Washington Apple Health (Medicaid)

Home Health (Acute Care Services) Billing Guide

April 1, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **April 1, 2022,** and supersedes earlier billing guides for this program.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

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

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item is the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Does HCA cover social worker services?	Amended the social worker services limitations to permit up to eight units per client per 365-day period	To align the billing guide with the limitations specified in **WAC 182-551-2115**
Client eligibility – Clients who are not enrolled in an HCA-contracted managed care plan for physical health services	Added clarification of who pays if a client received Medicaid-covered services before being automatically enrolled in a BHSO	Program enrollment clarification
Client eligibility – Integrated managed care	Revised paragraph to reflect enrollment in an <u>integrated</u> managed care plan	Clarification
Client eligibility – American Indian/Alaska Native (AI/AN) Clients	Created new subsection and moved this information out of the Integrated managed care section.	Creating a stand-alone section for just AI/AN clients.

Table of Contents

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's **Billers, providers, and partners** webpage.
Finding out about payments, denials, claims processing, HCA-contracted managed care organizations (MCO)	See HCA's **Billers, providers, and partners** webpage.
Electronic billing	See HCA's **Billers, providers, and partners** webpage.
Finding HCA documents (e.g., billing guides, provider notices, fee schedules)	See HCA's **Billers, providers, and partners** webpage.
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's **Billers, providers, and partners** webpage.
Sending medical verification of visits, plan of care, and change orders during focused review periods	Health Care Benefits and Utilization Management Home Health Program Manager PO Box 45506 Olympia, WA 98504-5506
Find out a list of interpreter agencies in my area	Visit HCA's **Interpreter services** webpage.
Home health policy or medical review questions	Home Health Program Coverage Home Health Program Manager Phone: 360-725-1611 Fax requests to: 866-668-1214
Long-term care (LTC) needs	LTC Exceptions Fax requests to: 866-668-1214
Developmental Disabilities Administration (DDA)	Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Spokane, Stevens 800-462-0624 or visit the **DDA service and information request** website
DDA	Adams, Asotin, Benton, Columbia, Franklin, Garfield, Grant, Kittitas, Klickitat, Walla Walla, Whitman, Yakima 800-822-7840 or visit the **DDA service and information request** website

Topic	Contact Information
DDA	Island, San Juan, Skagit, Snohomish, Whatcom 800-788-2053 or visit the **DDA service and information request** website
DDA	King 800-314-3296 or visit the **DDA service and information request** website
DDA	Kitsap, Pierce 800-248-0949 or visit the **DDA service and information request** website
DDA	Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum 800-339-8227 or visit the **DDA service and information request** website
Pharmacy Authorization	See HCA's **Biller, providers, and partners** webpage.
First Steps – Maternity Support Services (MSS)	HCA Family Services Program Manager Phone: 360-725-1293 Email: **FirstSteps@hca.wa.gov** Visit: **First steps maternity support services and infant case management** webpage.
Aging and Long-Term Support Administration (ALTSA), including Home and Community Services (HCS)	See **ALTSA's webpage** for local county resources or call the ALTSA State Reception Line at 800-422-3263 and ask for the local HCS number.
How do I obtain prior authorization or a limitation extension or request a noncovered service?	For prior authorization or a limitation extension, providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's **Prior authorization** webpage for details. Providers may also fax requests to 866-668-1214, along with the following: A completed, TYPED General Information for Authorization form (HCA 13-835). This request form MUST be the cover page when you submit your request. A completed Home Health Authorization Request form (HCA 13-847), all documentation listed on this form, and any other medical justification. See **Where can I download HCA forms**?

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Topic	Contact Information
Where do I find HCA's maximum allowable fees for service?	See HCA's online **Provider billing guides and fee schedules** webpage.

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Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC** for a complete list of definitions for Washington Apple Health.

Acute care – Care provided by a home health agency for clients who are not medically stable or who have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

Authorized practitioner –

- A physician, nurse practitioner, clinical nurse specialist, or physician assistant who may order and conduct home health services, including face-to-face encounter services; or

- A certified nurse midwife under **42 C.F.R. 440.70**, when furnished by a home health agency that meets the conditions of participation for Medicare, who may conduct home health services, including face-to-face encounter services.

Brief skilled nursing visit – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client for:

- An injection

- A blood draw

- Placement of medications in containers

Case manager – A social worker or a nurse assigned by the Aging and Long-Term Care Administration (ALTSA) in the Department of Social and Health Services to manage and coordinate the client's case.

Case resource manager (CRM) – A person assigned by the Developmental Disabilities Administration (DDA) to meet with the family, conduct an assessment, develop a plan with the client and/or the family, and help to connect to appropriate resources

Chronic care – Long-term care for medically stable clients.

