

Health and Recovery Services Administration (HRSA)



Speech/Audiology Program

**Billing Instructions
for
Audiologists and Speech-Language Pathologists**

(WAC 388-545-0700)

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About this publication

This publication supersedes all previous billing instructions for Speech Therapy Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School Medical Services
- Neurodevelopmental Centers
- Outpatient Hospital

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Important Contacts

How do I apply for a provider number?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H **360.664.0300**
I-O **360.753.4712**
P-Z **360.753.4711**

Where do I send hardcopy claims?

Division of Healthcare Services
PO Box 9248
Olympia WA 98507-9248

How do I request billing instructions?

Check out our website:

<http://maa.dshs.wa.gov>

or write/call:

Provider Relations
PO Box 45562
Olympia WA 98504-5562
800.562.3022

Who do I call if I have questions regarding...

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations
800.562.3022 (Select Option #2)

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits
800.562.6136

Electronic billing?

<http://maa.dshs.wa.gov/ecs>

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Client - An applicant for, or recipient of, DSHS medical care programs.

Department - The state Department of Social and Health Services (DSHS).
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) - A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Health Care Financing Administration (HCFA)

Health Maintenance Organization (HMO) - An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.
[WAC 388-500-0005]

Managed Care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.
(WAC 388-538-001)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to person's eligible for the:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. [WAC 388-500-0005]

Medical Identification (ID) card – Medical Identification (ID) cards are the forms DSHS use to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. [WAC 288-500-0005]

Primary Care Case Manager (PCCM) – A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Program Support, Division of (DPS) - The division within the Health and Recovery Services Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

Provider, or Provider of Service - An institution, agency, or person:

- (a) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- (b) Eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number - A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with the Health and Recovery Services Administration.

Remittance and Status Report - A report produced by the claims processing system in the HRSA Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Client Eligibility

Who is eligible? [WAC 388-545-0700 (2)]

Clients presenting Medical ID Cards with the following identifiers **are eligible** for services under the Speech/Audiology Program:

- **CNP** (Categorically Needy Program)
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)
 - ✓ Only clients 20 years of age or younger; or
 - ✓ Clients receiving home health care services only

Who is not eligible?

Clients presenting Medical ID Cards with the following identifiers **are not eligible** for services under the Speech/Audiology Program:

- **Family Planning Only** (Limited Coverage)
- **QMB Medicare Only**

Are clients enrolled in managed care eligible?

YES! Clients with an identifier in the HMO column on their Medical ID Card are enrolled in one of HRSA's Healthy Options managed care plans and must receive all speech/audiology services directly through their Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their Medical ID Card.

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Coverage

HRSA pays only for covered speech/audiology services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- For conditions which are the result of medically recognized diseases and defects;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What is covered? [WAC 388-545-0700 (4)]

Unlimited speech/audiology visits for clients 20 years of age and younger.

HRSA covers the following services per client, per calendar year:

- One (1) medical diagnostic evaluation;
- Speech Therapy Re-Evaluation (CPT code S9152);

Allowed once per calendar year, per client. Use CPT code S9152 when billing for the re-evaluation of a client who has been under a plan of care established by a physician or speech therapist. This re-evaluation is to assess the client's condition and revise the client's plan of care.

- Twelve (12) speech/audiology program visits; and
- Twenty-four (24) additional speech/audiology program visits (see next page).

Additional Coverage (Client 21 years of age and older) [WAC 388-545-0700 (4)(e)]

HRSA will cover a maximum of 24 speech/audiology program visits in addition to the original 12 visits **only** when billed with one of the following **principle** HCPCS diagnosis codes.

