Washington State Health Care Authority

Washington Apple Health (Medicaid)

Habilitative Services Program Billing Guide

January 1, 2021

Washington State Health Care Authority

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 rule arises, the 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 January 1, 2021**, and supersedes earlier billing guides to 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.

Neurodevelopmental Centers, Outpatient Hospital Services, Physician-Related Services/Healthcare Professional Services (which includes audiology), Home Health Services, and Outpatient Rehabilitation providers who provide physical therapy, occupational therapy, or speech language pathology to treat a condition that qualifies for habilitative services, in a client enrolled in the Alternative Benefit Plan, must bill for these therapies under this billing guide.

Services and equipment related to any of the following programs must be billed using their program-specific billing guide:

- Wheelchairs, Durable Medical Equipment, and Supplies
- Prosthetic/Orthotic Devices and Supplies
- Complex Rehabilitative 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.

[*] This publication is a billing instruction.

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How can I get HCA Apple Health provider documents?

To access providers 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?

Subject	Change	Reason for Change
Entire Guide	Housekeeping changes	To improve usability and clarity
Coverage Table	Added CPT® codes 96112 and 96113	To clarify code coverage for qualified provider types under the Physician-Related Services/Professional Healthcare Services Fee Schedule

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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See HCA's Billers and Providers webpage
Finding out about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's Billers and Providers webpage
Electronic billing	See HCA's Billers and Providers webpage
Accessing HCA publications, including Medicaid Billing Guides, provider notices, and fee schedules	See HCA's Billers and Providers webpage
Private insurance or third-party liability	See HCA's Billers and Providers webpage
How do I obtain prior authorization or a limitation extension?	Providers may submit their requests online or by submitting the request in writing. See HCA's prior authorization webpage for details. Written requests for prior authorization or limitation extensions must include a completed, typed General Information for Authorization form (HCA 13-835), which must be the first page of your request packet. Fax your request to: 866-668-1214 For information about downloading HCA forms, see Where can I download agency forms?
General definitions	See chapter 182-500 WAC

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Program Overview

WAC 182-545-400

What is the purpose of the habilitative services program?

The purpose of the habilitative services program is to provide medically necessary services that 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. The Health Care Authority does not require the diagnosis of a specific condition for an eligible client to receive habilitative services.

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Client Eligibility

Who is eligible for habilitative services?

Eligibility for habilitative services is limited to clients who are enrolled in the Alternative Benefit Plan (ABP) defined in WAC 182-501-0060. ABP clients who do not qualify under the habilitative services benefit may still qualify for outpatient rehabilitation under the outpatient rehabilitation benefit and billed according to the Health Care Authority's current Outpatient Rehabilitation Billing Guide.

How do I verify a client's 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.**

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.

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Note: Patients who are not 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.
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 the Washington Healthplanfinder's website or call the Customer Support Center.

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:**
  - Visit the **ProviderOne Client Portal website**:
  - 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."
  - 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. Clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO with the exception of American Indian/Alaska 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.

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Integrated managed care

Clients qualified for managed care enrollment will receive all physical health services, mental health services, and substance use disorder treatment through their HCA-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 Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.
>
> For more information about the services available under the FFS program, see HCA's **Mental Health Services Billing Guide** and the **Substance Use Disorder Billing Guide**.

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."

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**."

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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*?

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Provider Eligibility

Who may provide habilitative services?

The following licensed health care professionals may enroll with the Health Care Authority to provide habilitative services within their scope of practice to eligible clients:

- Physiatrists
- Occupational therapists
- Occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Physical therapists
- Physical therapist assistants (PTA) supervised by a licensed physical therapist
- Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech, Hearing and Language Association
- Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate

> **Note**: Other licensed professionals, such as physicians, podiatrists, PA-Cs, ARNPs, audiologists, and specialty wound centers, refer to the Health Care Authority's Physician-Related Services/Healthcare Professional Services Billing Guide and Outpatient Hospital Services Billing Guide.

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Coverage

When does the Health Care Authority pay for habilitative services?

The Health Care Authority pays for habilitative services that are:

- Covered within the scope of the client's alternative benefits plan under WAC 182-501-0060;
- Medically necessary, as defined in WAC 182-500-0070;
- Within currently accepted standards of evidence-based medical practice;
- Ordered by a physician, physician assistant, or an advanced registered nurse practitioner;
- Begun within 30 calendar days of the date ordered;
- Provided by an approved health care professional (refer to Who may provide habilitative services?)
- Authorized if required in this billing guide;
- Billed according to this billing guide;
- Provided as part of a habilitative treatment program:
    - In an office or outpatient hospital setting;
    - In the home, by a home health agency as described in chapter 182-551 WAC; or
    - In a neurodevelopmental center, as described in WAC 182-545-900.