Full skilled nursing services – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

- Observation

- Assessment

- Treatment

- Teaching

- Training

- Management

- Evaluation

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Home health aide – A person registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

Home health aide services – Services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by, or under contract with, a home health agency. These services are provided under the supervision of the previously identified authorized practitioners, and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

Home health skilled services – Skilled health care (nursing, specialized therapy, and home health aide) services provided on an intermittent or part-time basis by a Medicare-certified home health agency with a current provider number in any setting where the client's normal life activities take place.

Long-term care – A generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the Department of Social and Health Services' Developmental Disabilities Administration (DDA) or Aging and Long-Term Support Administration (ALTSA).

Medical social services - Services delivered by a medical social worker intended to address social or emotional factors that may impede the effective treatment of the client's medical condition or rate of recovery. Medical social services include:

- Assessing social and emotional factors related to the client's illness, need for care, response to treatment, and adjustment to care;

- Evaluating the client's home situation, financial resources, and availability of community resources;

- Assisting with obtaining available community resources and financial resources; and

- Counseling and partnering with the client and their family to address socio-emotional needs related to the illness.

Plan of Care (POC) – (Also known as "plan of treatment" (POT)). A written document established and periodically reviewed and signed by an authorized practitioner and a home health agency provider. The plan describes the home health care to be provided in any setting where normal life activities take place. (For information on clients in residential facilities whose home health services are not covered through HCA's home health program, see When does HCA pay for covered home health services?)

Review period – The three-month period HCA assigns to a home health agency, based on the address of the home health agency's main office, during which HCA reviews all claims submitted by that home health agency.

Specialized therapy – Skilled therapy services provided to clients that include physical, occupational, and speech/audiology services.

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Supervision - Authoritative procedural guidance given by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides initial direction and periodic inspection of the actual act of accomplishing the function or activity.

About the Program

What is the purpose of the home health program?

The purpose of HCA's home health program is to provide equally effective, less restrictive quality care to the client, in any setting where the client's normal life activities take place, when the client is not able to access the medically necessary services in the community, or in lieu of hospitalization.

Home health skilled services are provided for **acute**, intermittent, short-term, and intensive courses of treatment.

> **Note:** See What home health services are not covered? for information on chronic, long-term maintenance care.

Who is an eligible home health provider?

The following may contract with HCA to provide health services through the home health program, subject to the restrictions or limitations in this billing guide and applicable published Washington Administrative Code (WAC):

- A home health agency that:
  - o Is Title XVIII (Medicare)-certified
  - o Is licensed by the Department of Health (DOH) as a home health agency
  - o Continues to meet DOH requirements
  - o Submits a completed, signed Core Provider Agreement to HCA
  - o Has a home health taxonomy on their provider file
- A registered nurse (RN) who:
  - o Is prior authorized by HCA to provide intermittent nursing services when a home health agency does not exist in the area a client resides
  - o Is unable to contract with a Medicare-certified home health agency
  - o Submits a completed, signed core provider agreement to HCA
  - o Has an RN home health taxonomy on their provider file

> **Note**: Notify HCA **within ten days** of any changes in name, address, or telephone number (see Resources Available).

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

> **It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.**

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website.

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

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In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the Washington Healthplanfinder's website or call the Customer Support Center.

What are the restrictions?

The CNP–Emergency Medical Only program covers two skilled nursing home health visits for those covered under the cancer treatment program and hemodialysis program.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

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.

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Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**

  o Visit the ProviderOne Client Portal website:

  o Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

  o Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

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Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's American Indian/Alaska Native webpage.

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Are primary care case management (PCCM) clients covered?

For the client who has chosen to obtain care with a PCCM provider, information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. 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 PCCM provider. See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

Are dually-enrolled clients eligible?

Dually-enrolled (Medicare-Medicaid) clients and **Medicare only** clients may be eligible to receive certain home and community-based services under the Community Options Program Entry System (COPES) or Title XIX Personal Care programs. These programs are administered under the Department of Social and Health Services' Aging and Long-Term Support Administration (ALTSA). Contact the local ALTSA field office for more information on these programs (see **Resources Available**).

Dually-enrolled clients who do NOT meet Home Bound status criteria per Medicare are eligible for Home Health through Medicaid. Providers must indicate NOT HOMEBOUND in the *Billing Note* section of the electronic institutional claim.

Coverage/Limits

When does the Health Care Authority (HCA) pay for covered home health services?

HCA pays for covered home health services provided to eligible clients when all the criteria listed in this section are met. Reimbursement is subject to the restrictions or limitations in this billing guide and other applicable published Washington Administrative Code (WAC).

For information about the Habilitative Services benefit, see **What are habilitative services under this program**?

Home health skilled services provided to eligible clients must:

- Meet the definition of acute care.

- Provide for the treatment of an illness, injury, or disability.

- Be medically necessary (see **chapter 182-500 WAC** for definition).

