Washington State Health Care Authority

Washington Apple Health (Medicaid)

Outpatient Rehabilitation Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2025**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in WAC 182-545-200.

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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

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

- Home health services
- Neurodevelopmental centers
- Wheelchairs, durable medical equipment, and supplies
- Prosthetic/orthotic devices and supplies
- Outpatient hospital services
- Physician-related services/healthcare professional services (includes audiology)

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* This publication is a billing instruction.

Washington State Health Care Authority

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's **provider alerts webpage**.

To access provider documents, go to HCA's **provider billing guides and fee schedules webpage.**

Health care privacy toolkit

The **Washington Health Care Privacy Toolkit** is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

Washington State Health Care Authority

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
What are the general billing requirements?	Added a note box to specify that claims must name the billing provider **and** the servicing provider	To ensure claims name the therapist performing the service

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Table of Contents

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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the Health Care Authority's Billers, providers, and partners webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See the Health Care Authority's Billers, providers, and partners webpage
Electronic billing	See the Health Care Authority's Billers, providers, and partners webpage
Finding HCA documents, (e.g., billing guides, provider notices, fee schedules)	See the Health Care Authority's Billers, providers, and partners webpage
Private insurance or third-party liability	See the Health Care Authority's Billers, providers, and partners webpage
How do I check how many units of therapy the client has remaining?	Providers may contact HCA's Medical Assistance Customer Service Center (MACSC) via either of the following: • Telephone toll-free at (800) 562-3022 • Web form or email
How do I obtain prior authorization or a limitation extension?	Providers may submit their requests online or by submitting the request in writing. See HCA's prior authorization webpage for details. Written requests for prior authorization or limitation extensions must include: • A completed, typed *General Information for Authorization* (HCA 13-835 form). This request form must be the cover page when you submit your request. • A completed *Outpatient Rehabilitation Authorization Request* (HCA 13-786 form) and all the documentation listed on that form and any other medical justification. Fax your request to: (866) 668-1214. For information about downloading HCA forms, see Where can I download HCA forms?

Topic	Resource
General definitions	See chapter 182-500 WAC
Where do I find HCA's maximum allowable fees for services?	See the Health Care Authority's Fee Schedules

Washington State Health Care Authority

Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Let's get started" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

Managed care enrollment

Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

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 **HCA's Apply for or renew coverage webpage**.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care plan will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement), or in the Unaccompanied Refugee Minors program
- Age 20 and younger 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**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

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 Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

Washington State Health Care Authority

Provider Eligibility

Who may provide outpatient rehabilitation services?

The following health professionals may enroll with the Health Care Authority to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy; see WAC 182-545-200) within their scope of practice to eligible clients:

- A licensed occupational therapist
- A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist
- A licensed optometrist, to provide vision occupational therapy only
- A physiatrist
- A licensed physical therapist
- A physical therapist assistant (PTA) supervised by a licensed physical therapist
- A licensed speech-language pathologist

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

Coverage

When does HCA pay for outpatient rehabilitation?

HCA pays for outpatient rehabilitation as described in WAC 182-545-200 when the services are:

- Covered.
- Medically necessary, as defined in WAC 182-500-0070.
- Within the scope of the eligible client's medical care program.
- Ordered by a physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Authorized, as required in chapter 182-545 WAC, chapter 182-501 WAC, and chapter 182-502 WAC, and HCA's published billing guides.
- Begun within 30 days of the date ordered.
- Provided by an approved health professional (see Who may provide outpatient rehabilitation services?).
- Billed as required in chapters 182-501, 182-502, and 182-545 WAC, and HCA's published billing guides.
- Provided as part of an outpatient treatment program:
  - In an office or outpatient hospital setting.
  - In the home, by a home health agency, as described in chapter 182-551 WAC.
  - In a neurodevelopmental center, as described in WAC 182-545-900.
  - For children with disabilities, age six or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.
  - When provided by licensed and certified behavioral health agencies as part of a mental health or substance use disorder treatment program.

