit is 365 days from the date the plan recouped the payment from the provider.

  - ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - DSHS certification of a client for a retroactive[2] period; or
    - The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the Medical Identification (ID) card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill HRSA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill HRSA.

- ✓ HRSA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim for a period of 36 months from the date of service.

  Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your HRSA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill HRSA directly.

- If Medicare has made payment, and there is a balance due from HRSA, you must submit a 1500 Claim Form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but HRSA covers them, you must bill on a 1500 Claim Form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

Note: Medicare/Medical Assistance billing claims must be received by HRSA within six (6) months of the Medicare EOMB paid date.

Note: A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to HRSA's maximum allowable.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification (ID) card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed Claim Form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 800.562.6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, *for six years from the date of service* or more if required by federal or state law or regulation.**

Fee Schedule

You may view HRSA's **Neurodevelopmental Centers Fee Schedule** on-line at

http://maa.dshs.wa.gov/RBRVS/Index.html

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Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 Claim Form instructions relate to **Neurodevelopmental Centers Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:
800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
1a.	**Insured's I.D. No.**:	Yes	Enter the HRSA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each HRSA client. This information is obtained from the client's current monthly Medical Identification (ID) card consisting of: • First and middle initials (a dash [-] *must* be used if the middle initial is not available). • Six-digit birthdate, consisting of *numerals only* (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). *For example:*

Field No.	Name	Field Required	Entry
			✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB. ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B. ✓ A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator *in field 19*. If the client is one of twins or triplets, enter **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C", as appropriate.
4.	**Insured's Name (Last Name, First Name, Middle Initial)**	When applicable	If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
9d.	**Insurance Plan Name or Program Name**		Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance). **Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are <u>inappropriate</u> entries for this field.
17.	**Name of Referring Physician or Other Source**	When applicable	Enter the referring physician or Primary Care Case Manager name. This field ***must*** be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source.)
17a.	**I.D. Number of Referring Physician**		Enter the seven-digit, HRSA-assigned identification number of the provider who *referred or ordered* the medical service; <u>OR</u> 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is <u>not</u> in this field when you bill HRSA, the claim will be denied.
23.	**Prior Authorization Number**	When applicable	If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.
24B.	**Place of Service**	Yes	Enter 11 (office or neurodevelopmental center).

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for 1500 Claim Form Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to HRSA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach HRSA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to HRSA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the HRSA Remittance and Status Report within 30 days of the Medicare statement date, you should bill HRSA on the 1500 Claim Form.

If **Medicare denies** a service, bill HRSA using the 1500 Claim Form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to HRSA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

Completing the 1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

Field No.	Name	Field Required	Entry
1a.	**Insured's I.D. No.**	Yes	Enter the HRSA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current Medical Identification (ID) card consisting of: • First and middle initials (a dash [-] *must* be used if the middle initial is not available). • Six-digit birthdate, consisting of *numerals only* (MMDDYY). • First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. • An alpha or numeric character (tiebreaker). *For example:* ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB. ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.
2.	**Patient's Name**	Yes	Enter the last name, first name, and middle initial of the HRSA client (the receiver of the services for which you are billing).
3.	**Patient's Birthdate**	Yes	Enter the birthdate of the HRSA client.
4.	**Insured's Name (Last Name, First Name, Middle Initial)**	When applicable	If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then

Field No.	Name	Field Required	Entry
			the word *Same* may be entered.
5.	**Patient's Address**	Yes	Enter the address of the HRSA client who has received the services you are billing for (the person whose name is in *field 2*).
9.	**Other Insured's Name**		Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
9a.			Enter the other insured's policy or group number *and* his/her Social Security Number.
9b.			Enter the other insured's date of birth.
9c.			Enter the other insured's employer's name or school name.
9d.			Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance). **Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are <u>inappropriate</u> entries for this field.
10.	**Is Patient's Condition Related To**	Yes	Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11.	**Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**		Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.
11a.	**Insured's Date of Birth**		Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
11b.	**Employer's Name or School Name**		Primary insurance. When applicable, enter the insured's employer's name or school name.
11c.	**Insurance Plan Name or Program Name**		Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.*
11d.	**Is There Another Health**	Yes	Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*.

Field No.	Name	Field Required	Entry
	Benefit Plan?		If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.
19.	**Reserved For Local Use**	Yes	**When Medicare allows services, enter *XO* to indicate this is a crossover claim.**
22.	**Medicaid Resubmission**	When applicable	If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).
24.			**Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional 1500 Claim Form.**
24A.	**Date(s) of Service**	Yes	Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 4, 2000 = 090400). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**
24B.	**Place of Service**	Yes	Enter a 11.
24D.	**Procedures, Services or Supplies CPT/HCPCS**	Yes	**Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.
24E.	**Diagnosis Code**		Enter the ICD-9-CM diagnosis code related to the procedure or service being billed. Enter the code exactly as shown in ICD-9-CM.
24F.	**$ Charges:**	Yes	Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.
24G.	**Days Or Units**	Yes	Enter appropriate number of units.
24K.	**Reserved for Local Use**	Yes	Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).
26.	**Your Patient's Account No.**	No	Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report

Field No.	Name	Field Required	Entry
			under the heading *Patient Account Number*.
27.	**Accept Assignment**	Yes	Check **yes**.
28.	**Total Charge**	Yes	Enter the sum of your charges. Do not use dollar signs or decimals in this field.
29.	**Amount Paid**	Yes	Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 Claim Forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**
30.	**Balance Due**	Yes	Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 Claim Forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**
32.	**Name and Address of Facility Where Services Are Rendered**	Yes	Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**
33.	**Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**	Yes	Put the *Name*, *Address*, and *Telephone Number* on all Claim Forms.