Duplicate occupational, physical, and speech-therapy services are not allowed for the same client when both providers are performing the same or similar intervention(s).

Telemedicine and Coronavirus (COVID-19)

Refer to the current Physician-related/professional services billing guide for telemedicine policy. See the Health Care Authority's Information about novel coronavirus (COVID-19) webpage for updated information regarding COVID-19.

What habilitative services does the Health Care Authority cover for clients age 20 and younger?

The Health Care Authority covers habilitative services for eligible clients age 20 and younger, as described in WAC 182-501-0060.

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What habilitative services does the Health Care Authority cover for clients age 21 and older?

The Health Care Authority covers limited outpatient habilitative services for eligible clients age 21 and older, which includes an on-going management plan for the client or the client's caregiver to support continued client progress. See the following tables for an explanation of limitations for clients age 21 and older. The Health Care Authority allows service beyond the limitations described below if authorization is obtained. See Authorization for additional information.

Habilitative services benefit limits for clients age 21 and older apply to the skilled therapy services provided through a Medicare-certified home health agency, as well as therapy provided by physical, occupational, and speech therapists in outpatient hospital clinics and freestanding therapy clinics.

Occupational therapy

Clients Age 21 and Older Without Prior Authorization

Description	Limit
Occupational therapy evaluation	One per client, per calendar year
Occupational therapy re-evaluation at time of discharge	One per client, per calendar year
Occupational therapy	24 units (approximately 6 hours), per client, per calendar year

Clients Age 21 and Older—Additional Benefit Limits with Expedited Prior Authorization

When the clinical situation is:	Limit	EPA#
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the Health Care Authority	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See Requesting a Limitation Extension for requesting units beyond the additional benefit limits.	870001329

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Physical therapy

Clients Age 21 and Older Without Prior Authorization

Description	Limit
Physical therapy evaluation	One per client, per calendar year
Physical therapy re-evaluation at time of discharge	One per client, per calendar year
Physical therapy	24 units (approximately 6 hours), per client, per calendar year

Clients Age 21 and Older—Additional Benefit Limits with Expedited Prior Authorization

Clients Age 21 and Older: Additional Benefit Limits with Expedited Prior Authorization		
When the clinical situation is:	**Limit**	**EPA#**
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the Health Care Authority	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See Requesting a Limitation Extension for requesting units beyond the additional benefit limits.	870001329

Speech therapy

Clients Age 21 and Older Without Prior Authorization

Description	Limit
Speech language pathology evaluation	One per client, per code, per calendar year
Speech language pathology re-evaluation at time of discharge	One per client, per evaluation code, per calendar year
Speech therapy	6 units (approximately 6 hours), per client, per calendar year

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Clients Age 21 and Older—Additional Benefit Limits with Expedited Prior Authorization

When the clinical situation is:	Limit	EPA#
Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the Health Care Authority	Six additional units, per client, per calendar year See Requesting a Limitation Extension for requesting units beyond the additional benefit limits.	870001328

Swallowing evaluations

Swallowing (dysphagia) evaluations must be performed by a speech-language pathologist who:

- Holds a master's degree in speech-language pathology.
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing.
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques.
- May include video fluoroscopy for further evaluation of swallowing status and aspiration risks.

Using timed and untimed procedure codes

For the purposes of this billing guide:

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

If time is included in the CPT code description, the beginning and ending times of each therapy modality must be documented in the client’s medical record.

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Limits

The following limits for therapies are per client, per calendar year.

- Bill timely. Claims will pay in date of service order. If a claim comes in for a previous date of service, the system will automatically pay the earlier date and recoup or adjust the later date.
- To check on limits, submit a service limit request to the Health Care Authority's Medical Assistance Customer Service Center (MACSC), using the Contact Us On-line Request Form.
- Consult *Client Eligibility, Benefit Packages, and Coverage Limits* in the Health Care Authority's ProviderOne Billing and Resource Guide.

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Coverage Table

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

The following abbreviations are used in the Coverage Table:

GP = Physical Therapy **GO** = Occupational Therapy **GN** = Speech Therapy

TS = Follow-up service **RT** = Right **LT** = Left.