- Be reasonable, based on the community standard of care, in amount, duration, and frequency.

- Be provided under a plan of care (POC). Any statement in the POC must be supported by documentation in the client's medical records.

- Be used to prevent placement in a more restrictive setting. **In addition**, the client's medical records must justify the medical reason(s) that the services should be provided in any setting where the client's normal life activities take place, instead of a licensed practitioner's office or clinic. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in any setting where the client's normal life activities take place on a short-term basis.

- HCA does not reimburse for services if provided at an adult day care, skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

  o **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under HCA's home health program.

  o It is the home health agencies' responsibility to request coverage for a client when the services are not available to the client in the community or through LTC.

  o If the client meets the criteria for therapy services in this billing guide, HCA will evaluate the need after receiving the request.

  o Refer to the Aging and Long-Term Support Administration's (ALTSA) **Residential Care Services** webpage for more information.

- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed

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> **Note:** HCA covers home health acute care skilled nursing services when furnished by a qualified provider.
>
> HCA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165.

Does HCA cover acute care services?

HCA covers the following home health acute care services:

- **Full skilled nursing services** that require the skills of a registered nurse (RN) **or** a licensed practical nurse (LPN) under the supervision of a RN, if the services involve **one or more** of the following:
    - Observation (based on medical necessity and up to three weeks)
    - Assessment (approximately three weeks)
    - Treatment
    - Teaching (approximately three days)
    - Training (up to four visits unless client remains unstable)
    - Management
    - Evaluation

> **Note**: Use revenue code **0551** when billing for skilled nursing care visits in the home setting.

- **Brief skilled nursing visit** if only one of the following activities is performed during the visit:
    - An injection
    - A blood draw
    - The placement of medications in containers (e.g., envelopes, cups, medisets)

> **Note**: Use revenue code **0580** when billing for a brief skilled nursing visit.
>
> HCA limits skilled nursing visits provided to eligible clients to **two visits (whether they are brief or full) per day**.

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- Home infusion therapy only if the client:
  o Is willing and capable of learning and managing the client's infusion care
  o Has a volunteer caregiver willing and capable of learning and managing the client's infusion care

> **Note**: HCA does not reimburse for any of the following services through the Home Health Program:
>
> - Administration of IV therapy
>
> - Teaching of IV therapy
>
> - Skilled observation of the IV site
>
> All other infusion therapy related services must be billed on a professional claim using the Home Infusion Therapy/Parenteral Nutrition Program Billing Guide.
>
> Although HCA clients may have a paid caregiver who is willing and capable of performing the skilled task, a paid caregiver cannot bill for these services. The client may want to be involved in self-directed care.

- Infant phototherapy for an infant diagnosed with hyperbilirubinemia:
  o When provided by an HCA-approved infant phototherapy agency
  o For up to five skilled nursing visits per infant

> **Note**: If the infant's mother is enrolled in an HCA-contracted managed care organization (MCO) at the time of the birth, approval must be received from the MCO listed on the mother's eligibility check. **Do not bill HCA for these services**.

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- **Limited high-risk obstetrical services for all the following**:
    - A medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn
    - Up to three home health visits per pregnancy, if:
        - Enrollment in or referral to the following providers of First Steps has been verified:
            - Maternity Support Services (MSS)
            - Infant Case Management (ICM)
        - The visits are provided by a registered nurse who has either of the following:
            - National perinatal certification
            - A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years

> **Note**: Use revenue code **0551** when billing for skilled high-risk obstetrical nursing care visits in the home setting.
>
> HCA does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See Criteria for High-Risk Obstetrical.

Additional information required in the plan of care
(See Criteria for High-Risk Obstetrical)

- Infant's name, mother's name, and ProviderOne Client ID(s)
- Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy
- Name of hospital where the infant was born and discharge date
- Visit notes that include family teaching and interventions
- Bilirubin levels

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How do I become an HCA-approved infant phototherapy agency?

You must:

- Be a Medicaid- and Medicare-certified home health agency.

- Have an established phototherapy program.

- Submit to HCA for review, all the following:

  - Six months of documented phototherapy services delivered for infants

  - A written policy for home phototherapy submitted to HCA for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health

  - Three letters of recommendation from pediatricians who have used your program

> **Note**: **HCA will not cover** infant phototherapy **unless** your agency has a pre-approval letter on file from HCA noting that you are an approved infant phototherapy agency. See HCA's current Medical Equipment and Supplies Billing Guide for equipment component.

Does HCA cover specialized outpatient rehabilitative therapy for clients age 20 and younger?

For eligible clients age 20 and younger, HCA covers **specialized therapy services**, which include physical, occupational, or speech/audiology services.

