Washington State Health Care Authority

Washington Apple Health (Medicaid)

Outpatient Rehabilitation Billing Guide

October 20, 2020

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 **October 20, 2020**, and supersedes earlier billing guides to this program. Unless other specified, the program in this guide is governed by the rules found in **WAC 182-545-200.**

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.

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

- Home health services
- Neurodevelopmental centers
- Wheelchairs, durable medical equipment, and supplies
- Prosthetic/orthotic devices and supplies
- Outpatient hospital services
- Physician-related services/healthcare professional services (includes audiology)

* This publication is a billing instruction.

Washington State 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).

Copyright disclosure

What has changed?

Subject	Change	Reason for Change
Coverage table	Fixed typographical error in modifier for CPT code 97018	Previously listed as CO. Modifier should be GO.

Washington State Health Care Authority

Table of Contents

Washington State Health Care Authority

Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the Health Care Authority's Billers, providers, and partners webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See the Health Care Authority's Billers, providers, and partners webpage
Electronic billing	See the Health Care Authority's Billers, providers, and partners webpage
Finding HCA documents, (e.g., billing guides, provider notices, fee schedules)	See the Health Care Authority's Billers, providers, and partners webpage
Private insurance or third-party liability	See the Health Care Authority's Billers, providers, and partners webpage
How do I check how many units of therapy the client has remaining?	Providers may contact HCA's Medical Assistance Customer Service Center (MACSC) via: • Telephone toll-free at (800) 562-3022 or • Web form or email
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* (HCA 13-835 form). This request form must be the cover page when you submit your request. • A completed *Outpatient Rehabilitation Authorization Request* (HCA 13-786 form) and all the documentation listed on that form and any other medical justification. Fax your request to: (866) 668-1214. For information about downloading HCA forms, see Where can I download HCA forms?
General definitions	See chapter 182-500 WAC
Where do I find HCA's maximum allowable fees for services?	See the Health Care Authority's Fee Schedules

Washington State Health Care Authority

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 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 Medicaid-eligible clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-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.

Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-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.

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:
  - 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 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.

Integrated managed care

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 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**."

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*?

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

Washington State Health Care Authority

Provider Eligibility

Who may provide outpatient rehabilitation services?

The following licensed healthcare professionals may enroll with the Health Care Authority to provide outpatient rehabilitation within their scope of practice:

- Occupational therapists
- Occupational therapy assistants (OTA) supervised by a licensed occupational therapist
- Optometrists, to provide vision occupational therapy only
- Physiatrists
- Physical therapists or physiatrists
- 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**: For other licensed professionals, such as physicians, podiatrists, PA-Cs, ARNPs, audiologists, and specialty wound centers, refer to the **Physician-Related Services/Health Care Professional Services Billing Guide** and **Outpatient Hospital Services Billing Guide**.

Coverage

When does the Health Care Authority pay for outpatient rehabilitation?

The Health Care Authority pays for outpatient rehabilitation when the services are:

- Covered.
- Medically necessary, as defined in WAC 182-500-0070.
- Within the scope of the eligible client's medical care program.
- Ordered by a physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP).
- Authorized, as required in chapter 182-545 WAC, chapter 182-501 WAC, and chapter 182-502 WAC, and Authorization.
- Begun within 30 days of the date ordered.
- Provided by an approved health professional (see Who may provide outpatient rehabilitation services?).
- Billed according to this billing guide.
- Provided as part of an outpatient treatment program in:
  - An office or outpatient hospital setting.
  - The home, by a home health agency, as described in chapter 182-551 WAC.
  - A neurodevelopmental center, as described in WAC 182-545-900.
  - In any natural setting, if the child is under three and has disabilities. Examples of natural settings include the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

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

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 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 outpatient rehabilitation does the Health Care Authority cover for clients age 20 and younger?

For eligible clients age 20 years and younger, the Health Care Authority covers unlimited outpatient rehabilitation, with the exception of clients age 19 through 20 receiving Medical Care Services (MCS). MCS clients age 19 through 20 have a limited outpatient rehabilitation benefit. See the outpatient benefit limit tables for occupational therapy, physical therapy, and speech therapy for MCS clients.

Which clients receive short-term outpatient rehabilitation coverage?

The Health Care Authority covers outpatient rehabilitation for the following clients as a short-term benefit to treat an acute medical condition, disease, or deficit resulting from a new injury or post-surgery:

- Clients age 19 through 20 receiving MCS
- All clients age 21 and older

What clinical criteria must be met for the short-term outpatient rehabilitation benefit?

