

**Washington Apple Health (Medicaid)**

# Outpatient Rehabilitation Billing Guide

**October 1, 2017**

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

## About this guide\*

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

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

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

Services and equipment related to the programs listed below are not covered by this 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.

## What has changed?

Subject	Change	Reason for Change
<p><a href="#"><u>Fully Integrated Managed Care (FIMC)</u></a></p>	<p><b>Effective January 1, 2018</b>, the agency is implementing a <b>second FIMC region</b>, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties.</p> <p>The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency’s <a href="#"><u>Managed Care web page</u></a>, the agency’s <a href="#"><u>Integrated physical and behavioral health care web page</u></a>, and the agency’s <a href="#"><u>Regional resource web page</u></a>.</p>	<p>Notification of new region moving to FIMC</p>
<p><a href="#"><u>Occupational Therapy, Physical Therapy, &amp; Speech Therapy</u></a></p>	<p>Renamed table headers from “CLIENTS 21 &amp; OLDER &amp; 19-20 in MCS” to “ALL CLIENTS 21 AND OLDER &amp; MCS CLIENTS AGES 19-20.”</p>	<p>Language clarification</p>

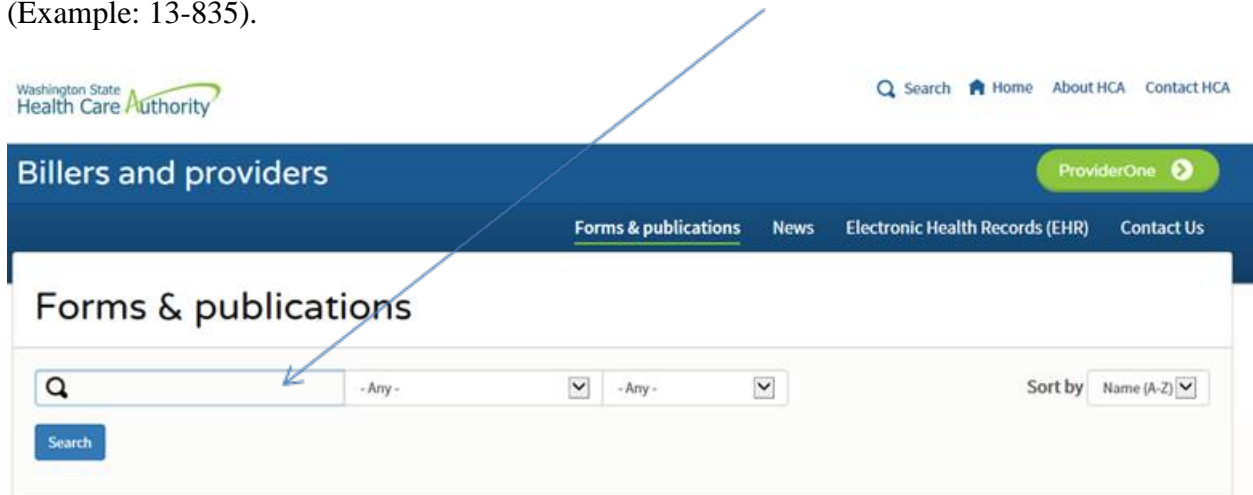
## How can I get agency provider documents?

To access provider alerts, go to the agency's [Provider Alerts](#) web page.

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

## Where can I download agency forms?

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



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# Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's <a href="#">Billers and Providers</a> web page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents, (e.g., billing guides, provider notices, fee schedules)	
Private insurance or third-party liability	
How do I check how many units of therapy the client has remaining?	<p>Providers may contact the agency's Medical Assistance Customer Service Center (MACSC) via:</p> <ul style="list-style-type: none"> <li>• Telephone toll-free at (800) 562-3022 or</li> <li>• <a href="#">Web form or email</a></li> </ul>
How do I obtain prior authorization or a limitation extension?	<p>Requests for prior authorization or limitation extensions must include:</p> <ul style="list-style-type: none"> <li>• A completed, typed <i>General Information for Authorization</i> (HCA 13-835 form). This request form must be the cover page when you submit your request.</li> <li>• A completed <i>Outpatient Rehabilitation Authorization Request</i> (HCA 13-786 form) and all the documentation listed on that form and any other medical justification.</li> </ul> <p>Fax your request to: (866) 668-1214. For information about downloading agency forms, see <a href="#">Where can I download agency forms?</a></p>
General definitions	See <a href="#">Chapter 182-500 WAC</a> .
Where do I find the agency's maximum allowable fees for services?	See the agency's <a href="#">Rates Development Fee Schedules</a> .

