Washington State Health Care Authority

**Washington Apple Health (Medicaid)**

# Outpatient Rehabilitation Billing Guide

**July 1, 2019**

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

# About this guide[1]

This publication takes effect July 1, 2019, 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)

[1]This publication is a billing instruction.

# What has changed?

| Subject | Change | Reason for Change |
|---|---|---|
| **Integrated Managed Care Regions** | Effective July 1, 2019, a new integrated managed care region, called **North Sound**, will be implemented. North Sound region includes Island, San Juan, Skagit, Snohomish, and Whatcom counties. | New integrated managed care region |
| **Behavioral Health Organization (BHO)** | Removed the North Sound Region | Effective July 1, 2019, behavioral health services in the North Sound region will be provided under integrated managed care |

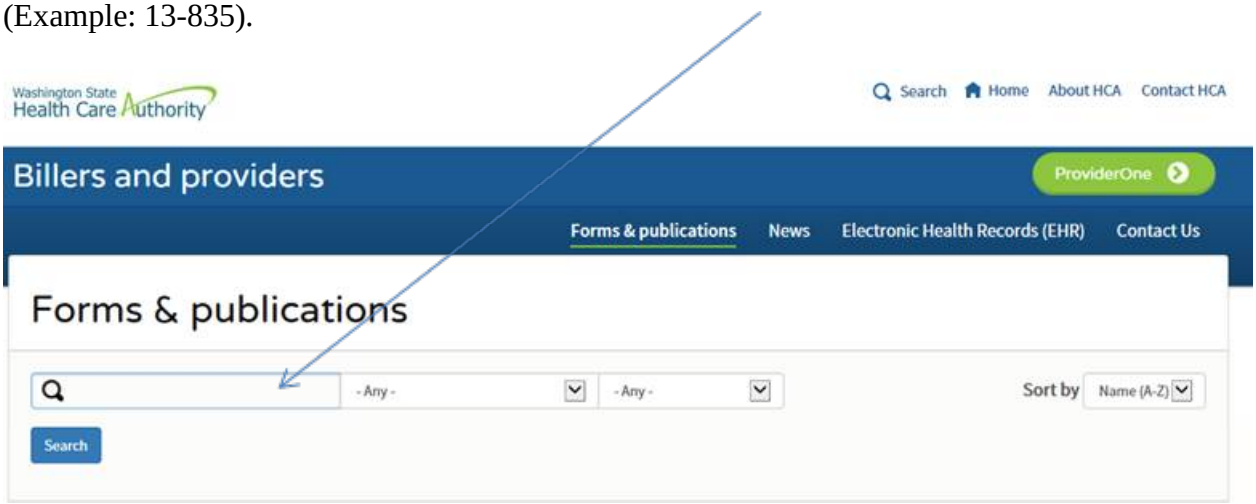
# How can I get agency provider documents?

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

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

# Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, 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, providers, and partners webpage. |
| 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:<br>• Telephone toll-free at (800) 562-3022 or<br>• 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 the agency's prior authorization webpage for details.<br><br>Written requests for prior authorization or limitation extensions must include:<br>• A completed, typed *General Information for Authorization* (HCA 13-835 form). This request form must be the cover page when you submit your request.<br>• A completed *Outpatient Rehabilitation Authorization Request* (HCA 13-786 form) and all the documentation listed on that form and any other medical justification.<br><br>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 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 webpage.

**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))**

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

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

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

See the agency's Mental health services billing guide for details.

# Apple Health – Changes for July 1, 2019

**Effective July 1, 2019**, HCA is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

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

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

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

Clients can change their plan at any time by:

- Visiting the ProviderOne client portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."
- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

# Integrated managed care

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

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

**American Indian/Alaska Native (AI/AN)** clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental health services billing guide and the Substance use disorder billing guide.