> **Note**: HCA covers habilitative services for clients enrolled in the Alternative Benefit Plan (ABP). See What are habilitative services under this program? for specialized therapy rendered under the habilitative services benefit (see chapter 182-545 WAC).

HCA reimburses for specialized therapy services only when the client is **not able to access these services in the client's local community**. HCA limits specialized therapy visits to one per client, per day, per type of specialized therapy. Documentation must justify the skilled need of the visit. Under specialized therapy, home health services may be provided in a residential care facility with skilled nursing services available.

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> **Note**: **The maximum number of visits allowed is based on appropriate medical justification**. HCA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure (s). If the client requires more than one therapist on the same day, HCA requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Does HCA cover skilled outpatient rehabilitative therapies for clients age 19 and 20 in MCS and clients age 21 and older?

Yes. The following are the short-term benefit limits for outpatient rehabilitation (occupational therapy [OT], physical therapy [PT], and speech therapy [ST]) that apply to clients age 19 and 20 in MCS (medical care services) medical and all clients age 21 and older. These benefit limits are **per client, per calendar year**, regardless of setting (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)

To ensure payment:

- Bill in a timely manner. 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 HCA to check on the limits by submitting the **information request form for providers** on the Contact Us webpage to the Medical Assistance Customer Service Center (MACSC).

- Consult the **ProviderOne Billing and Resource Guide**: Client Eligibility, Benefit Packages, and Coverage Limits sections.

See expedited prior authorization (EPA) in the **Outpatient Rehabilitation Billing Guide** to obtain additional visits for qualifying conditions. If the client does not have a qualifying condition as outlined in the EPA section, HCA requires the home health agency to request a **limitation extension (LE)** from HCA.

For Department of Social and Health Services occupational therapy (OT) assessments, see the **Outpatient Rehabilitation Billing Guide**.

Does HCA cover social worker services?

Yes. HCA covers social work services, with the following limitations:

- Each unit is a 15-minute increment
- Eight units per client per 365-day period

HCA requires a provider to request prior authorization for a limitation extension (LE) to exceed the stated limits.

How are timed/untimed CPT® codes billed?

For specialized therapies:

- Each 15 minutes of timed CPT® codes equals one unit
- Each non-timed CPT® code equals one unit, regardless of how long the procedure takes

Therapy codes, including evaluations, must be billed as described in this billing guide. Failure to bill correctly will result in denials or recoupment.

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Short Description	Modifiers
PT	0421	G0151	Services performed by a qualified physical therapist in the home health or hospice setting each 15 minutes	GP
Physical Therapy Assistant				CQ
OT	0431	G0152	Services performed by a qualified occupational therapist in the home health or hospice setting each 15 minutes	GO
Occupational Therapy Assistant				CO
ST	0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder individual	GN

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Modality	Home Health Revenue Codes	Home Health Procedure Codes	Short Description	Modifiers
SW	0561	G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes	AJ

If the client's outpatient rehabilitation services maximum benefit limit has been reached (initial units and any additional EPA units, when appropriate), a provider may request authorization for a limitation extension from HCA.

Does HCA pay for outpatient rehabilitative therapy evaluations for clients age 21 and older?

Yes. HCA pays for therapy evaluations for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Evaluations do not count toward the limit but are subject to annual limits. See the Outpatient Rehabilitation Billing Guide. Providers bill with revenue code, the CPT® code, and the appropriate modifier. Providers must request authorization for a limitation extension (LE) if additional evaluations are needed.

Outpatient Rehabilitative Therapy Evaluation Codes

For outpatient rehabilitative therapy evaluation codes, see the Outpatient Rehabilitation Billing Guide.

What is the expedited prior authorization (EPA) for additional units of outpatient rehabilitative services for clients age 21 and older?

When a client meets the EPA criteria listed in Authorization 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 prior authorization.

> **Note:** EPA may be used once, per client, per calendar year, per each therapy type.

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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.

Clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, HCA covers outpatient physical, occupational, and speech therapy to treat one of the qualifying conditions listed in HCA's Habilitative Services Billing Guide, under *Client Eligibility*.

How do I bill for habilitative services?

See the Habilitative Services Billing Guide for details on billing habilitative services provided in the home health setting.

What are the limits for home health aide services?

- HCA limits home health aide visits to **one per day**.

- HCA reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

  o Skilled nursing services

  o Specialized therapy services

- HCA covers home health aide services only when a registered nurse or licensed therapist visits the client at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide. Supervisory visits may be conducted on-site or via telemedicine. HCA does not reimburse for services covered by another state administration such as LTC services, Community Options Program Entry System (COPES), CHORE, or CAP services.

- Documentation in the client's file must justify the need for the home health aide visits.

> **Note**: Contact the client's case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

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Does HCA cover home health services through telemedicine?

HCA covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis or diagnoses where there is a high risk of sudden change in medical condition which could compromise health outcomes.