# Client Eligibility

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[\(WAC 182-545-0200 \(2\)\)](#)

## How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

**Step 2. Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Program benefit packages and scope of services](#) web page.

**Note:** Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

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

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



## **Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?**

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

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

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

## **Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO**

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

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

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

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

For additional information, see the agency's [Managed Care web page](#), under Providers and Billers.

# Effective April 1, 2016, important changes to Apple Health

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

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

## New MCO enrollment policy – earlier enrollment

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

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

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

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

## How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

## Behavioral Health Organization (BHO)

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

## Fully Integrated Managed Care (FIMC)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted managed care organization (MCO). The Behavioral Health Organization (BHO) will not provide behavioral health services in these counties.

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

**Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington must choose to enroll in one of the agency-contracted MCOs available in that region; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavior health services. For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).**

For full details on FIMC, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency's [Managed Care web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

## FIMC Regions

### North Central Region (NC) – Douglas, Chelan and Grant Counties

**Effective January 1, 2018**, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Managed Care web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

### Southwest Washington Region (SW WA) – Clark and Skamania Counties

**Effective April 1, 2016**, the agency implemented the first FIMC region known as the SW WA region which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

## Apple Health Core Connections (AHCC)

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

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

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

## AHCC complex mental health and substance use disorder services

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


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


## Contact Information for Southwest Washington

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

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

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

 <b>MOLINA HEALTHCARE</b>	<a href="#">Molina Healthcare of Washington, Inc.</a> 1-800-869-7165
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 <b>COMMUNITY HEALTH PLAN of Washington</b>	<a href="#">Community Health Plan of Washington</a> 1-866-418-1009
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<b>Beacon Health Options</b>	<a href="#">Beacon Health Options</a> 1-855-228-6502
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## Are clients enrolled in Primary Care Case Management (PCCM) eligible?

**Yes.** For the client who has obtained care with a PCCM, this information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services provided at ambulatory surgery centers through their PCCM providers. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

**Note:** To prevent claim denials, check the client's eligibility prior to scheduling services and at the time of the service, and make sure proper authorization or referral is obtained from the plan. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

# Provider Eligibility

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(WAC [182-545-200](#))

## Who may provide outpatient rehabilitation services?

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

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

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

# Coverage

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## When does the agency pay for outpatient rehabilitation?

(WAC [182-545-200](#)(4))

The agency pays for outpatient rehabilitation when the services are:

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

**Note:** For information about the 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).

## What outpatient rehabilitation does the agency cover for clients age 20 and younger?

(WAC [182-545-200\(5\)](#))

For eligible clients age 20 years and younger, the agency 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?

(WAC [182-545-200\(6\)](#))

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

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

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

(WAC [182-545-200 \(7\)](#))

Outpatient rehabilitation must:

- Meet reasonable medical expectation of significant functional improvement within 60 days of initial treatment.
- Restore or improve the client to a prior level of function that has been lost due to medically documented injury or illness.
- Meet currently accepted standards of medical practice and be specific and effective treatment for the client's existing condition.



- Include an on-going management plan for the client and/or the client's caregiver to support timely discharge and continued progress.

## **What are the short-term outpatient rehabilitation benefit limits?**

The following are the short-term benefit limits for outpatient rehabilitation for 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.

