Washington State Health Care Authority

Washington Apple Health (Medicaid)

Habilitative Services Program Billing Guide

January 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 January 1, 2020, and supersedes earlier billing 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.

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.

*This guide is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being 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)	Effective January 1, 2020, 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 (IMC).

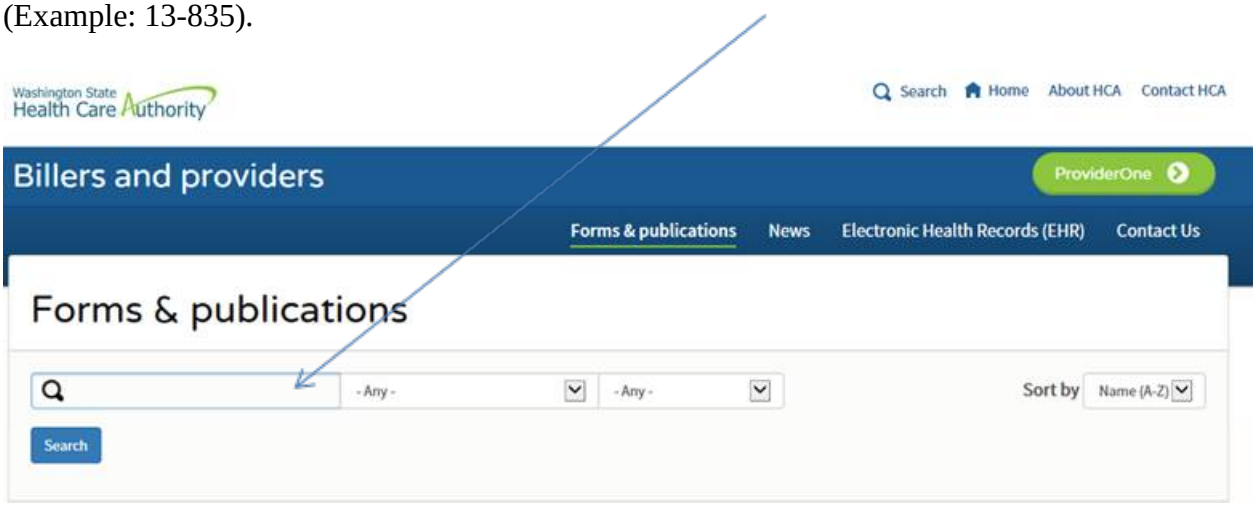
How can I get agency provider documents?

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.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers webpage.
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Accessing agency publications, including Medicaid Billing Guides, provider notices, and fee schedules	
Private insurance or third-party liability	
How do I obtain prior authorization or a limitation extension?	Providers may submit their requests online or by submitting the request in writing. See the agency'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 agency forms, see Where can I download agency forms?
General definitions	See Chapter 182-500 WAC.

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 agency does not require the diagnosis of a specific condition for an eligible client to receive habilitative services.

Client Eligibility

(WAC 182-545-400)

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 agency's current Outpatient Rehabilitation Billing Guide.

How do I verify a client's 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 MCOs 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.

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 the agency 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 the agency'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 the agency'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 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 with an agency-contracted managed care organization eligible?

(WAC 182-538-060 and -095, or WAC 182-538-063 for Medical Care Services clients)

Yes. Most Medicaid-eligible clients are enrolled in one of the agency'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 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 Healthcare. 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 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 (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*?

Provider Eligibility

(WAC 182-545-400)

Who may provide habilitative services?

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

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

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

Coverage

(WAC 182-545-400)

What habilitative services does the agency cover for clients age 20 and younger?

The agency covers unlimited outpatient habilitative services for eligible clients age 20 and younger.

What habilitative services does the agency cover for clients age 21 and older?

The agency 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 agency allows service beyond the limitations described below if authorization is obtained. See Authorization for additional information.

Occupational therapy

CLIENTS 21 & 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 21 & 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 agency	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

Physical therapy

CLIENTS 21 & 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 21 & 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 agency	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 21 & Older Without Prior Authorization		
Description	**Limit**	**PA?**
Speech language pathology evaluation	One per client, per code, per calendar year	No
Speech language pathology re-evaluation at time of discharge	One per client, per evaluation code, per calendar year	No
Speech therapy	6 units (approximately 6 hours), per client, per calendar year	No

CLIENTS 21 & Older: 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 agency.	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.

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 agency'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 agency's ProviderOne Billing and Resource Guide.