When billing HCA for home health services delivered through telemedicine, use the following codes:

Revenue Code	HCPCS Code	Short Description	Limitation
0780	T1030	RN home care per diem	One per client, per day
0780	T1031	LPN home care per diem	One per client, per day

Payment

HCA pays for one telemedicine interaction, per eligible client, per day, based on the ordering licensed practitioner's home health plan of care.

Payment requirements

To receive payment for the delivery of home health services through telemedicine, the services must involve:

- A documented assessment, identified problem, and evaluation, which includes:
  - Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also included is an assessment of response to previous changes in the plan of care.
  - Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care.

- Implementation of a documented management plan through one or more of the following:
  - Education regarding medication management as appropriate, based on the findings from the telemedicine encounter
  - Education regarding other interventions as appropriate to both the patient and the caregiver
  - Management and evaluation of the plan of care, including changes in visit frequency or the addition of other skilled services
  - Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter
  - Coordination and referral to other medical providers as needed
  - Referral to the emergency room as needed

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Telemedicine-related costs

HCA does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.

Prior authorization

HCA does not require prior authorization for the delivery of home health services through telemedicine.

What home health services are not covered?

HCA does not cover the following home health services under the Home Health program, unless otherwise specified:

- Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the Department of Social and Health Services Aging and Long-Term Support Administration (ALTSA) or Developmental Disabilities Administration (DDA).

  - **HCA may consider requests** for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ALTSA or DDA to implement a long-term care skilled nursing plan or specialized therapy plan.

  - On a case-by-case basis, HCA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an ALTSA or DDA long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this billing guide and other published WACs.

  Home Health Agencies

  - The client must have a stable, chronic skilled nursing need.

  - The client's skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community).

  - The home health provider must **contact HCA and request coverage** through the home health program.

  HCA will first contact the client's ALTSA or DDA case manager to see if long-term care skilled nursing services are accessible in the community or through ALTSA or DDA

  If there are no other options, HCA will send a notification letter to the client, home health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through HCA for a limited time until a long-term care plan is in place.

- Psychiatric skilled nursing services

- Pre and postnatal skilled nursing services, except those listed under Covered – Acute Nursing Services

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- Well-baby follow-up care

- Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available

- Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services

- Home health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change, unless the client meets the applicable criteria in this guide)

- Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations

  Examples:

  o The client or caregiver is not willing and/or capable of managing the client's infusion therapy care.

  o A client requires daily visits in excess of program limitations.

- More than one of the same type of specialized therapy and/or home health aide visit per day. HCA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

- Any home health services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.

- Home health visits made without an authorized practitioner's written order, unless the verbal order is:

  o Documented prior to the visit

  o The document is signed by the authorized practitioner within 45 days of the order being given

HCA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

> **Note:** HCA evaluates a request for any service that is listed as noncovered under the provisions of WAC 182-501-0165. Requests must include the following:
>
> Name of agency and NPI
>
> Client's name and ProviderOne Client ID
>
> Copy of the plan of care
>
> Explanation of client-specific medical necessity

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Send requests for noncovered services to HCA (see **Resources Available**). See **Authorization** for information regarding Limitation Extensions.

Authorization

HCA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services **beyond** those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165.

> **Note**: A provider may request an exception to rule (ETR) for a noncovered service as described in WAC 182-501-0160.

What is a limitation extension (LE)?

A limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide **more units of service** than allowed in HCA's Washington Administrative Code (WAC) and Medicaid billing guides.

How is LE authorization obtained?

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's Prior authorization webpage for details).

LE may also be obtained by using the written/fax authorization process. **Your request must include the following**:

- Name of agency and NPI
- Client's name and ProviderOne Client ID
- Copy of the plan of care
- Explanation of client-specific medical necessity to exceed limitation

What forms are required for LE authorization?

HCA requires **both** of the following forms to request LE authorization:

- A completed, TYPED *General Information for Authorization* form (HCA **13-835**). This request form MUST be the cover page when you submit your request. See Where can I download HCA forms?
- A completed *Home Health Authorization Request* form (HCA **13-847**), and all the documentation listed on this form and any other medical justification. See Where can I download HCA forms?

Fax your request to 866-668-1214.

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What does expedited prior authorization (EPA) do?

EPA is designed to eliminate the need for written authorization from HCA. HCA establishes clinical criteria for the provider to apply and determine if the client's condition is medically necessary and qualifies for additional services. HCA assigns each criteria-set a specific numeric code.

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

> **Note**: HCA denies claims submitted without a required EPA number.

HCA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how EPA criteria were met and make this information available to HCA upon request. If HCA determines the documentation does not meet the criteria, the claim will be denied.

What are the EPA guidelines for documentation?

The provider must verify medical necessity for the services billed using the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon HCA request. If HCA determines the documentation does not meet EPA criteria, the claim will be denied.