> **Note**: For information about the Habilitative Services benefit, see What are habilitative services under this program?

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

Documentation Requirements

Using timed and untimed procedure codes

For the purpose of this billing guide:

Each 15 minutes of a timed CPT® code equals one unit.

Each nontimed CPT® code equals one unit regardless of how long the procedure takes.

The client's medical record must include detailed documentation for each timed CPT® code, specifying the date of service with the therapy modality start and end times.

> **Example:** CPT® code 97032 – Electrical Stimulation (Timed, 15-minute unit)
>
> GO Electrical Stimulation (CPT® 97032)
>
> Date of therapy service: 2/21/2025
>
> Therapy start time: 9:05 AM
>
> Therapy end time: 9:20 AM (15 minutes)

Telemedicine

Refer to HCA's **Provider billing guides and fee schedules webpage**, under Telehealth, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine/telehealth policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and *Clinical policy and billing for COVID-19*.

Effective for dates of service on and after October 1, 2023

Audio-visual telemedicine

HCA pays for evaluation, re-evaluation, and treatment of some physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services when provided via audio-visual telemedicine.

HCA pays for telehealth services for PT, OT, or ST when provided via audio-visual telemedicine and billed with specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care.

Services delivered by synchronous audio-visual technology may require participation of a caregiver to assist with the treatment. Providers are responsible

for making this determination and ensuring there is appropriate assistance or supervision, or both.

Providers may bill for services provided via audio-visual telemedicine using the following procedure codes:

- **Physical therapy evaluations—low, moderate, and high complexity and re-evaluation**

CPT® code	Short description
97161	PT eval low complex 20 min
97162	PT eval mod complex 30 min
97163	PT eval high complex 45 min
97164	PT re-eval est plan care

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Occupational therapy evaluation—low, moderate, and high complexity and re-evaluation**

CPT® code	Short description
97165	OT eval low complex 30 min
97166	OT eval mod complex 45 min
97167	OT eval high complex 60 min
97168	OT re-eval est plan care

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Physical therapy or occupational therapy services (individual or group)**

CPT® code	Short description
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97535	Self care mngment training
97750	Physical performance test

- **Speech evaluation and re-evaluation**

Procedure code	Short description
CPT® 92521	Evaluation of speech fluency
CPT® 92522	Evaluate speech production
CPT® 92523	Speech sound lang comprehen
CPT® 92524	Behavral qualit analys voice
CPT® 92610	Evaluate swallowing function
HCPCS S9152	Speech therapy, re-eval

Note: If, during the telemedicine evaluation, it is determined that a satisfactory and valid examination cannot be performed, arrange for an in-person assessment. Do not begin treatment until an acceptable evaluation has been performed and a treatment plan has been developed.

- **Speech therapy (individual or group) services**

CPT® code	Short description
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92521	Evaluation of speech fluency
92522	Evaluate speech production
92523	Speech sound lang comprehen
92526	Oral function therapy

Audio-only telemedicine
(CPT® codes 92507, 92521, 92522, and 92523)

Audio-only telemedicine may require participation of a caregiver to assist with the treatment. Providers are responsible for making this determination and ensuring appropriate assistance or supervision, or both.

Audio-only telemedicine for the evaluation of speech is:

- Allowed for patients who have already had a face-to-face (in-person), initial evaluation with the provider.
- Permitted for less than 50% of the visits per year.
- Not allowed for outpatient physical or occupational therapy.

What outpatient rehabilitation does the Health Care Authority cover for clients age 20 and younger?

For eligible clients age 20 years and younger, the Health Care Authority covers unlimited outpatient rehabilitation, with the exception of clients age 19 through 20 receiving Medical Care Services (MCS). MCS clients age 19 through 20 have a limited outpatient rehabilitation benefit. See the outpatient benefit limit tables for occupational therapy, physical therapy, and speech therapy for MCS clients.

