Washington State Health Care Authority

Washington Apple Health (Medicaid)

Neurodevelopmental Centers Billing Guide

April 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect April 1, 2020, and supersedes earlier guides to this program.

HCA 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.

Services and equipment related to the programs listed below are not covered by this guide and must be billed using their specific provider guide:

- Hearing Hardware for Clients Age 20 and Younger
- Home Health Services
- Outpatient Hospital Services
- Outpatient Rehabilitation
- Physician-Related Services/Health Care Professional Services

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Telemedicine and Coronavirus (COVID-19)	Added section with link to telemedicine policy located in HCA's Physician-Related Services/Health Care Professional Services Billing Guide	To provide clarification on telemedicine policy and provide hyperlink to HCA's information page regarding COVID-19
Coverage Table - Occupational Therapy	Removed procedure codes 95831, 95832, 95833, and 95834 Removed procedure code 97127 and replaced with 97129 and 97130	Revised to reflect procedure code updates
Are modifiers required for billing?	Added modifiers for physical therapy and occupational therapy assistants to table, along with additional information about these modifiers	Revised to align with Section 53107 of the Bipartisan Budget Act of 2018

How can I get agency provider documents?

To access Provider Alerts, go to the agency's Provider Alerts webpage.

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

Table of Contents

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

Resources

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources webpage.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Private insurance or third-party liability, other than agency managed care	
Obtaining prior authorization	
Definitions	Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.
Provider billing guides, fee schedules, and other agency documents	See the agency's online Rates Development Fee Schedules

About the Program

What do neurodevelopmental centers do?

Neurodevelopmental centers (NDCs) provide outpatient physical therapy, speech therapy, occupational therapy, and audiology services to children with neuromuscular or developmental disorders, such as cerebral palsy, Down syndrome, autism, and pervasive developmental delay. NDCs serve clients age 20 and younger, although some NDCs further limit the age range they serve.

Who may provide services?

(WAC 182-545-200, WAC 182-531-0375)

After a client's primary care physician initiates NDC services by requesting an evaluation, the following health care professionals may provide services within their scope of practice to eligible clients in neurodevelopmental centers:

- Licensed occupational therapists
- Licensed occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Licensed physical therapists
- Physiatrists
- Licensed 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
- Audiologists who are licensed or registered to perform audiology services

Client Eligibility

Most Apple Health clients are enrolled in an agency-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 the agency'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 can I verify a patient's eligibility?

Clients age 20 and younger may be eligible to receive services in a neurodevelopmental center, 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 Program Benefit Packages and Scope of Services webpage.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

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

Yes. Clients enrolled in an agency-contracted managed care plan who are referred for outpatient rehabilitation services (Physical Therapy, Occupational Therapy and Speech Therapy) by their primary care provider are eligible to receive those services in a neurodevelopmental center (NDC). Managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. 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.

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 agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, 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.

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.

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.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina and United. If a client is currently enrolled in one of these three health plans, their health plan will not change.

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:**

  ✓ Visit the ProviderOne Client Portal website:

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

  ✓ 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."

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

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

Some Medicaid clients do not meet he 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. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with exception of American Indian/Alaskan Native clients. 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 (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

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

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

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

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

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

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

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 the agency'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 the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Coverage

What services are covered?

(WAC 182-545-900)

The Health Care Authority (agency) covers unlimited services in a neurodevelopmental center for clients age 20 and younger, with the following exception: clients age 19 through 20 in Medical Care Services (MCS) are eligible for **limited** outpatient rehabilitation. For these clients, the outpatient rehabilitation benefit applies. See the Outpatient Rehabilitation Billing Guide.

Telemedicine and Coronavirus (COVID-19)

Refer to Physician-Related/Professional Services Billing Guide dated April 2020 for telemedicine policy. See the Health Care Authority's Information about novel coronavirus (COVID-19) webpage for updated information regarding COVID-19.

.

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.

Procedure Code	Modifier	Short Description	Comments
Physical therapy			
64550		Apply neurostimulator	Not covered
95831	GP	Limb muscle testing, manual	Muscle testing procedures cannot be billed in combination with each other. They can be billed alone or with other PT/OT procedure codes.
95832	GP	Hand muscle testing, manual	
95833	GP	Body muscle testing, manual	
95834	GP	Body muscle testing, manual	
95851	GP	Range of motion measurements	Excluding hands
95852	GP	Range of motion measurements	Including hands
96125	GP	Cognitive test by hc pro	
97010	GP	Hot or cold packs therapy	Included in primary services. Bundled
97012	GP	Mechanical traction therapy	
97014	GP	Electric stimulation therapy	
97016	GP	Vasopneumatic device therapy	
97018	GP	Paraffin bath therapy	
97022	GP	Whirlpool therapy	
97024	GP	Diathermy treatment	
97026	GP	Infrared therapy	
97028	GP	Ultraviolet therapy	
Note: The following procedures codes require the therapy provider be in constant attendance.			
97161	GP	PT eval low complex 20 min	
97162		PT eval mod complex 30 min	
97163		PT eval high complex 45 min	
97164	GP	PT re-eval est plan care	
97005		Athletic train evaluation	Not covered
97006		Athletic train re-evaluation	Not covered
97032	GP	Electrical stimulation	Timed 15 min units
97033	GP	Electric current therapy	Timed 15 min units