> **Note**: When medical necessity for the service cannot be established using the EPA clinical criteria, prior authorization is required.

Which services require EPA?

To determine which services require EPA, see the Outpatient Rehabilitation Billing Guide.

Provider Requirements

What are HCA's documentation requirements?

HCA requires home health providers to keep individual medical records for each client and report to Medicare's Outcome and Assessment Information Set (OASIS).

Documentation to keep in the client's medical record in the event of an HCA request

The individual client medical record must comply with community standards of practice, and must include documentation of:

- Visit notes for every billed visit.
- The face-to-face encounter required by WAC 182-551-2040 that supports the medical necessity for home health services.
- Supervisory visits for home health aide services as described in Coverage/Limits.
- All medications administered and treatments provided.
- All orders, new orders, and change orders, with notation that the order was received prior to treatment.
- New or changed orders must be signed by an authorized practitioner.
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan.
- Interdisciplinary and multidisciplinary team communications.
- Inter-agency and intra-agency referrals.
- Medical tests and results.
- Pertinent medical history.
- Notations and charting with signature and title of writer.

> **Note**: For billing information related to an authorized practitioner co-signing home health or medical equipment orders, see HCA's Physician-Related/Professional Services Billing Guide.

Visit notes

At a minimum, the provider must document:

- Skilled interventions per the plan of care (POC)
- Client response to POC
- Any clinical change in the client status

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- Follow-up interventions specific to a change in status with significant clinical findings
- Any communications with the licensed practitioner

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, client compliance, and client response
- **Weekly** documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided
- If a client's wound is not healing, the client's licensed practitioner has been notified, the client's wound management program has been appropriately altered and if possible, the client has been referred to a wound care specialist
- The client's physical system assessment as identified in the POC

Will insufficiently documented home health care service cause a denial of claims?

HCA may take back or deny payment for any insufficiently documented home health care service when HCA determines that:

- The service did not meet the conditions listed in Coverage/Limits.
- The service was not in compliance with program policy.

What are the plan of care (POC) requirements?

For any delivered home health service to be payable, HCA requires home health providers to develop and implement an individualized POC for the client.

> **Note**: Home health providers are required to comply with audits and/or site visits to ensure quality of care and compliance with state rule. All documentation in the client record, including the signed plan of care, must be made available to HCA upon request. (See WAC 182-502-0020)

General requirements

The POC must:

- Be documented in writing and located in the client's home health medical record.
- Be developed, supervised, and signed by a licensed registered nurse or licensed therapist.
- Include the authorized practitioner orders and client's current health status.
- Contain specific goals and treatment plans.

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- Be reviewed and revised by the licensed registered nurse or licensed therapist and the client's licensed practitioner at least every 60 calendar days.

- Signed or co-signed by the authorized practitioner within 45 days of the verbal order.

- Returned to the home health agency's file.

- Be available to HCA staff or its designated contractor(s) on request.

> **Note**: For billing information related to an authorized practitioner co-signing home health or medical equipment orders, see the Physician-Related/Professional Services Billing Guide.

Information that must be in the POC

The POC must include:

- The client's name and date of birth

- The start of care

- The date(s) of service

- The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services, and the reason for the visit frequency)

- All secondary medical diagnosis including date(s) of onset (O) or exacerbation (E)

- The prognosis

- The type(s) of equipment required

> **Note**: Medical supplies and equipment must be billed on a separate claim using an NPI and taxonomy for which these services are allowed. Do not bill medical equipment on a Home Health claim.

- A description of each planned service and goals related to the services provided

- Specific procedures and modalities

- A description of the client's mental status

- A description of the client's rehabilitation potential

- A list of permitted activities

- A list of safety measures taken on behalf of the client

- A list of medications which indicates:

  - Any new (N) prescription.

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- o   Which medications are changed (C) for dosage or route of administration.

The following important information must be included in or attached to the POC:

- The client's address, including the name of the residential care facility where the client is residing (if applicable)

- A description of the client's functional limits and the effects

- Documentation that justifies why the medical services should be provided in any setting where the client's normal life activities take place, instead of at a licensed practitioner's office or clinic

- Significant clinical findings

- The dates of recent hospitalization

- Notification to the home health agency's designated case manager of admittance

- A discharge plan, including notification to the home health agency's designated case manager of the planned discharge date and client disposition at time of discharge

- A short summary of:

- o   What is happening with the client

OR-

- o   What has happened since last review

Is it required that clients be notified of their rights (Advance Directives)?

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions. Keep a copy of the written information in the client's record.

Clients have the right to all the following:

- Accept or refuse medical treatment

- Make decisions concerning their own medical care

- Formulate an advance directive, such as a living will or durable power of attorney, for their health care

Criteria for High-Risk Obstetrical

When is home care for hyperemesis gravidarum (HG) initiated?