Which clients receive short-term outpatient rehabilitation coverage?

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

- Clients age 19 through 20 receiving MCS
- All clients age 21 and older

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

Outpatient rehabilitation must:

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

What are the short-term outpatient rehabilitation benefit limits?

The following are the short-term benefit limits for outpatient rehabilitation for clients age 21 and older, and clients age 19 through 20 receiving MCS. These benefit limits are per client, per calendar year regardless of setting.

Benefit	Limits
Occupational therapy	• 24 units (equals approximately 6 hours) to treat physical conditions • 24 units (equals approximately 6 hours) to treat behavioral health conditions
Physical therapy	24 units (equals approximately 6 hours)
Speech therapy	6 units (equals a total of 6 untimed visits)

Clients age 18 and younger with an MCS benefit package have unlimited units for outpatient rehabilitation benefits.

ALWAYS VERIFY AVAILABLE UNITS BEFORE PROVIDING SERVICES

Providers must check with the Health Care Authority to make sure the client has available units. Providers may contact the Health Care Authority's Medical Assistance Customer Service Center (MACSC) toll-free at (800) 562-3022 or by Webform or email.

For each **new prescription for therapy** within the same calendar year, whether the original units have been exhausted, providers must first obtain an authorization for a new evaluation from the Health Care Authority before providing any further care.

Additional units must be used only for the specific condition they were evaluated or authorized for. Units do not roll over to different conditions.

For occupational therapy (OT) assessments conducted by the Department of Social and Health Services (DSHS), see the Coverage Table.

Occupational therapy to treat physical conditions

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20
benefit limits 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

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20
additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015

When client's diagnosis is:	Limit	EPA#
Brain injury with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns – 2nd or 3rd degree only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Cerebral vascular accident with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Lymphedema	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000008

When client's diagnosis is:	Limit	EPA#
Major joint surgery – partial or total replacement only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Reflex sympathetic dystrophy	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016

When client's diagnosis is:	Limit	EPA#
Swallowing deficits due to injury or surgery to face, head, or neck	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary	870001416

Occupational therapy services for behavioral health conditions (provided by a behavioral health agency)

BEHAVIORAL HEALTH AGENCY BILLING TAXONOMIES

When billing for occupational therapy services to treat behavioral health conditions, behavioral health agencies must use one of the following billing taxonomies:

Billing taxonomy	Description
261QM0801X	Clinic/Center Mental Health (including CMHC)
261QR0405X	SUD Clinic
261QM2800X	Methadone Clinic
324500000X	Substance Abuse Rehab Facility/Adult/Nonhospital
3245S0500X	Substance Abuse Rehab Facility/Youth/Nonhospital

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20 benefit limits without prior authorization (Note: The benefit coverage and limitations are in addition to occupational therapy for physical conditions.)

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

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20
additional benefit limits with expedited prior authorization (Note: The benefit coverage and limitations are in addition to occupational therapy for physical conditions.)

When client's diagnosis is:	Limit	EPA#
Behavioral health condition	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870001673

Physical therapy

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
benefit limits 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

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual cognitive or functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns – 2nd or 3rd degree only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015

When client's diagnosis is:	Limit	EPA#
Cerebral vascular accident with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Lymphedema	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000008
Major joint surgery – partial or total replacement only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014

When client's diagnosis is:	Limit	EPA#
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Reflex sympathetic dystrophy	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **When is a limitation extension (LE) required?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011

When client's diagnosis is:	Limit	EPA#
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary, when it is ordered by the client's primary care provider or orthopedic surgeon	870001417

Speech therapy

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER benefit limits without prior authorization

Description	Limit
Speech Language Pathology Evaluation	One per client, per code, per calendar year
Speech Language Pathology Re-evaluation at time of discharge	One per client, per evaluation code, per calendar year
Speech Therapy	6 Units (approximately 6 hours), per client, per calendar year