Procedure Code	Modifier	Short Description	Comments
97034	GP	Contrast bath therapy	Timed 15 min units
97035	GP	Ultrasound therapy	Timed 15 min units
97036	GP	Hydrotherapy	Timed 15 min units
97039	GP	Physical therapy treatment	
97110	GP	Therapeutic exercises	Timed 15 min units
97112	GP	Neuromuscular reeducation	Timed 15 min units
97113	GP	Aquatic therapy/exercises	Times 15 min units
97116	GP	Gait training therapy	Timed 15 min units
97124	GP	Massage therapy	Timed 15 min units
97139	GP	Physical medicine procedure	
97140	GP	Manual therapy	Timed 15 min units
97150	GP	Group therapeutic procedures	
97530	GP	Therapeutic activities	Timed 15 min units
97533		Sensory integration	Not covered
97535	GP	Self-care management training	Timed 15 min units
97542	GP	Wheelchair management training	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	Active wound care/20 cam or <	Do not use in combination with 11040-11044. Limit one per client per day.
97598	GP	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GP	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GP	Neg press wound tx, <50 cm	Included in primary services. Bundled
97606	GP	Neg press wound tx, >50 cm	Included in primary services. Bundled
97750	GP	Physical performance test	Do not use to bill for an evaluation
97755	GP	Assistive technology assess	Timed 15 min units
97760	GP	Orthotic mgmt and training	Can be billed alone or with other PT/OT procedure codes
97761	GP	Prosthetic training	Timed 15 min units
97762	GP	C/o for orthotic/prosth use	Use this code for DME assessment. Use modifier TS for follow up service. Can be billed

Procedure Code	Modifier	Short Description	Comments
			alone or with other PT/OT procedure codes.
97799	GP	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.
Team conferences			
99367		Team conf w/o pat by phys	
Pediatric evaluations			
99201		Office/outpatient visit, new	
99202		Office/outpatient visit, new	
99203		Office/outpatient visit, new	
99204		Office/outpatient visit, new	
99205		Office/outpatient visit, new	
99211		Office/outpatient visit, est	
99212		Office/outpatient visit, est	
99213		Office/outpatient visit, est	
99214		Office/outpatient visit, est	
99215		Office/outpatient visit, est	
Speech-language pathologists			
92521	GN	Evaluation of speech fluency	
92522	GN	Evaluate speech production	
92523	GN	Speech sound lang comprehen	
92524	GN	Behavral qualit analys voice	
92507	GN	Speech/hearing therapy	
92508	GN	Speech/hearing therapy	
92526	GN	Oral function therapy	
92551	GN	Pure tone hearing test, air	
92597	GN	Oral speech device eval	
92605	GN	Evaluation for rx of nonspeech device 1 hr	Limit 1 hour Included in primary services. Bundled
92618	GN	Eval for rx of nonspeech device addl	Add on to 92605 Each additional 30 minutes. Bundled
92606	GN	Non-speech device service	Included in Primary services. Bundled

Procedure Code	Modifier	Short Description	Comments
92607	GN	Ex for speech device rx, 1hr	Limit 1 hour
92608	GN	Ex for speech device rx addl	Each additional 30 min
92609	GN	Use of speech device service	
92610	GN	Evaluate swallowing function	
92611	GN	Motion fluoroscopy/swallow	
92630	GN	Aud rehab pre-ling hear loss	
92633	GN	Aud rehab postling hear loss	
96125	GN	Cognitive test by hc pro	
97129	GN	Ther ivntj 1st 15 min	1st 15 minutes
97130	GN	Ther ivntj ea addl 15 min	Each additional 15 minutes
97533	GN	Sensory integration	Timed 15 min units
S9152	GN	Speech therapy, re-eval	
Audiologists			
69210	AF	Remove impacted ear wax	
92521	AF	Evaluation of speech fluency	
92522	AF	Evaluate speech production	
92523	AF	Speech sound lang comprehen	
92524	AF	Behavral qualit analys voice	
92541	AF	Spontaneous nystagmus test	
92542	AF	Positional nystagmus test	
92544	AF	Optokinetic nystagmus test	
92545	AF	Oscillating tracking test	
92546	AF	Sinusoidal rotational test	
92547	AF	Supplemental electrical test	
92550	AF	Tympanometry & reflex thresh	
92551	AF	Pure tone hearing test, air	
92552	AF	Pure tone audiometry, air	
92553	AF	Audiometry, air & bone	
92555	AF	Speech threshold audiometry	
92556	AF	Speech audiometry, complete	
92557	AF	Comprehensive hearing test	
92558	AF	Evoked otoacoustic emissions screening- audiologists	
92567	AF	Tympanometry	
92568	AF	Acoustic reflex testing	