Outpatient rehabilitation must:

- Meet reasonable medical expectation of significant functional improvement within 60 days of initial treatment.
- Restore or improve the client to a prior level of function that has been lost due to medically documented injury or illness.
- Meet currently accepted standards of medical practice and be specific and effective treatment for the client's existing condition.
- Include an on-going management plan for the client and/or the client's caregiver to support timely discharge and continued progress.

Washington State Health Care Authority

What are the short-term outpatient rehabilitation benefit limits?

The following are the short-term benefit limits for outpatient rehabilitation for clients age 21 and older, and clients age 19 through 20 receiving MCS. These benefit limits are per client, per calendar year regardless of setting.

- Physical therapy: 24 units (equals approximately 6 hours)
- Occupational therapy: 24 units (equals approximately 6 hours)
- Speech therapy: 6 units (equals a total of 6 untimed visits)

ALWAYS VERIFY AVAILABLE UNITS BEFORE PROVIDING SERVICES

Providers must check with the Health Care Authority to make sure the client has available units. Providers may contact the Health Care Authority's Medical Assistance Customer Services Center (MACSC) toll-free at (800) 562-3022 or by **Webform or email**.

For each **new prescription for therapy** within the same calendar year, whether or not the original units have been exhausted, providers must first obtain an authorization for a new evaluation from the Health Care Authority before providing any further care.

Additional units must be used only for the specific condition they were evaluated or authorized for. Units do not roll over to different conditions.

For occupational therapy (OT) assessments conducted by the Department of Social and Health Services (DSHS), see the **Coverage Table**.

Occupational therapy

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20
benefit limits without prior authorization

Description	Limit	PA?
Occupational Therapy Evaluation	One per client, per calendar year	No
Occupational Therapy Re-evaluation at time of discharge	One per client, per calendar year	No
Occupational Therapy	24 Units (approximately 6 hours), per client, per calendar year	No

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20
additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns – 2nd or 3rd degree only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015

When client's diagnosis is:	Limit	EPA#
Cerebral vascular accident with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Lymphedema	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000008
Major joint surgery – partial or total replacement only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016

When client's diagnosis is:	Limit	EPA#
Reflex sympathetic dystrophy	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Swallowing deficits due to injury or surgery to face, head, or neck	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary	870001416

Physical therapy

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
benefit limits without prior authorization

Description	Limit	PA?
Physical Therapy Evaluation	One per client, per calendar year	No
Physical Therapy Re-evaluation at time of discharge	One per client, per calendar year	No
Physical Therapy	24 Units (approximately 6 hours), per client, per calendar year	No

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Acute, open, or chronic non-healing wounds	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Brain injury with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns – 2nd or 3rd degree only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015

When client's diagnosis is:	Limit	EPA#
Cerebral vascular accident with residual functional deficits within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Lymphedema	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000008
Major joint surgery – partial or total replacement only	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000013
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016

When client's diagnosis is:	Limit	EPA#
Reflex sympathetic dystrophy	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Swallowing deficits due to injury or surgery to face, head, or neck	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000010
Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000012
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **How can I request a limitation extension (LE)?** for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011
One additional evaluation for a new injury or health condition	In addition to the one allowed evaluation, when medically necessary	870001417

Speech therapy

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
benefit limits without prior authorization

Description	Limit	PA?
Speech Language Pathology Evaluation	One per client, per code, per calendar year	No
Speech Language Pathology Re-evaluation at time of discharge	One per client, per evaluation code, per calendar year	No
Speech Therapy	6 Units (approximately 6 hours), per client, per calendar year	No

MCS CLIENTS AGES 19-20 & ALL CLIENTS 21 AND OLDER
additional benefit limits with expedited prior authorization

When client's diagnosis is:	Limit	EPA#
Brain injury with residual functional deficits within the past 24 months	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
Burns of internal organs such as nasal oral mucosa or upper airway	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015
Burns of the face, head, and neck – 2nd or 3rd degree only	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000015

When client's diagnosis is:	Limit	EPA#
Cerebral vascular accident with residual functional deficits within the past 24 months	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000009
New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000014
New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre))	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000016
Speech deficit due to injury or surgery to face, head, or neck	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000017
Speech deficit which requires a speech generating device	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000007

When client's diagnosis is:	Limit	EPA#
Swallowing deficit due to injury or surgery to face, head, or neck	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000010
As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by HCA	Six additional units, per client, per calendar year See How can I request a limitation extension (LE)? for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table.	870000011

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.
- Includes 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.

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.

For those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, refer to the Health Care Authority's **Habilitative Services Billing Guide**.

How do I bill for habilitative services?

See the **Habilitative Services Billing Guide** for details on billing habilitative services.