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Brain injury with residual cognitive or functional deficits within the past 24 months	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009

When client's diagnosis is:	Limit	EPA#
Burns of internal organs such a nasal oral mucosa or upper airway	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Burns of the face, head, and neck – 2nd or 3rd degree only	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Cerebral vascular accident with residual functional deficits within the past 24 months	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014

When client's diagnosis is:	Limit	EPA#
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre))	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Speech deficit due to injury or surgery to face, head, or neck	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000017
Speech deficit which requires a speech generating device	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000007
Swallowing deficit due to injury or surgery to face, head, or neck	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000010

When client's diagnosis is:	Limit	EPA#
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Six additional units, per client, per calendar year See When is a limitation extension (LE) required? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011

Swallowing evaluations

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

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

A swallowing evaluation:

- Includes an oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing.
- Includes 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.

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.

For those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, refer to the Health Care Authority's Habilitative Services Billing Guide.

How do I bill for habilitative services?

See the Habilitative Services Billing Guide for details on billing habilitative services.

Coverage Table

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

The following abbreviations are used in the Coverage Table:

GP = Physical Therapy
GN = Speech Therapy
RT = Right; **LT** = Left
GO = Occupational Therapy
TS = Follow-up service
BR = By Report

***** = **Included in the benefit limitation for all clients age 21 and over and MCS clients age 19 through 20**.

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
92507*	GN	Speech/hearing therapy			X	
92508*	GN	Speech/ hearing therapy			X	
92521	GN	Evaluation of speech fluency			X	One per client, per code, per calendar year
92522	GN	Evaluate speech production			X	One per client, per code, per calendar year
92523	GN	Speech sound lang comprehen			X	One per client, per code, per calendar year
92524	GN	Behavral qualit analys voice			X	One per client, per code, 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	

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
92605	GN	Eval for rx of nonspeech device 1 hr			X	Limit 1 hour Included in the primary services; 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 CPT® code 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
92618	GN	Eval for rx of nonspeech device ea addl 30 min			X	Add on to CPT® code 92605 each additional 30 minutes; Bundled
92630*	GN	Aud rehab pre-ling hear loss			X	
92633*	GN	Aud rehab post-ling hear loss			X	
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
95992*	GP	Canalith repositioning procedure (eg, Epley maneuver)	X			One per client, per day
96112	GO, GN	Devel tst phys/ghp 1st hr		X	X	Covered under the Physician-Related Services/Professional Healthcare Services Fee Schedule for qualified providers
96113	GO, GN	Devel tst phys/ghp ea addl		X	X	Covered under the Physician-Related Services/Professional Healthcare Services Fee Schedule for qualified providers
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97010	GP, GO	Hot or cold packs therapy	X	X		Bundled
97012*	GP	Mechanical traction therapy	X			
97014*	GP, GO	Electric stimulation therapy	X	X		
97016*	GP	Vasopneumatic device therapy	X			
97018*	GP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units
97035*	GP	Ultrasound therapy	X			Timed 15 min units
97036*	GP	Hydrotherapy	X			Timed 15 min units
97039*	GP	Physical therapy treatment	X			
97110*	GP, GO	Therapeutic exercises	X	X		Timed 15 min units
97112*	GP, GO	Neuromuscular re-education	X	X		Timed 15 min units
97113*	GP, GO	Aquatic therapy/exercises	X	X		Timed 15 min units
97116*	GP	Gait training therapy	X			Timed 15 min units
97124*	GP, GO	Massage therapy	X	X		Timed 15 min units
97129*	GO, GN	Ther ivntj 1st 15 min		X	X	1st 15 minutes
97130*	GO, GN	Ther ivntj ea addl 15 min		X	X	Each additional 15 minutes
97139*	GP	Physical medicine procedure	X			Timed 15 min units
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			One per client per calendar year
97162	GP	PT eval med complex 30 min	X			One per client per calendar year
97163	GP	PT eval high complex 45 min	X			One per client per calendar year