Coverage Table

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

The abbreviations used in the modifier column in the table below mean the following: **GP** = Physical Therapy; **GO** = Occupational Therapy; **GN** = Speech Therapy; **TS** = Follow-up service; **RT** = Right; **LT** = Left. An asterisk (*) indicates that a procedure code is included in the benefit limitation for clients age 21 and older.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92521	GN	Evaluation of speech fluency			X	1 per client, per calendar year
92522	GN	Evaluate speech production			X	1 per client, per calendar year
92523	GN	Speech sound lang comprehen			X	1 per client, per calendar year
92524	GN	Behavral qualit analys voice			X	1 per client, per calendar year
S9152	GN	Speech therapy re-eval			X	1 per client, per code: 92521, 92522, 92523, 92524, 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.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
92618	GN	Eval for rx of nonspeech device addl			X	Add on to 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 92607
92609*	GN	Use of speech device service			X	
92610	GN	Evaluate swallowing function			X	No limit
92611	GN	Motion fluoroscopy/swallow			X	No longer limited
92630*	GN	Aud rehab pre-ling hear loss			X	
92633*	GN	Aud rehab post-ling hear loss			X	
95831*	GP, GO	Limb muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
95832*	GP, GO	Hand muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95833*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95834*	GP, GO	Body muscle testing manual	X	X		1 muscle testing procedure, per client, per day. Muscle testing procedures cannot be billed in combination with each other. Can be billed alone or with other PT/OT procedure codes.
95851*	GP, GO	Range of motion measurements	X	X		Excluding hands
95852*	GP, GO	Range of motion measurements	X	X		Including hands
96125*	GP, GO, GN	Cognitive test by hc pro	X	X	X	1 per client, per calendar year
97005		Athletic train eval				NC
97006		Athletic train re-eval				NC
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

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97116*	GP	Gait training therapy	X			Timed 15 min units
97124*	GP, GO	Massage therapy	X	X		Timed 15 min units
97139*	GP	Physical medicine procedure	X			
97140*	GP, GO	Manual therapy	X	X		Timed 15 min units
97150*	GP, GO	Group therapeutic procedures	X	X		
97161	GP	PT eval low complex 20 min	X			Only one of these codes is allowed per client, per calendar year.
97162		PT eval mod complex 30 min	X			
97163		PT eval high complex 45 min	X			
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
97166		OT eval mod complex 45 min		X		
97167		OT eval high complex 60 min		X		
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
97532*	GO, GN	Cognitive skills development		X	X	Timed 15 min units
97533*	GO, GN	Sensory integration		X	X	Timed 15 min units

Procedure Code	Modifier	Short Description	PT	OT	SLP	Comments
97535*	GP, GO	Self care mngment training	X	X		Timed 15 min units
97537*	GP, GO	Community/work reintegration	X	X		Timed 15 min units
97542	GP, GO	Wheelchair mngment training	X	X		1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
97545		Work hardening				NC
97546		Work hardening add-on				NC
97750*	GP, GO	Physical performance test	X	X		Do not use to bill for an evaluation (97001) or re-eval (97002)
97755	GP, GO	Assistive technology assess	X	X		Timed 15 min units
97760*	GP, GO	Orthotic mgmt and training	X	X		Two 15-minute units, per client, per day. Can be billed alone or with other PT/OT procedure codes.
97799*	GP, GO & RT or LT	Physical medicine procedure	X	X		Use this code for custom hand splints. 1 per hand, per calendar year. Use modifier to indicate right or left hand. Documentation must be attached to claim.

Note: In addition to standard billing modifiers, use the informational SZ modifier to denote habilitative services provided on or after July 1, 2014.

The agency 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 the agency for the services.

Payment

When does the agency pay for outpatient habilitative services?

The agency pays for outpatient habilitative services that are:

- Covered within the scope of the client's alternative benefit plan under WAC 182-501-0060.
- Medically necessary.
- Within currently accepted standards of evidence-based medical practice.
- Ordered by a physician, physician assistant, or an advanced registered nurse practitioner.
- Begun within thirty calendar days of the date ordered.
- Provided by one of the health professionals listed in subsection (3) of this section.
- Authorized under chapters 182-501, 182-502, and section 182-545-400 WAC, and the agency's published Medicaid billing guides and published provider notices.
- Billed under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published Medicaid billing guides and published provider notices.
- Provided as part of a habilitative treatment program in one of the following locations:
    - ✓ 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

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

Fee schedule

Habilitative services are paid according to the agency's fee schedule.

Authorization

What are the general guidelines for authorization?

- When a service requires authorization, the provider must properly request authorization in accordance with the agency's rules, this billing guide, and applicable provider notices.
- When the provider does not properly request authorization, the agency returns the request to the provider for proper completion and resubmission. The agency does not consider the returned request to be a denial of service.
- Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for using the expedited prior authorization (EPA) code or limitation extension (LE).
- The agency's authorization of service(s) does not guarantee payment.
- The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100(1)(c) and WAC 182-544-0560(7).

When is the expedited prior authorization (EPA) process used?

When a client meets the criteria for additional units of habilitative services, 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).

For EPA, 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 authorization.

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 agency.

The agency 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 agency's prior authorization webpage for details.

Fax the forms and all documentation to: **866-668-1214**

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 referring and 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 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.

What are the general billing requirements?

These 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 free-standing therapy clinics.

Use billing and servicing taxonomy specific to the service being billed. Do not mix modalities on the same claim. For example, use the billing and servicing taxonomy for physical therapy when billing physical therapy services. Do not bill occupational therapy or speech therapy on the same claim as physical therapy services.

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.

Home health agencies

Home Health Agencies must use the following procedure codes and modifiers when billing the agency for habilitative services:

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

See the agency'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 agency for habilitative services:

Modality	Revenue Code	Modifiers
Physical Therapy	042X	GP
Occupational Therapy	043X	GO
Speech Therapy	044X	GN

See the agency'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 on or after July 1, 2014.