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
GN = Speech Therapy
RT = Right; **LT** = Left.
GO = Occupational Therapy
TS = Follow-up service

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

Procedure 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	
92605	GN	Eval for rx of nonspeech device 1 hr			X	Limit 1 hour Included in the primary services; Bundled
92606	GN	Nonspeech device service			X	Included in the primary services; Bundled

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92607	GN	Ex for speech device rx 1 hr			X	Limit 1 hour
92608	GN	Ex for speech device rx addl			X	Each additional 30 min Add on to 92607
92609*	GN	Use of speech device service			X	
92610	GN	Evaluate swallowing function			X	No limit
92611	GN	Motion fluoroscopy/swallow			X	No longer limited
92618	GN	Eval for rx of nonspeech device ea addl 30 min			X	Add on to 92605 each additional 30 minutes; Bundled
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
95992*	GP	Canalith repositioning procedure (eg, Epley maneuver)	X			One per client, per day
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*	GP, GO	Paraffin bath therapy	X	X		
97022*	GP	Whirlpool therapy	X			
97024*	GP	Diathermy eg microwave	X			
97026*	GP	Infrared therapy	X			

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97028*	GP	Ultraviolet therapy	X			
97032*	GP, GO	Electrical stimulation	X	X		Timed 15 min units
97033*	GP	Electric current therapy	X			Timed 15 min units
97034*	GP, GO	Contrast bath therapy	X	X		Timed 15 min units
97035*	GP	Ultrasound therapy	X			Timed 15 min units
97036*	GP	Hydrotherapy	X			Timed 15 min units
97039*	GP	Physical therapy treatment	X			
97110*	GP, GO	Therapeutic exercises	X	X		Timed 15 min units
97112*	GP, GO	Neuromuscular re-education	X	X		Timed 15 min units
97113*	GP, GO	Aquatic therapy/exercises	X	X		Timed 15 min units
97116*	GP	Gait training therapy	X			Timed 15 min units
97124*	GP, GO	Massage therapy	X	X		Timed 15 min units
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			One per client per calendar year
97162	GP	PT eval med complex 30 min	X			One per client per calendar year
97163	GP	PT eval high complex 45 min	X			One per client per calendar year
97164	GP	PT re-eval est plan care	X			One per client per calendar year

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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 billing code 0434-97165
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 complex 60 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
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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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 11042-11047.
97602*	GP, GO	Wound(s) care non-selective	X	X		One per client, per day Do not use in combination with 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 (97001) or re-eval (97002)
97755*	GP, GO	Assistive technology assess	X	X		Timed 15 min units
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.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
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.
S9152	GN	Speech therapy re-eval			X	One per client, per evaluation code, per calendar year

Note: For occupational therapists making orthotics, bill using taxonomy 225X00000X and the appropriate procedure code and refer to the coverage table in the Prosthetics and Orthotics Billing Guide for the proper orthotic code. The Health Care Authority does not pay:

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

Washington State Health Care Authority

Where can I find the fee schedule?

Rehabilitation services provided in an office setting are paid according to the Health Care Authority's **outpatient rehabilitation fee schedule**.

Rehabilitation services provided in hospital and hospital-based clinic settings are subject to the Health Care Authority's **outpatient prospective payment system (OPPS) fee schedule and outpatient hospitals fee schedule**.

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

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 rules, this billing guide, and applicable provider notices.

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

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

The Health Care Authority's authorization of service(s) does not guarantee payment.

The Health Care Authority may recoup any payment made to a provider if the Health Care Authority later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100 and WAC 182-544-0560.

How can I request additional units for clients age 21 and older, and clients age 19 through 20 in MCS?

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

Expedited Prior Authorization

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

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

How can I request a limitation extension (LE)?

When clients reach their benefit limit of outpatient rehabilitation (the initial units and any additional EPA units, if appropriate), a provider may request authorization for a limitation extension (LE) from the Health Care Authority.

The Health Care Authority evaluates requests for authorization of covered outpatient rehabilitation 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/or 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.

A completed *Outpatient Rehabilitation Authorization Request* form, HCA 13-786, and all the documentation listed on this form and any other medical justification is required for an LE.

Fax the forms and all documentation to: **866-668-1214**. (See Where can I download HCA forms?)

Washington State Health Care Authority

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.

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, providers, and partners 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	Modifier
Physical Therapy	GP
Physical Therapy Assistant	CQ
Occupational 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
- 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

The outpatient rehabilitation benefit limits for clients age 21 and older and clients age 19 through 20 in MCS apply to the skilled therapy services provided through a Medicare-certified home health agency, as well as therapy provided by physical, occupational, and speech therapists in outpatient hospital clinics and free-standing therapy clinics.

For professional services billed using the electronic 837P format, Physical Therapy performed by physical therapists must be billed separately 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.

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.