HCPCS Diagnosis Codes	Condition
237.7-237.72	Neurofibromatosis
315.3-315.39, 315.5-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
315.4,	Severe oral/motor dyspraxia
335.20	Amyotrophic lateral sclerosis (ALS)
340	Multiple sclerosis
343-343.9	Cerebral palsy (CP)
344.0	Quadriplegia
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
388.45	Acquired auditory processing disorder
436	Acute, but ill-defined, cerebrovascular disease
741.9	Meningomyelocele
749-749.25	Cleft palate and cleft lip
758.0	Down's syndrome
781.3	Lack of coordination
784.3	Severe aphasia
784.5	Other speech disturbance (severe Dysarthria)
787.2 – 787.29	Dysphagia
800-800.9	Fracture of vault of skull
801-801.9	Fracture of base of skull
803-803.9	Other and unqualified skull fractures
804-804.9	Multiple fractures involving skull or face with other bones
806.0-806.19	Fracture of cervical column, closed or open
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
851.1-851.9	Cerebral laceration and contusion
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
853-853.1	Other and unspecified intracranial hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature
900-900.9	Injury to blood vessels of head and neck
941.33,941.35,941.38,	Severe burn of face, head, and neck
941.43,941.45,941.48,	
941.53,941.55,941.58	
946.3-946.5	Burns of multiple specified sites
947.0-947.2	Burn of internal organs
952.0-952.09	Spinal cord injury without evidence of spinal bone injury-cervical

Are school medical services covered?

HRSA covers speech/audiology services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to HRSA's *School Medical Services Billing Instructions*. (See *Important Contacts*.)

What is not covered? [WAC 388-545-0700 (6)]

HRSA does not cover speech/audiology 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.

Fee Schedule

You may view HRSA's **Speech and Audiology Program Fee Schedule** on-line at

<http://maa.dshs.wa.gov/RBRVS/Index.html>

Speech and Audiology Coverage Table

Note: Due to its licensing agreement with the American Medical Association, HRSA publishes only the official, brief CPT™ code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
Audiologists and Speech Therapy Pathologists				
92506		Speech/hearing evaluation		Limit of one per year, per client
92507*		Speech/hearing therapy		
92508*		Speech/hearing therapy		
92551		Pure tone hearing test, air		
92611		Motion fluoroscopy/swallow		
92630		Aud rehab pre-ling hear loss		
92633		Aud rehab postling hear loss		
97532*		Cognitive skills development		One 15 minute increment equals one visit
97533*		Sensory integration		One 15 minute increment equals one visit
Audiologists				
69210		Remove impacted ear wax		
92541	26	Spontaneous nystagmus test		
92541	TC	Spontaneous nystagmus test		
92541		Spontaneous nystagmus test		
92542	26	Positional nystagmus test		
92542	TC	Positional nystagmus test		
92542		Positional nystagmus test		
92543	26	Caloric vestibular test		
92543	TC	Caloric vestibular test		
92543		Caloric vestibular test		
92544	26	Optokinetic nystagmus test		
92544	TC	Optokinetic nystagmus test		
92544		Optokinetic nystagmus test		

An asterisk (*) means the code is included in the 12 visit limitation (applies to clients 21 and over).

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B.5

Coverage Table

Memo 07-19

Speech/Audiology Program

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists Continued				
92545	26	Oscillating tracking test		
92545	TC	Oscillating tracking test		
92545		Oscillating tracking test		
92546	26	Sinusoidal rotational test		
92546	TC	Sinusoidal rotational test		
92546		Sinusoidal rotational test		
92547		Supplemental electrical test		
92552		Pure tone audiometry, air		
92553		Audiometry, air & bone		
92555		Speech threshold audiometry		
92556		Speech audiometry, complete		
92557		Comprehensive hearing test		
92567		Tympanometry		
92568		Acoustic reflex testing		
92569		Acoustic reflex decay test		
92579		Visual audiometry (vra)		
92582		Conditioning play audiometry		
92584		Electrocochleography		
92585	26	Auditor evoke potent, compre		
92585	TC	Auditor evoke potent, compre		
92585		Auditor evoke potent, compre		
92586		Auditor evoke potent, limit		
92587	26	Evoked auditory test		
92587	TC	Evoked auditory test		
92587		Evoked auditory test		
92588	26	Evoked auditory test		
92588	TC	Evoked auditory test		
92588		Evoked auditory test		
92601		Cochlear implt f/up exam < 7		
92602		Reprogram cochlear implt < 7		
92603		Cochlear implt f/up exam 7 >		
92604		Reprogram cochlear implt 7 >		
92620		Auditory function, 60 min		