- Physical therapy: 24 units (equals approximately 6 hours)
- Occupational therapy: 24 units (equals approximately 6 hours)
- Speech therapy: 6 units (equals a total of 6 untimed visits)

**ALWAYS VERIFY AVAILABLE UNITS BEFORE PROVIDING SERVICES**

Providers must check with the agency to make sure the client has available units. Providers may contact the agency's Medical Assistance Customer Services 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 or not the original units have been exhausted, providers must first obtain an authorization for a new evaluation from the agency 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

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

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 <a href="#">Requesting a Limitation Extension</a> for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months		870000009
Burns – 2 <sup>nd</sup> or 3 <sup>rd</sup> degree only		870000015
Cerebral vascular accident with residual functional deficits within the past 24 months		870000009
Lymphedema		870000008
Major joint surgery – partial or total replacement only		870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)		870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)		870000016
Reflex sympathetic dystrophy		870000016
Swallowing deficits due to injury or surgery to face, head, or neck		870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months		870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency		870000011

## Physical therapy

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

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 <a href="#">Requesting a Limitation Extension</a> for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months		870000009
Burns – 2 <sup>nd</sup> or 3 <sup>rd</sup> degree only		870000015
Cerebral vascular accident with residual functional deficits within the past 24 months		870000009
Lymphedema		870000008
Major joint surgery – partial or total replacement only		870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)		870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)		870000016
Reflex sympathetic dystrophy		870000016
Swallowing deficits due to injury or surgery to face, head, or neck		870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months		870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency		870000011

## Speech therapy

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

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

## Swallowing evaluations

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

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

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing.
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques.

Swallowing evaluations **may** include video fluoroscopy for further evaluation of swallowing status and aspiration risks.

## Using timed and untimed procedure codes

For the purposes of this billing guide:

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

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

## 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, the agency will cover outpatient physical, occupational, and speech therapy to treat one of the qualifying conditions listed in the agency's [Habilitative Services Billing Guide](#), under *Client Eligibility*.

## How do I bill for habilitative services?

See the [Habilitative Services Billing Guide](#) for details on billing habilitative services. To review the appropriate ICD diagnosis codes that are required in the primary diagnosis field on the claim, see the agency's [Approved Diagnosis Codes by Program](#) web page for Habilitative Services.

# Coverage Table

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

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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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
92507*	GN	Speech/hearing therapy			X	
92508*	GN	Speech/ hearing therapy			X	
92526*	GO, GN	Oral function therapy		X	X	
92551*	GN	Pure tone hearing test air			X	
92597*	GN	Oral speech device eval			X	
92605	GN	Eval for rx of nonspeech device 1 hr			X	Limit 1 hour Included in the primary services Bundled
92618	GN	Eval for rx of nonspeech device addl			X	Add on to 92605 each additional 30 minutes Bundled

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Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92606	GN	Nonspeech device service			X	Included in the primary services Bundled
92607	GN	Ex for speech device rx 1 hr			X	Limit 1 hour
92608	GN	Ex for speech device rx addl			X	Each additional 30 min Add on to 92607
92609*	GN	Use of speech device service			X	
92610	GN	Evaluate swallowing function			X	No limit
92611	GN	Motion fluoroscopy/swallow			X	No longer limited
92630*	GN	Aud rehab pre-ling hear loss			X	
92633*	GN	Aud rehab post-ling hear loss			X	
95831*	GP, GO	Limb muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95832*	GP, GO	Hand muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95833*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with



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Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
						other PT/OT procedure codes.
95834*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97005		Athletic train eval				Not covered
97006		Athletic train re-eval				Not covered
97010	GP, GO	Hot or cold packs therapy	X	X		Bundled
97012*	GP	Mechanical traction therapy	X			
97014*	GP GO,	Electric stimulation therapy	X	X		
97016*	GP	Vasopneumatic device therapy	X			
97018*	OP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units

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Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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
97139*	GP	Physical medicine procedure	X			
97140*	GP, GO	Manual therapy	X	X		Timed 15 min units
97150*	GP, GO	Group therapeutic procedures	X	X		
97165	GO	DSHS OT eval (bed rail assessment)		X		<a href="#">EPA</a> required. One per client, unless change of residence or condition OT Eval for bedrails is a DSHS program. Use EPA# 870001326 with billing code 0434-97165.
97166	GO	DSHS OT eval (personal care for children)		X		<a href="#">EPA</a> required. One per client, unless change of residence or condition OT eval for personal care is a DSHS program. Use EPA# 870001343 with billing code 0434-97166.

