Washington State Health Care Authority

Medicaid Provider Guide

Outpatient Rehabilitation
(Occupational Therapy, Physical Therapy, and Speech Therapy)

[Refer to WAC 182-545-200]

A Billing Instruction

About This Publication

This publication supersedes all previous Outpatient Rehabilitation Program Medicaid Provider Guides published by the Medicaid Program of the Health Care Authority (the Agency). Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- 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)

What Has Changed?

Reason for Change	Effective Date	Page No.	Subject	Change
PN 12-95	**01/01/2013**	All	Housekeeping	Added automated Table of Contents, fixed and added hyperlinks, updated form names, removed old "effective dates" from Coverage table.
		5	Clients 20 years of age and younger	Added an exception (19 through 20 years olds in MCS/ADATSA) to the unlimited benefits.
		5	Clients 21 Years of Age and Older and Clients 19 through 20 Years of Age in MCS/ADATSA	Updated titles within section for clarity; added new section titled "What are the short term benefit outpatient rehabilitation benefit limits"
		7, 8, 9, 18	OT, PT, ST, and Requesting a Limitation Extension	Added "19 and 20 in MCS/ADATSA" to each Benefit Limits Chart, changed "Adult" to "Client" and clarified when a provider may request a limitation extension.
		11, 12, 13, 14, 15	Coverage Table	Added "and clients 19 through 20 years of age in MCS/ ADATSA" to meaning of *Asterisk at top of each table.
		19	Billing Requirements	Added "and clients 19 through 20 years of age in MCS/ ADATSA." Added clarification on billing and servicing taxonomy specific to the service being billed for Therapists.

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print Agency Provider Notices and Medicaid Provider Guides, go to the Agency's Provider Publications website.
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Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Important Contacts

Note: This page contains important contact information relevant to Outpatient Rehabilitation. For more contact information, see the Agency's Resources Available web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency's Resources Available.
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED General Information for Authorization form (HCA 13-835). This request form MUST be the initial page when you submit your request. • A completed Outpatient Rehabilitation Authorization Request form (HCA 13-786) and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Agency's Resources Available web page.
General Definitions and Abbreviations	Please refer to the Agency's Medical Assistance Glossary.

Outpatient Rehabilitation

Who Is Eligible to Provide Outpatient Rehabilitation?

[WAC 182-545-200(1)]

The following healthcare professionals may enroll with the Agency to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible clients:

- A licensed occupational therapist;
- A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
- A licensed physical therapist or physiatrist;
- A physical therapist assistant supervised by a licensed physical therapist.
- A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; and
- A speech-language pathologist who has 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, please refer to the Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide and Outpatient Hospital Services Medicaid Provider Guide.

Client Eligibility

Who Is Eligible? [WAC 182-545-0200 (2)]

Eligible clients may receive the outpatient rehabilitation services described in these billing instructions depending on their benefit package.

> **Note:** Refer to the Scope of Healthcare Services Table for an up-to-date listing of Benefit Service Packages.

Please see the Agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Are Clients Enrolled in an Agency Managed Care Organization (MCO) Eligible?

[Refer to WAC 182-538-060 and -095 or WAC 182-538-063 for Medical Care Services clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care organization (MCO), managed care enrollment will be displayed on the Client Benefit Inquiry screen.

Outpatient rehabilitation must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

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

> **Note:** To prevent billing denials, please 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.

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's 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 the Authorization section of these billing instructions;
- Begun within 30 days of the date ordered;
- Provided by an approved health professional (see Who Is Eligible to Provide Outpatient Rehabilitation?);
- Billed according to these billing instructions; and
- Provided as part of an outpatient treatment program:
  - ✓ In an office or outpatient hospital setting;
  - ✓ In the home, by a home health agency, as described in Chapter 182-551 WAC;
  - ✓ In a neurodevelopmental center, as described in WAC 182-545-900; or
  - ✓ For children with disabilities, age two or younger, in natural environments, including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

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

Clients 20 Years of Age and Younger

[WAC 182-545-200(5)]

For eligible clients 20 years of age and younger, the Agency covers unlimited outpatient rehabilitation with the following exception:

> Clients **19 through 20 years** of age in Medical Care Services or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) are not eligible for *unlimited* outpatient rehabilitation. For these clients, see the **Clients – 21 Years of Age and Older and Clients 19 through 20 Years of Age in MCS/ADATSA** benefit.

Clients 21 Years of Age and Older and Clients 19 through 20 Years of Age in MCS/ADATSA

Who is Eligible for the Short Term Outpatient Rehabilitation Benefit? [WAC 182-545-200(6)]

The Agency pays for 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 21 years of age and older; and
- Clients 19 through 20 years of age receiving MCS or ADATSA.

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; and
- 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 (occupational therapy, physical therapy, and speech therapy) for adults. These benefit limits are **per client**, **per calendar year** regardless of setting (example, home health, outpatient hospital and freestanding therapy clinics.) Authorization is not required.

- 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).

Occupational Therapy (OT) [WAC 182-545-200(8)(a)]

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) - 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

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) - 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

Physical Therapy (PT) [WAC 182-545-200(8)(b)]

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) – 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

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) – 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

Speech Therapy (ST) [WAC 182-545-200(8)(c)]

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) – BENEFIT LIMITS Without Prior Authorization		
Description	**Limit**	**PA?**
Speech Language Pathology Evaluation	One per client, per calendar year	No
Speech Language Pathology Re-evaluation at time of discharge	One per client, per calendar year	No
Speech Therapy	6 Units (approximately 6 hours), per client, per calendar year	No

CLIENTS (21 & Older & 19-20 in MCS/ADATSA) – 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	**Up to 6 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.	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; and
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques; and
- (May include) A video fluoroscopy for further evaluation of swallowing status and aspiration risks.

