

# **Social Services ProviderOne Billing Supplement for Providers of Physical, Occupational, or Speech Therapy**

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The purpose of this billing supplement is to assist ProviderOne social services providers to properly bill the Health Care Authority (agency) for services provided to eligible clients. **Services referred to in this guide are NOT payable in an outpatient setting.**

## **What procedure codes may I bill the agency?**

### **Home Health**

Refer to the *Outpatient Rehabilitation Therapy Evaluation Codes Table* in the agency's [Home Health Provider Guide](#) for a complete listing of procedure codes to bill for services provided. When authorized for a blanket code:

- Code SA888 applies to the following PT procedure codes:
  - ✓ 97001
  - ✓ 97002
  - ✓ 97542
- Code SA889 applies to the following OT procedure codes:
  - ✓ 97003
  - ✓ 97004
  - ✓ 97542
- Code SA892 applies to the following ST procedure codes:
  - ✓ 92521
  - ✓ 92522
  - ✓ 92523
  - ✓ 92524

#### **Note:**

Even though your authorization may not include modifiers (GO, GN, etc.), when billing the agency, you must use the appropriate modifier from the *Modifier* column in the *Outpatient Rehabilitation Therapy Evaluation Codes Table*.

Any limits referenced on the coverage table apply to medical eligibility only. If the service authorized exceeds the duration or scope of the Medicaid State Plan, or if the client is not covered by the Medicaid State Plan, the services are limited to the authorization you received for the client.

## Outpatient Rehabilitation and Neurodevelopmental Centers

Refer to the *Coverage Tables* in the agency's [Outpatient Rehabilitation Provider Guide](#) and [Neurodevelopmental Centers Provider Guide](#) for a complete listing of procedure codes to bill for services provided. When authorized for a blanket code<sup>1</sup>:

- Code SA888 applies to physical therapy current procedural terminology (CPT®) procedure codes.
- Code SA889 applies to the occupational therapy CPT procedure codes.
- Code SA892 applies to the following speech-language pathology CPT procedure codes:
  - ✓ 92521
  - ✓ 92522
  - ✓ 92523
  - ✓ 92524

### Note:

Even though your authorization may not include modifiers (GO, GN, etc.), when billing the agency, you must use the appropriate modifier from the *Modifier* column in the *Coverage Table*.

Any limits referenced on the coverage table apply to medical eligibility only. If the service authorized exceeds the duration or scope of the Medicaid State Plan, or if the client is not covered by the Medicaid State Plan, the services are limited to the authorization you received for the client.

## How do I bill for services?

The agency's online Webinars are available to providers with instructions on how to bill shared services<sup>2</sup> on professional claims and crossover claims electronically:

- [DDE<sup>3</sup> 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 (version 02/12).

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<sup>1</sup> A blanket code is a service code the DSHS worker authorizes that is connected to one or more CPT® or HCPCS procedure codes. Social service providers may bill the agency using any procedure code connected to the blanket code, up to the maximum amount authorized. Both the blanket code and the maximum amount appear on the authorization letter DSHS sends to the social service provider.

<sup>2</sup> Shared services are medical services shared between Washington Apple Health and the Department of Social and Health Services.

<sup>3</sup> DDE stands for direct data entry.

CPT® codes and descriptions only are copyright 2014 American Medical Association.

**Note:** To prevent billing denials, check the client's eligibility for other coverage **before** scheduling services and at the **time of the service**. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility and how to request a limitation extension or exception to rule. Providers must exhaust other coverage before submitting a request for payment to the agency under a social services authorization.

## National correct coding initiative

The agency continues to follow the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the agency to control improper coding that may lead to inappropriate payment. The agency bases coding policies on the following:

- The American Medical Association's (AMA) CPT® manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Procedure code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

The agency may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system. Visit the [NCCI](#) on the web.

## Who do I contact if I have questions?

Visit the agency's [website](#) for further information about program coverage, how to bill, or who to contact with questions.