Home care for the client with HG may be initiated when weight loss and significant metabolic changes require fluid and nutritional replacement therapy that can be managed in the home setting. The client or caregiver must be willing and capable of learning and managing the client's intravenous therapy.

Goals:

- Assess the client's condition

- Teach the client to help maintain the pregnancy to term

- Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances

Therapeutic Skilled Nursing Services may be initiated with the obstetrical provider's request for care. These services are designed to reinforce the clinic, hospital and/or provider's teaching. The nursing services assist the client and family in managing the client's care in the home and may include the following:

- Education about the factors that may contribute to HG, such as stress and coping with pregnancy

- Education on the symptoms related to dehydration and electrolyte disturbances and their effects on the mother and fetus (e.g., parenteral fluids and nutritional supplements)

- Assurance that the client can follow the treatment regimen (parenteral fluids and nutritional supplements) and comply with medications (antiemetics)

- Reinforcement of the obstetrical provider's plan of care, including the plan for resuming oral intake

- Demonstration of the ability to manage and administer the infusion treatment ordered by the obstetrical provider (hydration or total parenteral nutrition)

- Education concerning when to notify the obstetrical provider

Documentation in the client record is not limited to, but must include the following:

- An estimated date of confinement

- The gravidity/parity

- A history of symptoms of hyperemesis gravidarum (HG)

- An evaluation of clinical status of mother and fetus, including maternal weight and vital signs

- An evaluation of the obstetrical provider's plan of care

- A referral to a maternity support services (MSS) provider

- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy

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When are skilled nursing services used for clients with gestational diabetes?

Therapeutic Skilled Nursing Services may be initiated when there is a documented reason for teaching gestational diabetes management in the home. It should reinforce the obstetrical provider's or clinic's teaching.

Goals:

- Assess the client's condition

- Provide adequate support and education to help the client reduce symptoms of gestational diabetes

- Maintain the pregnancy to planned delivery

Whenever possible, education should be given at suitable diabetes teaching centers. A more complete and comprehensive training is available at these sites. A few cases may merit skilled nursing services. For example, skilled nursing may be provided to a client who is unable to get to a diabetes educational center or to a client who has special learning needs.

Therapeutic Skilled Nursing services may include the following:

- Assuring the client understands the plan of care

- Managing insulin injections

- Diet and exercise

- Demonstrating and teaching the blood glucose monitoring techniques, and the necessary times to test and documentation of testing results

- Explaining the differences between normal and abnormal blood glucose test results

- Explaining protocols for results of abnormal blood glucose, ketones, and protein in the urine

- Planning with the client for emergency treatment of hyper/hypoglycemia

- Explaining when to notify the obstetrical provider about symptoms

Documentation in the client record is not limited to, but must include the following:

- The estimated date of confinement

- The gravidity/parity

- A history of symptoms of gestational diabetes

- An evaluation of clinical status of mother and fetus

- An evaluation of obstetrical provider's plan of care

- Rationale for in-home gestational diabetes education

- A referral to a maternity support services (MSS) provider

- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

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When is home care for clients in preterm labor initiated?

Home care for preterm labor (PTL) symptoms may be initiated with the obstetrical provider's prescription for care and when there is an assurance of a viable newborn.

Goals:

- Assess the client's condition

- Provide adequate support and education to help the client maintain the pregnancy to term

Preventive services may be initiated between 20-25 weeks when an eligible client has a history of preterm births and/or has a multiple gestation and has been started on oral tocolytics.

Therapeutic Skilled Nursing Services may be initiated between 25-36 weeks gestation or birth (whichever comes first) or until the tocolytics are discontinued. Cervical changes should be documented at the start of care.

Skilled nursing care reinforces the medical protocol and assures that:

- The client comprehends and is compliant with the medication.

- The client can manage the restricted activity plan.

- The plan of care is coordinated with maternity support services (MSS) so that childcare and transportation services are readily available, if needed.

- The client education includes fetal movement count, signs and symptoms of preterm labor, and when to notify the obstetrical provider.

Documentation in the client record is not limited to, but must include the following:

- The estimated date of confinement

- The gravidity/parity

- A history of pre-term labor (PTL)

- Documentation of cervical change

- The obstetrical provider's plan of care

- An assessment of maternal and fetal clinical status

- A list of medications

- A referral to an MSS provider

- Education of the client and family in management of the prescribed care for a high-risk pregnancy

When is home care used for clients with pregnancy-induced hypertension?

Home care for Pregnancy-Induced Hypertension (PIH) may be initiated after 20 weeks gestation when:

- Blood pressure readings have increased by 30 mm Hg (systolic pressure) /15 mm Hg (diastolic pressure) over the baseline.