Using Timed/Untimed Procedure Codes

For the purposes of these billing instructions:

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

Addressing Limits

The limits for therapies are per client, per calendar year.

- 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.
- Contact the Agency to check on limits, by submitting a service limit request to the Agency's Medical Assistance Customer Service Center (MACSC) by using the Contact Us On-line Request Form.
- Please consult the ProviderOne Billing and Resource Guide.
  Section: Client Eligibility, Benefit Packages, and Coverage Limits

Coverage Table

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

Procedure Code	Modifier	Brief Description	PT	OT	SLP	Policy Comments
*** Asterisk means - This procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS/ADATSA.**						
92506	GN	Speech/hearing evaluation			X	1 per client, 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.
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	

Modifiers: **GP** = Physical Therapy; **GO** = Occupational Therapy;
GN = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left

Other: **NC =** Service is not covered

Procedure Code	Modifier	Brief Description	PT	OT	SLP	Policy Comments
*** Asterisk means - This procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS/ADATSA.**						
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 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
97001	GP	Pt evaluation	X			1 per client, per calendar year
97002	GP	Pt re-evaluation	X			1 per client, per calendar year
97003	GO	OT evaluation		X		1 per client, per calendar year
97004	GO	OT re-evaluation		X		1 per client, per calendar year
97005		Athletic train eval				NC
97006		Athletic train re-eval				NC

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GN = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left

Other: **NC =** Service is not covered

Procedure Code	Modifier	Brief Description	PT	OT	SLP	Policy Comments
*** Asterisk means - This procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS/ADATSA.**						
97010	GP, GO	Hot or cold packs therapy	X	X		Bundled
97012*	GP	Mechanical traction therapy	X			
97014*	GP, GO	Electric stimulation therapy	X	X		
97016*	GP	Vasopneumatic device therapy	X			
97018*	GP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units
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
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		
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

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Procedure Code	Modifier	Brief Description	PT	OT	SLP	Policy Comments
*** Asterisk means - This procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS/ADATSA.**						
97542	GP, GO	Wheelchair mngment training	X	X		1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97545		Work hardening				NC
97546		Work hardening add-on				NC
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		1 per client, per day. Do not use in combination with 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		1 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		Two 15-minute units, per client, per day. 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	C/o for orthotic/prosth use	X	X		Use this code for DME assessment. 1 per client, per calendar year. Use with two 15-min units per session. **Use modifier TS for follow up service. Can be billed alone or with other PT/OT procedure codes.**

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GN = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left

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Procedure Code	Modifier	Brief Description	PT	OT	SLP	Policy Comments
*** Asterisk means - This procedure code is included in the benefit limitation for clients 21 years of age and over and clients 19 through 20 years of age in MCS/ADATSA.**						
97799*	GP, GO & RT or LT	Physical medicine procedure	X	X		Use this code for custom hand splints. 1 per hand, per calendar year. Use modifier to indicate right or left hand. Documentation must be attached to claim.
S9152	GN	Speech therapy re-eval			X	1 per client, per calendar year

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GN = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left
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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.

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.

Modifiers: **GP** = Physical Therapy; **GO** = Occupational Therapy;
GN = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left
Other: **NC =** Service is not covered

Authorization

General Guidelines

- Please note that authorization requirements are not a denial of service.
- When a service requires authorization, the provider **must properly request** written authorization in accordance with the Agency's rules, these billing instructions, 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 necessarily 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. Refer to WAC 182-502-0100(1)(c) and WAC 182-544-0560(7).

EPA - Additional Units for Clients 21 and Older and Clients 19 through 20 Years of Age in MCS/ADATSA

When a client meets the criteria for additional benefit units of outpatient rehabilitation, providers must use the expedited prior authorization (EPA) process. When a client's situation does not meet the conditions for EPA, a provider must request a limitation extension.

The EPA units may be utilized **once, per client, per calendar year**, **per each therapy type**.

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/or limitation extensions (LE) do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

Requesting a Limitation Extension (LE)

If a client's benefit limit of outpatient rehabilitation has been reached (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 these billing instructions 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 completed **General Information for Authorization** form**,** HCA 13-835**.** This request form MUST be the first page when you submit your request; and
- 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: 1-866-668-1214.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the billing requirements in 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; and
- Record keeping requirements.

Billing Requirements

These outpatient rehabilitation benefit limits for clients 21 years of age and older and clients 19 through 20 years of age in MCS/ADATSA 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.

Therapists

Therapists must use the appropriate modifier on the CMS-1500 when billing the Agency:

MODALITY	MODIFIERS
Physical Therapy	GP
Occupational Therapy	GO
Speech Therapy	GN

Completing the CMS-1500 Claim Form

Use billing and servicing taxonomy specific to the service being billed.
Do not mix modalities on the same claim form. **For example:** Use billing and servicing taxonomy specific to physical therapy for billing physical therapy services. Do not bill occupational therapy services on the same claim form as physical therapy services.

Note: Refer to the Agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 Claim Form.

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

Note: Refer to the Agency's Outpatient Hospital Medicaid Provider Guide for further details.