Procedure Code	Modifier	Short Description	Comments
92570	AF	Acoustic immittance testing	
92579	AF	Visual audiometry (vra)	
92582	AF	Conditioning play audiometry	
92584	AF	Electrocochleography	
92585	AF	Auditor evoke potent, compre	
92586	AF	Auditor evoke potent, limit	
92587	AF	Evoked auditory test	
92588	AF	Evoked auditory test	
92601	AF	Cochlear implt f/up exam < 7	
92602	AF	Reprogram cochlear implt < 7	
92603	AF	Cochlear implt f/up exam 7 >	
92604	AF	Reprogram cochlear implt 7 >	
92611	AF	Motion fluoroscopy/swallow	
92620	AF	Auditory function, 60 min	
92621	AF	Auditory function, + 15 min	
92625	AF	Tinnitus assessment	
92626	AF	Oral function therapy	
92627	AF	Oral speech device eval	
92630	AF	Aud rehab pre-ling hear loss	
92633	AF	Aud rehab postling hear loss	
97533	AF	Sensory integration	One 15 minute increment equals one visit
Occupational therapy			
64550		Apply neurostimulator	Not covered
92526	GO	Oral function therapy	
95851	GO	Range of motion measurements	Excluding hands
95852	GO	Range of motion measurements	Including hands
96125	GO	Cognitive test by hc pro	
97165	GO	OT eval low complex 30 min	
97166	GO	OT eval mod comple 45 min	
97167	GO	OT eval high complex 60 min	
97168	GO	OT re-eval est plan care	
97010	GO	Hot or cold packs therapy	Included in Primary services. Bundled
97014	GO	Electric stimulation therapy	

Procedure Code	Modifier	Short Description	Comments
97018	GO	Paraffin bath therapy	
97032	GO	Electrical stimulation	Timed 15 min units
97034	GO	Contrast bath therapy	Timed 15 min units
97110	GO	Therapeutic exercises	Timed 15 min units
97112	GO	Neuromuscular reeducation	Timed 15 min units
97113	GO	Aquatic therapy/exercises	Timed 15 min units
97124	GO	Massage therapy	Timed 15 min units
97140	GO	Manual therapy	Timed 15 min units
97150	GO	Group therapeutic procedures	
97530	GO	Therapeutic activities	Timed 15 min units
97533	GO	Sensory integration	Timed 15 min units
97535	GO	Self-care management training	Timed 15 min units
97542	GO	Wheelchair management training	Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97597	GO	Active wound care/20 cm or <	Do not use in combination with 11040-11044. Limit one per client per day
97598	GO	Active wound care > 20 cm	Do not use in combination with 11040-11044
97602	GO	Wound(s) care non-selective	Do not use in combination with 11040-11044
97605	GO	Neg press wound tx, <50 cm	Included in Primary services. Bundled
97606	GO	Neg press wound tx, >50 cm	Included in Primary services. Bundled
97750	GO	Physical performance test	Do not use to bill for an evaluation
97755	GO	Assistive technology assess	Timed 15 min units
97760	GO	Orthotic management and training	Can be billed alone or with other PT/OT procedure codes
97761	GO	Prosthetic training	Timed 15 min units
97762	GO, TS	C/o for orthotic/prosth use	Use this code for DME assessment. Use modifier TS for follow up service. Can be billed alone or with other PT/OT procedure codes
97799	GO & RT or LT	Physical medicine procedure	Use this code for custom hand splints. Use modifier to indicate right (RT) or left (LT) hand. Documentation must be attached to claim.

Payment

What must an NDC do to be reimbursed by the agency?

To be reimbursed for the services listed in the coverage section, an NDC must:

- Contract with the Department of Health (DOH) as a neurodevelopmental center.
- Provide documentation of its DOH contract to the agency.
- Have an approved core-provider agreement with the agency.

To be reimbursed for the services listed in the coverage section, each service must be:

- Covered by the client's benefit package.
- 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 assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Begun within 30 days of the date ordered.
- Provided by an approved health professional.
- Billed according to this guide.
- Provided as part of an outpatient treatment program in a neurodevelopmental center, as described in WAC 182-545-900.

What services does the agency not pay for?

The agency does not pay for:

- Duplicate services for the same client when two or more providers are performing the same or similar intervention on the same date.

- Services included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services (see WAC 182-545-900).

Billing

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

Are servicing provider national provider identifiers (NPIs) required on all claims?

Yes. Neurodevelopmental centers (NDCs) must use the servicing provider's national provider identifier (NPI) on *all* claims in order to be paid. If the servicing provider's NPI is not listed on the claim, the claim may be denied. Providers must follow the billing requirements listed in the agency'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 the agency's Billers and Providers webpage, under Webinars.

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. Neurodevelopmental centers must use the appropriate modifier when billing the agency:

MODALITY	MODIFIERS
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupational Therapy	GO
Occupational Therapy Assistant	CO
Speech Therapy	GN
Audiology and Specialty Physician	AF

CMS has established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). The modifiers are defined as follows:

- CQ modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- CO modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Effective for claims with dates of service on and after January 1, 2020, the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by PTAs and OTAs on the claim line of the service alongside the respective GP or GO therapy modifier, to identify those PTA and OTA services furnished under a PT or OT plan of care. Claims not so paired will be rejected/returned as unprocessed.

What are the general billing requirements?

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

- 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