- The client has accompanying symptoms (e.g., lab changes, proteinuria, and a weight gain greater than two lbs. / week). Late signs/symptoms may include hyperreflexia, epigastric pain, and/or visual changes.

Goals:

- Assess the client's condition

- Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension

- Maintain the pregnancy to term

Therapeutic Skilled Nursing Services may be initiated at the prescribing medical provider's request when the:

- Documented signs and symptoms indicate the PIH may be safely managed in the home setting.

- Client requires bed rest with bathroom privileges.

- Client understands and can comply with bed rest or reduced activities in the home.

- Assessment includes vital signs, fetal heart tones, fundal height, deep tendon reflexes, and a check for proteinuria, edema, and signs and symptoms of PIH.

- Client and family members receive education on the following:

  o How to monitor blood pressure

  o How to evaluate urine for protein

  o When to notify the obstetrical provider

- Skilled nursing service provider reinforces education that the client received from the obstetrical provider's office. This may include the following:

  o Etiology and diagnosis of PIH

  o Treatment and rationale

  o Nutrition needs

  o Need for rest

  o Client monitoring of uterine and fetal activity

  o The role of medication in reducing symptoms (if provided)

- Plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

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Documentation in the client record is not limited to, but must include the following:

- The gravidity/parity
- A history of symptoms of PIH
- An evaluation of clinical status of birthing parent and fetus
- An obstetrical provider's plan of care
- Frequency of clinic visits
- Activity level
- List of medication, if prescribed
- A referral to a maternity support services (MSS) provider
- Education of the client and family on management of the prescribed care

Billing

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

Are referring provider NPIs required on all claims?

Yes. Providers must use the referring provider's national provider identifier (NPI) on all claims to be paid. If the referring provider's NPI is not listed on the claim, the claim may be denied. Providers must follow the billing requirements listed in HCA's ProviderOne Billing and Resource Guide.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage.

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

Are modifiers required for billing?

Yes. Providers must use the appropriate modifier when billing HCA:

Modality	Modifier
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupation Therapy	GO
Occupational Therapy Assistant	CO
Speech Therapy	GN
Audiology and Specialty Physician	AF

Effective for claims with dates of service on and after January 1, 2020, the following two modifiers must be included on the claim, when applicable, for services furnished in whole or in part for either a physical therapy assistant (PTA) or an occupational therapy assistant (OTA):

- CQ modifier: Outpatient physical therapy assistant
- CO modifier: Outpatient occupational therapy assistant

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The CQ or GO modifier must be included on the claim line of the service, along with the appropriate GP or CO therapy modifier to identify those PTA or OTA services furnished under a PT or OT plan of care. Claims that do not reflect this combination will be rejected/returned as unprocessed.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

Billing for clients age 21 and older and MCS clients age 19 through 20

For clients age 21 and older and clients receiving Medical Care Services (MCS) age 19 through 20, the outpatient rehabilitation benefit limits apply to the skilled therapy services provided through a Medicare-certified home health agency, as well as to therapy provided by physical, occupational, and speech therapists in outpatient hospital clinics and free-standing therapy clinics. See the Outpatient Rehabilitation Billing Guide for specifics.

Billing and servicing taxonomies

For professional services billed using the electronic 837P format, use billing and servicing taxonomy specific to the service being billed. Do not mix taxonomies on the same claim. **Example:** If you are billing for physical therapy services, use the billing and servicing taxonomy specific to physical therapy. **Do not bill occupational therapy services on the same claim as physical therapy services**.

For services provided in an outpatient hospital setting, the hospital bills under the UB format and uses the servicing taxonomy most appropriate for the clinician and service being provided. The billing provider taxonomy must be listed as the hospital's institutional billing taxonomy.

Bill timely

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.

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> **Note**:   When billing on an institutional claim, services provided on different days are required to be listed separately along with revenue code, procedure code, modifier, dates of service, and units.
>
> **Medical review rebilling**: Prior to rebilling, remove all lines on the claim that have already been paid by HCA.
>
> **ATTN: Special Handling,** Home Health Services Program, Manager, PO Box 45506, Olympia, WA98504-5506

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Coverage

Home health agencies must use the following procedure codes and modifiers when billing HCA:

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Modifiers
Physical Therapy	0421	G0151 = 15 min units	GP
Physical Therapy Assistant			CQ
Occupational Therapy	0431	G0152 = 15 min units	GO
Occupational Therapy Assistant			CO
Speech Therapy	0441	92507 = 1 unit	GN

Where is the home health services fee schedule?

See HCA's home health services fee schedule webpage.

> **Note**: External cause codes (V00-Y99) are required to be submitted in groups of three for a claim to be processed.

Telemedicine and Coronavirus (COVID-19)

Refer to the Health Care Authority's Provider Billing Guides and Fee Schedules webpage, under Telehealth, for current telemedicine policy.

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