Speech/Audiology

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists Continued				
92621		Auditory function, + 15 min		
92625		Tinnitus assessment		
92626		Eval aud rehab status		
92627		Eval aud status rehab add-on		
Speech Language Pathologists Only				
S9152		Speech therapy re-eval		One per calendar year per client.
92526		Oral function therapy		
92597		Oral speech device eval		
92605		Eval for nonspeech device rx		Included in the primary services. Bundled service
92606		Non-speech device service		
92607		Ex for speech device rx, 1hr		
92608		Ex for speech device rx addl		
92609		Use of speech device service		
92610		Evaluate swallowing function		
96125		Cognitive test by hc pro		Limit: One hour per calendar year, per client

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Speech-Language Pathology

For HRSA to pay for speech-language therapy, a client must have a medically recognized disease or defect which requires speech-language therapy services.

Who is eligible to provide speech-language therapy? [WAC 388-545-0700 (1)(a)(b)]

Speech-language therapy must be provided by a speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Language, and Hearing Association or by an individual who has completed the equivalent educational and work experience necessary for such a certificate.

Swallowing Evaluations

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

- Holds a master's degree in speech-language pathology; and
- 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; and
- (May include) A videofluoroscopy for further evaluation of swallowing status and aspiration risks.

Visit Limitations

NOTE: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

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

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other speech-language allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.
- HRSA allows evaluation of speech (CPT procedure code 92506) once per year, per client, per provider and it is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.19	Intracranial injury of other and unspecified nature
- Duplicative services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request HRSA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

HRSA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

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Audiology

HRSA may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects.

Who is eligible to provide audiology services?

[WAC 388-545-0700 (1)(c)]

Audiologists who are appropriately licensed or registered to provide speech/audiology services within their state of residence to HRSA clients.

What type of equipment must be used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

What about children with special health care needs?

Refer to HRSA's *Hearing Aid Program Billing Instructions* for information regarding Children with Special Health Care Needs (CSHCN). See *Important Contacts*.

Visit Limitations

Note: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other audiology allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.
- Evaluation of speech (CPT procedure Code 92506) is allowed once per year, per client, per provider and is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature

- For caloric vestibular testing (CPT procedure code 92543), bill one unit per irrigation. If necessary, you may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT procedure code 92546), bill 1 unit per velocity/per direction. If necessary, you may bill up to 3 units for each direction.

How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request HRSA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

Division of Healthcare Services
Medical Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

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Billing

What is the time limit for billing?

State law requires that you present your final bill to HRSA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill HRSA within 365 days after you provide a service(s).
- **For clients who are not eligible at the time of service, but are later found to be eligible:** Bill HRSA within 365 days from the Retroactive¹ or Delayed² certification period.
- **HRSA will not pay if:**
 - ✓ The service or product is not covered by HRSA;
 - ✓ The service or product is not medically necessary;
 - ✓ The client has third party coverage, and the third party pays as much as, or more than HRSA allows for the service or product; or
 - ✓ HRSA is not billed within the time limit indicated above.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

¹ **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for these services.

² **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the Medical ID Card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill HRSA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID Card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits at 800.562.6136.

How do I bill for clients who are eligible for both Medicare and Medicaid?

Some Medicaid clients are also eligible for Medicare benefits. When you have a client who is eligible for both Medicaid **and** Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payer of claims.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. HRSA will pay up to Medicare's Allowable or HRSA's allowable, whichever is less.

An **X** in the *Medicare* area on the client's Medical ID Card (area 9) indicates Medicare enrollment.

QMB (Qualified Medicare Beneficiaries Program Limitations):

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

- If the client has a CNP or MNP Medical ID Card in addition to the QMB Medical ID Card, and the service you provide is covered by Medicare *and* Medicaid, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- HRSA will also reimburse for services that are *not* covered by Medicare but *are* covered under the CNP or MNP program.

QMB-MEDICARE Only (Qualified Medicare Beneficiaries)

The reimbursement criteria for this program is as follows:

- If Medicare **and** Medicaid cover the service, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- If only Medicare and **not** Medicaid covers the service, HRSA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- If Medicare does not cover or denies the service, HRSA will **not** reimburse for it.