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

# Integrated managed care regions

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

| Region | Counties | Effective Date |
|---|---|---|
| North Sound | Island, San Juan, Skagit, Snohomish, and Whatcom | July 1, 2019 (new) |
| Greater Columbia | Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman | January 1, 2019 |
| King | King | January 1, 2019 |
| Pierce | Pierce | January 1, 2019 |
| Spokane | Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens | January 1, 2019 |
| North Central | Grant, Chelan, Douglas, and Okanogan | January 1, 2018<br>January 1, 2019 (Okanogan) |
| Southwest | Clark, Skamania, and Klickitat | April 2016<br>January 1, 2019 (Klickitat) |

# Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

## Fee-for-service Apple Health Foster Care

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

# 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<br><br>See How can I request a limitation extension (LE)? 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<br><br>See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits<br>-or-<br>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<br>benefit limits without prior authorization | | |
|---|---|---|
| **Description** | **Limit** | **PA?** |
| Speech Language Pathology Evaluation | One per client, per code,<br>per calendar year | No |
| Speech Language Pathology<br>Re-evaluation at time of discharge | One per client, per evaluation code,<br>per calendar year | No |
| Speech Therapy | 6 Units (approximately 6 hours),<br>per client, per calendar year | No |

| ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20<br>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,<br>per client,<br>per calendar year<br><br>See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits<br>-or-<br>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, refer to the agency'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 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<br><br>Included in the primary services; 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 |
|---|---|---|---|---|---|---|
| 92618 | GN | Eval for rx of nonspeech device addl | | | X | Add on to 92605<br><br>each additional 30 minutes; 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<br><br>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. |

*** 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 |
|---|---|---|---|---|---|---|
| 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 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 | | | |

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| Procedure Code | Modifier | Short Description | PT | OT | SLP | Comments |
|---|---|---|---|---|---|---|
| 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 |
| 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 | Ther ivntj w/ focus cog funcj | | X | X | Untimed, allowed once per day |
| 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 | | |

*** 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 |
|---|---|---|---|---|---|---|
| 97165 | GO | DSHS OT eval<br>(bed rail assessment) | | X | | EPA required.<br><br>One per client, unless change of residence or condition<br><br>OT Eval for bedrails is a DSHS program.<br><br>Use EPA# 870001326 with billing code 0434-97165. |
| 97166 | GO | DSHS OT eval<br>(personal care for children) | | X | | EPA required.<br><br>One per client, unless change of residence or condition<br><br>OT eval for personal care is a DSHS program.<br><br>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<br>30 min | | X | | Only one of these codes allowed, per client, per calendar year |
| 97166 | GO | OT eval mod complex<br>45 min | | X | | |
| 97167 | GO | OT eval high complex<br>60 min | | 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 |
|---|---|---|---|---|---|---|
| 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 |
| 97542 | GP, GO | Wheelchair mngment training | X | X | | One per client, per calendar year<br><br>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 |

*** 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 |
|---|---|---|---|---|---|---|
| 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 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<br>-or-<br>GP,GO & TS | Checkout for orthotic/prosth use | X | X | | One per client, per calendar year.<br><br>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. |

*** 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 |
|---|---|---|---|---|---|---|
| 97799* | GP,<br>&<br>RT or LT | Physical medicine procedure | X | | | Use this code for custom splints. 1 per client per extremity per calendar year.<br><br>Use modifier to indicate right or left. Documentation must be attached to claim. Do not use in combination with any L-code.<br><br>OTs refer to the Prosthetics and orthotics billing guide 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 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.

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

# 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 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 a limitation extension (LE)?

When clients reach their benefit limit of outpatient rehabilitation (the initial units and any additional EPA units, if appropriate), a provider may request authorization for a limitation extension (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.

**Providers may submit their request by direct data entry into ProviderOne or by submitting the request in writing. See the agency'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 agency forms?)

# Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless billing at HCA.
For providers approved to bill paper claims, see the agency's Paper claim billing resource.

## Are 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, providers, and partners webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

## Are modifiers required for billing?

Yes. 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.