***** = Included in the benefit limitation for clients age 21 and over and MCS clients age 19 through 20

CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
92507*	GN	Speech/hearing therapy			X	
92508*	GN	Speech/ hearing therapy			X	
92521	GN	Evaluation of speech fluency			X	One per client, per code, per calendar year
92522	GN	Evaluate speech production			X	One per client, per code, per calendar year
92523	GN	Speech sound lang comprehen			X	One per client, per code, per calendar year
92524	GN	Behavral qualit analys voice			X	One per client, per code, per calendar year
92526*	GO, GN	Oral function therapy		X	X	
92551*	GN	Pure tone hearing test air			X	
92597*	GN	Oral speech device eval			X	

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
92605	GN	Eval for rx of nonspeech device 1 hr			X	Limit 1 hour Included in the primary services; Bundled
92618	GN	Eval for rx of nonspeech device addl 30 min			X	Add on to CPT® code 92605 each additional 30 minutes; Bundled
92606	GN	Nonspeech device service			X	Included in the primary services; Bundled
92607	GN	Ex for speech device rx 1 hr			X	Limit 1 hour
92608	GN	Ex for speech device rx addl			X	Each additional 30 min Add on to CPT® code 92607
92609*	GN	Use of speech device service			X	
92610	GN	Evaluate swallowing function			X	No limit
92611	GN	Motion fluoroscopy/swallow			X	No longer limited
92630*	GN	Aud rehab pre-ling hear loss			X	
92633*	GN	Aud rehab post-ling hear loss			X	
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
95992*	GP	Canalith repositioning procedure (eg, Epley maneuver)	X			One per client, per day
96112	GO, GN	Devel tst phys/ghp 1st hr		X	X	Covered under the Physician-Related Services/Professional Healthcare Services Fee Schedule for qualified providers
96113	GO, GN	Devel tst phys/ghp ea addl		X	X	Covered under the Physician-Related Services/Professional Healthcare Services Fee Schedule for qualified providers
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97010	GP, GO	Hot or cold packs therapy	X	X		Bundled
97012*	GP	Mechanical traction therapy	X			
97014*	GP GO,	Electric stimulation therapy	X	X		
97016*	GP	Vasopneumatic device therapy	X			
97018*	OP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units
97035*	GP	Ultrasound therapy	X			Timed 15 min units
97036*	GP	Hydrotherapy	X			Timed 15 min units
97039*	GP	Physical therapy treatment	X			
97110*	GP, GO	Therapeutic exercises	X	X		Timed 15 min units
97112*	GP, GO	Neuromuscular re-education	X	X		Timed 15 min units
97113*	GP, GO	Aquatic therapy/exercises	X	X		Timed 15 min units
97116*	GP	Gait training therapy	X			Timed 15 min units
97124*	GP, GO	Massage therapy	X	X		Timed 15 min units
97129*	GO, GN	Ther ivntj 1st 15 min		X	X	1st 15 minutes
97130*	GO, GN	Ther ivntj ea addl 15 min		X	X	Each additional 15 minutes
97139*	GP	Physical medicine procedure	X			Timed 15 min units
97140*	GP, GO	Manual therapy	X	X		Timed 15 min units
97150*	GP, GO	Group therapeutic procedures	X	X		
97161	GP	PT eval low complex 20 min	X			Only one of these codes is allowed, per client, per calendar year.
97162	GP	PT eval med complex 30 min	X			Only one of these codes is allowed, per client, per calendar year.

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97163	GP	PT eval high complex 45 min	X			Only one of these codes is allowed, per client, per calendar year.
97164	GP	PT re-eval est plan care	X			One per client per calendar year
97165	GO	OT eval low complex 30 min		X		Only one of these codes allowed, per client, per calendar year
97165	GO	DSHS OT eval (bed rail assessment)		X		EPA required. One per client, unless change of residence or condition OT Eval for bedrails is a DSHS program. Use EPA# 870001326 with Rev code 0434 and CPT® code 97165.
97166	GO	OT eval mod complex 45 min		X		Only one of these codes allowed, per client, per calendar year
97167	GO	OT eval high complex60 min		X		Only one of these codes allowed, per client, per calendar year
97168	GO	OT re-eval est plan care		X		One per client, per calendar year
97530*	GP, GO	Therapeutic activities	X	X		Timed 15 min units
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units
97535*	GP, GO	Self care mngment training	X	X		Timed 15 min units

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units
97542	GP, GO	Wheelchair mngment training	X	X		One per client, per calendar year Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97597*	GP, GO	Rmvl devital tis 20 cm/<	X	X		Do not use in combination with 11042-11047. Limit one per client, per day
97598*	GP, GO	Rmvl devital tis addl 20 cm<	X	X		One per client, per day Do not use in combination with CPT® codes 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		One per client, per day. Do not use in combination with CPT® codes 11042-11047.
97605*	GP, GO	Neg press wound tx < 50 cm	X	X		One per client, per day
97606*	GP, GO	Neg press wound tx > 50 cm	X	X		One per client, per day
97750*	GP, GO	Physical performance test	X	X		Do not use to bill for an evaluation (CPT® code 97001) or re-eval (CPT® code 97002)
97755*	GP, GO	Assistive technology assess	X	X		Timed 15 min units