What records does HRSA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Health and Recovery Services Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and shall include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006**, HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA’s current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA’s website at:
<http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html>

The following 1500 claim form instructions relate to **Speech and Audiology Billing Instructions**. Click the link above to view general 1500 claim form instructions.

HRSA requires HRSA-approved Family Planning providers to list the National Drug Code (NDC) number **on all drug claims** and the amount of drug given to the client in Box 19 of the 1500 claim form, or in the *Comments* section of the electronic 1500 claim form, when billing for an unlisted contraceptive identified by an EPA number.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

Field No.	Name	Field Required	Entry
19.	Reserved for Local Use		Enter “T” for school contracted services that are noted in the client’s IEP or IFSP.

Speech/Audiology Program

Field No.	Name	Field Required	Entry										
24B.	Place of Service	Yes	<p>These are the only appropriate codes for this program:</p> <table> <tr> <td>Code Number</td> <td>To Be Used For</td> </tr> <tr> <td>22</td> <td>Outpatient</td> </tr> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>99</td> <td>Other</td> </tr> </table>	Code Number	To Be Used For	22	Outpatient	11	Office	12	Home	99	Other
Code Number	To Be Used For												
22	Outpatient												
11	Office												
12	Home												
99	Other												
24C.	Type of Service	Yes	Enter a 3 for all services billed.										
24D.	Procedures, Services or Supplies CPT/HCPCS	Yes	Enter the appropriate HCPCS Common Procedure Coding System procedure code for the services being billed.										

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark “XO,” in box 19 on crossover claim?

A: The “XO” allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the 1500 claim form.

Q: What fields do I use for 1500 Medicare information?

A: In Field:

Please Enter:

19

an “XO”

24D

total combined coinsurance and deductible

24K

Medicare’s allowed charges

29

Medicare’s total deductible

30

Medicare’s total payment

32

Medicare’s EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to HRSA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate “XO.”

Q: How do my claims reach Medicaid?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to HRSA for any supplemental Medicaid payment. When the words, “*This information is being sent to either a private insurer or Medicaid fiscal agent,*” appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the HRSA Remittance and Status Report within 30 days of the Medicare statement date, you should bill HRSA on the 1500 claim form.

If **Medicare denies** a service, bill HRSA using the 1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to HRSA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

Completing the 1500 Claim Form for Medicare Part B/Medicaid Crossovers

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at:
<http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html>

The following 1500 Claim Form instructions relate to Medicare Part B/Medicaid Crossovers, see link above for general 1500 Claim Form instructions.

Note: The 1500 Claim Form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

Field No.	Name	Field Required	Entry										
19.	Reserved For Local Use	Yes	When Medicare allows services, enter <i>XO</i> to indicate this is a crossover claim.										
22.	Medicaid Resubmission		When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).										
24B.	Place of Service	Yes	These are the only appropriate codes for this program: <table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Code Number</th> <th>To Be Used For</th> </tr> </thead> <tbody> <tr> <td>22</td> <td>Outpatient</td> </tr> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>99</td> <td>Other</td> </tr> </tbody> </table>	Code Number	To Be Used For	22	Outpatient	11	Office	12	Home	99	Other
Code Number	To Be Used For												
22	Outpatient												
11	Office												
12	Home												
99	Other												
24C.	Type of Service	Yes	Enter a 3 .										

Speech/Audiology Program

Field No.	Name	Field Required	Entry
24D.	Procedures, Services or Supplies CPT/HCPCS	Yes	Enter the appropriate HCPCS Common Procedure Coding System procedure code for the services being billed. Coinsurance and Deductible: Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.
24K.	Reserved for Local Use	Yes	Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).
27.	Accept Assignment	Yes	Check yes .
29.	Amount Paid	Yes	Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. Do not include coinsurance here.
30.	Balance Due	Yes	Enter the Medicare Total Payment . Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple 1500 claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. Do not include coinsurance here.
32.	Name and Address of Facility Where Services Are Rendered	Yes	Enter Medicare Statement Date <i>and</i> any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). Do not include coinsurance here.