Washington State Health Care Authority

Washington Apple Health (Medicaid)

Outpatient Rehabilitation Billing Guide

January 1, 2018

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

About this guide*

This publication takes effect January 1, 2018, and supersedes earlier billing guides to this program.

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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)

*This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Client Eligibility	This section is reformatted and consolidated for clarity and hyperlinks have been updated. **Effective January 1, 2018,** the agency is implementing another **FIMC region**, known as the North Central region, which includes Douglas, Chelan, and Grant Counties.	Housekeeping and notification of new region moving to FIMC
Occupational Therapy	Added new EPA# 870001416 for allowing one additional evaluation for a new injury or health condition.	New EPA number
Physical Therapy	Added new EPA# 870001417 for allowing one additional evaluation for a new injury or health condition.	New EPA number
Coverage Table	Added new procedure codes 97763 and 97127.	New procedure code
	Removed code 97532.	Policy Change

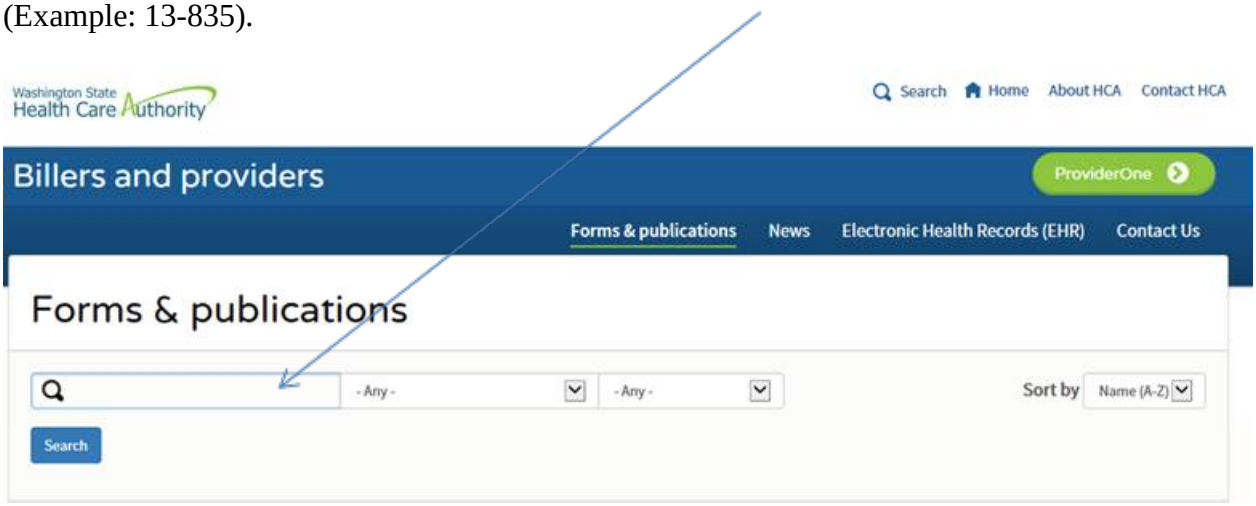
How can I get agency provider documents?

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

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

Where can I download agency forms?

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



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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers web page.
Finding out about payments, denials, claims processing, or agency 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?	Providers may contact the agency's Medical Assistance Customer Service Center (MACSC) via: • Telephone toll-free at (800) 562-3022 or • Web form or email
How do I obtain prior authorization or a limitation extension?	Requests for prior authorization or limitation extensions must include: • A completed, typed *General Information for Authorization* (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 agency forms, see Where can I download agency forms?
General definitions	See Chapter 182-500 WAC.
Where do I find the agency's maximum allowable fees for services?	See the agency's Rates Development Fee Schedules.

Client Eligibility

(WAC 182-545-0200 (2))

Most Apple Health clients are enrolled in an agency-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 the agency'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 the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

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 the agency'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 the agency's Program Benefit Packages and Scope of Services web page.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

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

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

(WAC 182-538-060 and -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.

Managed care enrollment

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

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

Checking eligibility

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

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

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

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these 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 may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.
>
> For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

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

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's Apple Health managed care webpage.

North Central Region – Douglas, Chelan and Grant Counties
Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties
Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington 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.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

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

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

See the agency's Apple Health managed care page, Apple Health Foster Care for further details.

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

(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

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 Requesting a Limitation Extension 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 – 2nd or 3rd 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
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary	870001416

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 Requesting a Limitation Extension 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 – 2nd or 3rd 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
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary	870001417

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 Requesting a Limitation Extension 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 – 2nd or 3rd 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 Coverage Table:
GP = Physical Therapy **GO** = Occupational Therapy **GN** = Speech Therapy
TS = Follow-up service **RT** = Right; LT = Left.

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

*** 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
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

*** 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
						with each other. Can be billed alone or with other PT/OT procedure codes.
95834*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97005		Athletic train eval				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			

*** 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
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
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
97127*	GO, GN	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact		X	X	Untimed, allowed once per day
97139*	GP	Physical medicine procedure	X			
97140*	GP, GO	Manual therapy	X	X		Timed 15 min units

*** 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
97150*	GP, GO	Group therapeutic procedures	X	X		
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 billing code 0434-97165.
97166	GO	DSHS OT eval (personal care for children)		X		EPA 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.
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

*** 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
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
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
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)

*** 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
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
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.
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.

*** 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
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 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.

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

Authorization

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

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.