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CPT® Code	Modifier	Short Description	PT	OT	SLP	Comments
97760*	GP, GO	Orthotic management & training 1st encounter	X	X		Timed 15 min units. Can be billed alone or with other PT/OT procedure codes.
97761*	GP, GO	Prosthetic training 1st encounter	X	X		Timed 15 min units
97763*	GP, GO	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	X	X		Timed 15 min units.
97799*	GP & RT or LT	Physical medicine procedure	X			Use this code for custom splints. 1 per client per extremity per calendar year. Use modifier to indicate right or left. Documentation must be attached to claim. Do not use in combination with any L-code. OTs refer to the Prosthetics and orthotics billing guide for appropriate L-code.
HCPCS code S9152		Speech therapy re-eval			X	One per client, per evaluation code, per calendar year

Note: In addition to standard billing modifiers, use the informational SZ modifier to identify habilitative services provided

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The Health Care Authority (HCA) does not pay:

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

Where can I find the fee schedule?

Habilitative services provided in an office setting are paid according to the Health Care Authority's Habilitative fee schedule.

Rehabilitative services provided in the home are paid according to the Health Care Authority's Home Health fee schedule.

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Washington State Health Care Authority

Authorization

What are the general guidelines for authorization?

When a service requires authorization, the provider must properly request authorization in accordance with the Health Care Authority's (HCA) rules, this billing guide, and applicable provider notices.

When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.

Upon request, a provider must provide documentation to HCA showing how the client's condition met the criteria for using the expedited prior authorization (EPA) code or limitation extension (LE).

HCA's authorization of service(s) does not guarantee payment.

HCA may recoup any payment made to a provider if HCA later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100(1)(c) and WAC 182-544-0560(7).

Expedited prior authorization (EPA)

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

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

When is a limitation extension (LE) required?

If a client's benefit limit of habilitative services has been reached (the initial units and any additional EPA units, if appropriate), a provider may request authorization for an LE from the Health Care Authority (HCA).

HCA evaluates requests for authorization of covered habilitative services that exceed limitations in this billing guide on a case-by-case basis in accordance with WAC 182-501 0169. The provider must justify that the request is medically necessary (as defined in WAC 182-500-0070) for that client.

> **Note:** Requests for an LE must be appropriate to the client's eligibility and program limitations. Not all eligibility programs cover all services.

Providers may submit their request by direct data entry into ProviderOne or by submitting the request in writing. See the Health Care Authority's **prior authorization webpage** for details. Fax the forms and all documentation to: **866-668-1214** (See Where can I download agency forms?)

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Billing

All claims must be submitted electronically to the Health Care Authority, 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 Health Care Authority'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 in order 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 the Health Care Authority's ProviderOne Billing and Resource Guide.

Are servicing provider NPIs required on all claims?

Yes. The servicing provider's national provider identifier (NPI) must be included 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.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the Health Care Authority'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. Providers must use the appropriate modifier when billing the Health Care Authority:

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

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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 by either a physical therapy assistant (PTA) or an occupational therapy assistant (OTA):

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

The CQ or CO modifier must be included on the claim line of the service along with the appropriate GP or GO therapy modifier to identify those PTA or OTA services furnished under a PT or OP 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 the Health Care Authority's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill the Health Care Authority for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

For professional services billed using the electronic 837P format, physical therapy performed by physical therapists must be billed separate from other services: use billing and servicing taxonomy specific to physical therapy.

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. 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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Home health agencies

Home health agencies must use the following procedure codes and modifiers when billing the Health Care Authority:

Modality	Home Health Revenue Codes	New 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

See the Health Care Authority's Home Health billing guide for further details

Outpatient hospital or hospital-based clinic setting

Hospitals must use the appropriate revenue code, CPT code, and modifier when billing the Health Care Authority:

Modality	Revenue Code	Modifiers
Physical Therapy	042X	GP
Physical Therapy Assistant		CQ
Occupational Therapy	043X	GO
Occupational Therapy assistant		CO
Speech Therapy	044X	GN

See the Health Care Authority's Outpatient hospital billing guide for further details.

> **Note**: In addition to standard billing modifiers, use the informational SZ modifier to denote habilitative services provided.

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