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
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
97165	GO	DSHS OT eval (bed rail assessment)		X		EPA required One per client, unless change of residence or condition OT Eval for bedrails is a DSHS program. Use EPA# 870001326 with Rev code 0434 and CPT® code 97165.
97166	GO	OT eval mod complex 45 min		X		Only one of these codes allowed, per client, per calendar year
97167	GO	OT eval high complex 60 min		X		Only one of these codes allowed, per client, per calendar year
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
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units
97535*	GP, GO	Self care mngment training	X	X		Timed 15 min units
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97542	GP, GO	Wheelchair mngment training	X	X		One per client, per calendar year Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97550		Caregiver traing 1st 30 min	X	X	X	
97551		Caregiver traing ea addl 15	X	X	X	
97552		Group caregiver training	X	X	X	
97597*	GP, GO	Rmvl devital tis 20 cm/<	X	X		Do not use in combination with CPT® codes 11042-11047. Limit one per client, per day
97598*	GP, GO	Rmvl devital tis addl 20 cm<	X	X		One per client, per day Do not use in combination with CPT® codes 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		One per client, per day Do not use in combination with CPT® codes 11042-11047.
97605*	GP, GO	Neg press wound tx < 50 cm	X	X		One per client, per day
97606*	GP, GO	Neg press wound tx > 50 cm	X	X		One per client, per day

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97750*	GP, GO	Physical performance test	X	X		Do not use to bill for an evaluation (CPT® code 97001) or re-eval (CPT® code 97002)
97755*	GP, GO	Assistive technology assess	X	X		Timed 15 min units
97760*	GP, GO	Orthotic management & training 1st encounter	X	X		Timed 15 min units. Can be billed alone or with other PT/OT procedure codes.
97761*	GP, GO	Prosthetic training 1st encounter	X	X		Timed 15 min units
97763*	GP, GO	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	X	X		Timed 15 min units.
97799	GP & RT or LT	Physical medicine procedure	X			Use this code for custom splints. 1 per client per extremity per calendar year. Use modifier to indicate right or left. Documentation must be attached to claim. Do not use in combination with any L-code. OTs refer to the **Prosthetics and orthotics billing guide** for appropriate L-code.

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
HCPCS code S9152	GN	Speech therapy re-eval			X	One per client, per evaluation code, per calendar year

Note: For occupational therapists making orthotics, bill using taxonomy 225X00000X and the appropriate procedure code and refer to the coverage table in the Prosthetics and Orthotics Billing Guide for the proper orthotic code. The Health Care Authority does not pay:

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

- A healthcare professional for outpatient rehabilitation performed in an outpatient hospital setting when the healthcare professional is not employed by the hospital. The hospital must bill the Health Care Authority for the services.

Place of Service

Place of service code	Place of service description
02*	Telehealth provided other than in patient's home
05	Indian Health Service freestanding facility
07	Tribal 638 freestanding facility
10*	Telehealth provided in patient's home
11	Home
12	Office
62	Comprehensive outpatient rehabilitation facility
99	Other place of service

**Refer to the telemedicine policy for the list of procedures covered when provided via telemedicine.*

Washington State Health Care Authority

Where can I find the fee schedule?

Rehabilitation services provided in an office setting are paid according to the Health Care Authority's **outpatient rehabilitation fee schedule**.

Rehabilitation services provided in hospital and hospital-based clinic settings are subject to the Health Care Authority's **outpatient prospective payment system (OPPS) fee schedule and outpatient hospitals fee schedule**.

Rehabilitative services provided in the home are paid according to the Health Care Authority's **home health fee schedule**.

Washington State Health Care Authority

Authorization

What are the general guidelines for authorization?

When a procedure's expedited prior authorization (EPA) criteria have not been met or the covered procedure requires prior authorization (PA), providers must request prior authorization from the Health Care Authority (HCA).

