Outpatient Rehabilitation Provider Guide

April 1, 2016

About this guide*

This publication takes effect April 1, 2016, 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
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016,** important changes are taking place that **all providers** need to know. Information has been added regarding a new policy for early enrollment into managed care, the implementation of fully integrated managed care in the SW WA region, Apple Health Core Connections for foster children, Behavioral Health Organizations (formerly RSNs), and contact information for Southwest Washington.	Program changes

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.

*This publication is a billing instruction.

Copyright disclosure

Current Procedural Terminology (CPT) copyright 2015 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Table of Contents

Important Changes to Apple Health Effective April 1, 2016 6

New MCO enrollment policy – earlier enrollment 6
How does this policy affect providers? 7
Behavioral Health Organization (BHO) 7
Fully Integrated Managed Care (FIMC) 7
Apple Health Core Connections (AHCC) 8
AHCC complex mental health and substance use disorder services 8
Contact Information for Southwest Washington 9

Resources Available 10

Client Eligibility 11

How can I verify a patient's eligibility? 11
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible? 12

Provider Eligibility 13

Coverage 14

What outpatient rehabilitation does the agency cover for clients age 20 and younger? 15
What clinical criteria must be met for the short-term outpatient rehabilitation benefit? 15
What are the short-term outpatient rehabilitation benefit limits? 16
Occupational therapy 17
Physical therapy 18
Speech therapy 19
Swallowing evaluations 20
Using timed and untimed procedure codes 20
What are habilitative services under this program? 20
How do I bill for habilitative services? 21

Coverage Table 22

Where can I find the fee schedule? 29

Authorization 30

EPA – What are the additional units for clients age 21 and older, and clients age 19 through 20 in MCS? 30
How can I request an LE? 31

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Billing and Claim Forms 32

Are referring provider NPIs required on all claims? 32
How is the CMS-1500 claim form completed? 32
Are modifiers required for billing? 32
What are the general billing requirements? 33
Home health agencies 33
Outpatient hospital or hospital-based clinic setting 34

Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available online.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- 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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

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

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

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

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will

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

use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

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

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 check how many units of therapy the client has remaining?	Providers may contact the agency's Medical Assistance Customer Service Center (MACSC) via: • Telephone toll-free at (800) 562-3022 or • Webform or email
How do I obtain prior authorization or a limitation extension?	Requests for prior authorization or limitation extensions must include: • A completed, typed *General Information for Authorization* (HCA 13-835 form). This request form must be the first page when you submit your request. • A completed *Outpatient Rehabilitation Authorization Request* (HCA 13-786 form) and all the documentation listed on that form and any other medical justification. Fax your request to: (866) 668-1214
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

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

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 wish to apply for Washington Apple Health can do so 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.

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

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 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.

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

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.

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

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?

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

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.

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

- 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.

- 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.

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

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 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

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

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 – 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

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

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 – 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

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

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 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.*

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

How do I bill for habilitative services?

See the Habilitative Services Provider Guide for details on billing habilitative services. To review the appropriate ICD diagnosis codes that are required in the primary diagnosis field on the claim form, refer to Program Policy Approved Diagnosis Codes for Habilitative Services.

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

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 age 21 and over and MCS clients age 19 through 20.

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

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

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.

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

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

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

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		

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

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

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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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
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				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.
97605	GP, GO	Neg press wound tx < 50 cm	X	X		Bundled
97606	GP, GO	Neg press wound tx > 50 cm	X	X		Bundled

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

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 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

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

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.

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

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 age 21 and older, and clients age 19 through 20 in MCS?

When a client meets the criteria for additional benefit units of outpatient rehabilitation, providers must use the EPA process. The EPA units may be used once per client, per calendar year for each therapy type. When a client's situation does not meet the conditions for EPA, a provider must request a limitation extension (LE).

Expedited Prior Authorization
Enter the appropriate 9-digit EPA code on the billing form in the authorization number field, or in the **Authorization** or **Comments** field when billing electronically. EPA codes are designed to eliminate the need for written authorization.

EPA numbers and LEs do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

How can I request an LE?

When clients reach their benefit limit of outpatient rehabilitation has been reached (the initial units and any additional EPA units, if appropriate), a provider may request authorization for an LE from the agency.

The agency evaluates requests for authorization of covered outpatient rehabilitation that exceed limitations in this 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 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 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 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.

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.

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 Provider Guide for further details.