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Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97161	GP	PT eval low complex 20 min	X			Only one of these codes is allowed, per client, per calendar year.
97162		PT eval med complex 30 min	X			
97163		PT eval high complex 45 min	X			
97164	GP	PT re-eval est plan care	X			One per client per calendar year
97165	GO	OT eval low complex 30 min		X		Only one of these codes allowed, per client, per calendar year
97166	GO	OT eval mod complex 45 min		X		
97167	GO	OT eval high complex 60 min		X		
97168	GO	OT re-eval est plan care		X		One per client, per calendar year
97530*	GP, GO	Therapeutic activities	X	X		Timed 15 min units
97532*	GO, GN	Cognitive skills development		X	X	Timed 15 min units
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units
97535*	GP, GO	Self care mngment training	X	X		Timed 15 min units
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units
97542	GP, GO	Wheelchair mngment training	X	X		One per client, per calendar year Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97545		Work hardening				Not covered
97546		Work hardening add-on				Not covered

## Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97597*	GP, GO	Rmvl devital tis 20 cm/<	X	X		Do not use in combination with 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 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		One per client, per day Do not use in combination with 11042-11047.
97605	GP, GO	Neg press wound tx < 50 cm	X	X		Bundled
97606	GP, GO	Neg press wound tx > 50 cm	X	X		Bundled
97750*	GP, GO	Physical performance test	X	X		Do not use to bill for an evaluation (97001) or re-eval (97002)
97755	GP, GO	Assistive technology assess	X	X		Timed 15 min units
97760*	GP, GO	Orthotic mgmt and training	X	X		Timed 15 min units. Can be billed alone or with other PT/OT procedure codes.
97761*	GP, GO	Prosthetic training	X	X		Timed 15 min units
97762	GP, GO -or- GP,GO & TS	Checkout for orthotic/prosth use	X	X		One per client, per calendar year.  Use modifier TS for additional follow up service. Can be billed alone or with other PT/OT procedure codes.

## Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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 <a href="#">Prosthetics and Orthotics Billing Guide</a> for appropriate L-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 evaluation code and refer to the coverage table in the [Prosthetics and Orthotics Billing Guide](#) for the proper orthotic code.

The agency does not pay:

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

## Where can I find the fee schedule?

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

# Authorization

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## What are the general guidelines for authorization?

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

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

### **Expedited Prior Authorization**

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

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

## How can I request an LE?

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

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

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

The following documentation is required for all requests for LE:

- A typed, completed *General Information for Authorization* form, HCA 13-835 (this request form **MUST** be the cover page when you submit your request), see [Where can I download agency forms?](#)
- A completed *Outpatient Rehabilitation Authorization Request* form, HCA 13-786, and all the documentation listed on this form and any other medical justification
- **Fax LE requests to: (866) 668-1214**

# Billing

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**Effective for claims billed on and after October 1, 2016**

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

## Are referring provider NPIs required on all claims?

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

## How do I bill claims electronically?

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

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.

## Are modifiers required for billing?

Yes. Providers must use the appropriate modifier when billing the agency:

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



## What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill the agency 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, use billing and servicing taxonomy specific to the service being billed. Do not mix taxonomies on the same claim.

**Example:** If you are billing for physical therapy services, use the billing and servicing taxonomy specific to physical therapy. **Do not bill occupational therapy services on the same claim as physical therapy services.**

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.

## Home health agencies

Home health agencies must use the following procedure codes and modifiers when billing the agency:

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

## Outpatient hospital or hospital-based clinic setting

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

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

See the agency's [Outpatient Hospital Billing Guide](#) for further details.