If the client does not meet the EPA clinical criteria in this section, HCA uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.

HCA's authorization of service(s) does not guarantee payment.

HCA may recoup any payment made to a provider if HCA later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100 and WAC 182-544-0560.

How can I request additional units for clients age 21 and older, and clients age 19 through 20 in MCS?

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

For expedited prior authorization (EPA)

A provider must establish that:

- The client's condition meets the clinically appropriate EPA criteria outlined in this section; and
- The services are expected to result in a reasonable improvement in the client's condition and achieve the client's therapeutic individual goal within sixty calendar days of initial treatment.

The appropriate EPA number for the following therapies must be used when the provider bills HCA:

- Occupational therapy
- Physical therapy
- Speech therapy

Upon request, a provider must provide documentation to HCA showing how the client's condition met the criteria for EPA.

Expedited Prior Authorization Instructions

EPA codes are designed to eliminate the need for written authorization. Enter the appropriate 9-digit EPA code on the billing form in the authorization number field, or in the **Authorization** or **Comments** field when billing electronically.

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

When is a limitation extension (LE) required?

The Health Care Authority evaluates requests for authorization of covered outpatient rehabilitation 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.

Providers may submit LE requests for additional units when any of the following are true:

- The criteria for an expedited prior authorization (EPA) does not apply.
- The number of available units under the EPA have been used and services are requested beyond the limits.
- A new qualifying condition arises after the initial six visits are used.

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

Providers may submit their request by direct data entry into ProviderOne or by submitting the request in writing. See the Health Care Authority's prior authorization webpage for details.

A completed *Outpatient Rehabilitation Authorization Request* form, HCA 13-786, and all the documentation listed on this form and any other medical justification is required for an LE.

Fax the forms and all documentation to **866-668-1214**. (See Where can I download HCA forms?)

Washington State Health Care Authority

Billing

All claims must be submitted electronically to the Health Care Authority, 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 Health Care Authority's Paper claim billing resource.

Are referring provider NPIs required on all claims?

Yes. Providers must use the referring provider's national provider identifier (NPI) on all claims 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 Health Care Authority'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 HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select 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. Providers must use the appropriate modifier when billing the Health Care Authority:

Modality	Modifier
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupational Therapy	GO
Occupational Therapy Assistant	CO
Speech Therapy	GN
Audiology and Specialty Physician	AF

Effective for claims with dates of service on and after January 1, 2020, the following two modifiers must be included on the claim, when applicable, for services furnished in whole or in part for either a physical therapy assistant (PTA) or an occupational therapy assistant (OTA):

- CQ modifier: Outpatient physical therapy
- CO modifier: Outpatient occupational therapy

The CQ or CO modifier must be included on the claim line of the service along with the appropriate GP or GO therapy modifier to identify those PTA or OTA services furnished under a PT or OP plan of care. Claims that do not reflect this combination will be rejected/returned as unprocessed.

What are the general billing requirements?

Providers must follow the Health Care Authority's **ProviderOne Billing and Resource Guide**. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill the Health Care Authority for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

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

For professional services billed using the electronic 837P format, Physical Therapy performed by physical therapists must be billed separately from other services; use billing and servicing taxonomy specific to physical therapy.

For services provided in an outpatient hospital setting, the hospital bills under the UB format and uses the servicing taxonomy most appropriate for the clinician and service being provided. The billing provider taxonomy must be listed as the hospital's institutional billing taxonomy.

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.

> **Note:** Both the servicing provider and billing provider must be documented on the claim. The servicing provider and billing provider can be the same if the servicing provider is also enrolled as the billing provider.

Home health agencies

Home health agencies must use the following procedure codes and modifiers when billing the Health Care Authority:

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

See the Health Care Authority'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 Health Care Authority:

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

See the Health Care Authority's Outpatient Hospital Billing Guide for further details.