



Outpatient Rehabilitation Provider Guide

July 1, 2014

Washington State
Health Care Authority

About this guide*

This publication takes effect July 1, 2014, and supersedes earlier guides to this program.

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 guide and must be billed using their specific provider 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 \(includes Audiology\)](#)

What has changed?

Subject	Change	Reason for Change
Billing and Claim Forms	Providers must use the servicing provider's national provider identifier (NPI) on <i>all</i> claims in order to be paid. If the servicing provider's NPI is not listed on the claim form, the claim may be denied.	This is now a requirement for payment.
Coverage Table	Occupational rehabilitative evaluation codes table updated for CPT code 97003. Expedited prior authorization required.	Policy change
Coverage Table	Speech language pathology re-evaluation at the time of discharge limited to one per client, per evaluation code, per calendar year.	Policy change
Coverage	Removed the list of habilitative services qualifying diagnoses and added a link to the agency's <i>Habilitative Services Provider Guide</i>	Linking directly to original provider guide reduces possibility for errors
All	Housekeeping throughout	Hyperlink repairs, formatting, pagination

*This publication is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.


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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.)

Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page .
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic or paper billing	
Finding agency documents, (e.g., provider guides, provider notices, fee schedules)	
Private insurance or third-party liability	
How do I obtain prior authorization or a limitation extension?	<p>Requests for prior authorization or limitation extensions must include:</p> <ul style="list-style-type: none"> • A completed, typed <i>General Information for Authorization</i> (HCA 13-835 form). This request form must be the first page when you submit your request. • A completed <i>Outpatient Rehabilitation Authorization Request</i> (HCA 13-786 form) and all the documentation listed on that form and any other medical justification. <p>Fax your request to: (866) 668-1214</p>
General definitions	See the agency's Washington Apple Health Glossary
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 \(2\)\)](#)

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

Note: Patients who are not Washington 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.

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 billing 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/Healthcare Professional Services Provider Guide](#) and [Outpatient Hospital Services Provider 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'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 [Authorization](#).
- 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 this provider 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 new Habilitative Services benefit available January 1, 2014, 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 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 exception of clients 19 through 20 years of age receiving [Medical Care Services](#) (MCS). MCS clients, 19 through 20 years of age 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 21 years of age and older
- Clients 19 through 20 years of age 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 adults. These benefit limits are per client, per calendar year regardless of setting. 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)

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

Occupational therapy

CLIENTS 21 & Older & 19-20 in MCS 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 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	870000015	
Brain injury with residual functional deficits within the past 24 months		870000009	
Burns – 2 nd or 3 rd 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)		See Requesting a Limitation Extension for requesting units beyond the additional benefit limits	870000016
Reflex sympathetic dystrophy		-or-	870000016
Swallowing deficits due to injury or surgery to face, head, or neck		if the client's diagnosis is not listed in this table.	870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months			870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency			870000011

Physical therapy

CLIENTS 21 & Older & 19-20 in MCS 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 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 – 2 nd or 3 rd 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

CLIENTS 21 & Older & 19-20 in MCS 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

CLIENTS 21 & Older & 19-20 in MCS 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 – 2 nd or 3 rd 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 provider 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 the benefit limits?

The following 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 online [Contact Us](#) information request form for providers.
- Consult *Client Eligibility, Benefit Packages, and Coverage Limits* in the agency's [ProviderOne Billing and Resource Guide](#).

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.

Effective January 1, 2014, and applicable to 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 Provider Guide](#), under *Client Eligibility*.

How do I bill for habilitative services?

Habilitative services must be billed using one of the qualifying diagnosis codes listed in the agency's [Habilitative Services Provider Guide](#) in the primary diagnosis field on the claim form.

Coverage Table

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

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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92521	GN	Evaluation of speech fluency			X	1 per client, per code, per calendar year
92522	GN	Evaluate speech production			X	1 per client, per code, per calendar year
92523	GN	Speech sound lang comprehen			X	1 per client, per code, per calendar year
92524	GN	Behavral qualit analys voice			X	1 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

Outpatient Rehabilitation

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.

Outpatient Rehabilitation

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
97001	GP	PT evaluation	X			1 per client, per calendar year
97002	GP	PT re-evaluation	X			1 per client, per calendar year

Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97003	GO	Occupational Therapy Evaluation		X		1 per client, per calendar year
	GO	DSHS Occupational Therapy Evaluation Personal Care for Children		X		EPA required. One per client, unless change of residence or condition OT Eval for bedrails and personal care are a DSHS program. Use EPA# 870001326 with billing code 0434-97003, assess for bedrails and bedrail safety.
	GO	DSHS Occupational Therapy Evaluation (bed rail assessment)		X		EPA required. One per client, unless change of residence or condition OT Eval for bedrails and personal care are a DSHS program. Use EPA# 870001326 with billing code 0434-97003, assess for bedrails and bedrail safety.
97004	GO	Occupational Therapy Re-Evaluation		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		

Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97016*	GP	Vasopneumatic device therapy	X			
97018*	OP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units
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		X	X	Timed 15 min units

Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
		development				
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units
97535*	GP, GO	Self care mngmt training	X	X		Timed 15 min units
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97542	GP, GO	Wheelchair mngmt 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				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		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.

Outpatient Rehabilitation

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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.
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 evaluation code, per calendar year

The agency does not pay:

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

Where can I find the fee schedule?

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

Authorization

What are the general guidelines for authorization?

- When a service requires authorization, the provider must properly request written authorization in accordance with the agency's rules, this provider 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\(7\)](#).

EPA – What are the additional units for clients 21 and older, and clients 19 through 20 years of age 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 provider 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 completed *General Information for Authorization* form, HCA [13-835](#) (this request form **MUST** be the first 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 LE requests to: (866) 668-1214

Billing and Claim Forms

Are servicing provider NPIs required on all claims?

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

How is the CMS-1500 claim form completed?

The agency’s online webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- [DDE Professional claim](#)
- [DDE Professional with Primary Insurance](#)
- [DDE Medicare Crossover Claim](#)

Also, see Appendix I of the agency’s [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 claim form.

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 21 years of age and older and clients 19 through 20 years of age 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.

Use billing and servicing taxonomy specific to the service being billed. Do not mix modalities on the same claim form. For example, use the 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.

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 Provider Guide](#) for further details.