

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Occupational Therapists
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 02-41 MAA
Issued: June 25, 2002

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supercedes: 01-36 MAA

Subject: Update to the RBRVS* and Vendor Rate Increase for the Occupational Therapy Program

Effective for dates of service on and after July 1, 2002, MAA will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2002 relative value units (RVUs);
- The Year 2002 additions of Current Procedural Terminology (CPT™) codes;
- Changes to the Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes;
- Technical changes; and
- A legislatively appropriated one and one-half (1.5) percent vendor rate increase.

Maximum Allowable Fees

In updating the fee schedule with Year 2002 RVUs, the Medical Assistance Administration (MAA) maintained overall budget neutrality. The 2001-2003 Biennium Appropriations Act authorizes this one and one-half (1.5) percent vendor rate increase for MAA fee-for-service programs. The maximum allowable fees have been adjusted to reflect the changes listed above.

Technical Changes

- CPT codes 97520, 97535, and 97537 are added to those billable by Occupational Therapists under those services subject to the 12-visit limitation.
- State-unique procedure code 0002M is added to those billable by Occupational Therapists under those services that are not subject to the 12-visit limitation.
- MAA clarified documentation requirements for timed visits.

Attached are updated replacement pages 7-10 for MAA's Occupational Therapy Billing Instructions, dated July 1999. To obtain this fee schedule electronically, go to MAA's website at <http://maa.dshs.wa.gov> (click on the Provider Publications/Fee Schedule link).

Bill MAA your usual and customary charge.

* RBRVS stands for Resource-Based Relative Value Scale

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Superseded

Visit Limitations

Visits are based on the CPT 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 code description the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered occupational therapy program visits and are part of the 12-visit limitation:

- Therapeutic exercises (CPT code 97110);
- Neuromuscular re-education (CPT code 97112);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530);
- Self-care/home management training (CPT code 97535); and,
- Community/work reintegration training (CPT code 97537).



Note: Two 15-minute increments, in any combination (same or different) of the above codes, will be counted as one occupational therapy visit.

- Cognitive Skills (CPT codes 97532 and 97533).



Note: Each 15-minute increment of cognitive skills will be counted as one occupational therapy program visit.

The following are not included in the 12-visit limitation:

- Evaluation of occupational therapy (CPT code 97003). Allowed once per calendar year, per client.
- Checkout for orthotic/prosthetic use (CPT code 97703). Two 15-minute increments are allowed per day. Procedure code 97703 can be billed alone or with other occupational therapy allowed CPT codes.
- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two 15-minute increments are allowed per assessment.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two 15-minute increments are allowed per day. Procedure code 97504 can be billed alone or with other occupational therapy CPT codes.
- Custom splints (cockup and/or dynamic) (State-unique procedure code 0002M).

Duplicate 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).

(CPT codes and descriptions are copyright 2001 American Medical Association.)

How do I request approval to exceed the limits?

For clients 21 years of age and older who need occupational therapy in addition to that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits.

Limitation extensions (LE) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services. For example: therapies are not covered under the medically indigent (MI) program.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instruction and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers will be subject to post payment review.

In cases where the EPA criteria cannot be met and the provider still feels that additional services are medically necessary, the provider must request MAA approval for limitation extension. The request must state the following in writing:

1. The name and Patient Identification Code (PIC) of the client;
2. The therapist's name, provider number, and fax number;
3. The prescription for therapy;
4. The number of visits used during that calendar year;
5. The number of additional visits 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 CPT code; and
10. The place of service.

Send your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

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Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an “EPA” number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must create a **9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for additional occupational therapy visits for a client who has used 12 OT visits this calendar year and subsequently has had knee surgery would be **870000644** (**870000** = first six digits of all expedited prior authorization numbers, **644** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must maintain documentation in the client’s file to support how the expedited criteria were met, and have this information available to MAA on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Occupational Therapy (OT) LEs

OCCUPATIONAL THERAPY

CPT: 97110, 97112, 97520, 97530, 97532, 97533, 97535, 97537

Code	Criteria
644	<p><u>An additional 12 Occupational Therapy</u> visits when the client has already used the allowed visits for the current year and has one of the following:</p> <ol style="list-style-type: none">1. Hand\Upper Extremity Joint Surgery2. CVA not requiring acute inpatient rehabilitation
645	<p><u>An additional 24 Occupational Therapy</u> visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.</p>

Are school medical services covered?

MAA covers occupational therapy 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 MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-0300 (7)]

MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is no limited to, hospital inpatient and nursing facility services.

(CPT procedure codes and descriptions are copyright 2001 American Medical Association.)

Fee Schedule

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

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable	
		Non Facility Setting	Facility Setting
64550	Apply neurostimulator	\$17.06	\$5.92
97003	OT evaluation	43.68	35.26
97110	Therapeutic exercises	16.38	16.38
97112	Neuromuscular reeducation	17.06	17.06
97504	Orthotic training	16.38	16.38
97520	Prosthetic training	15.24	15.24
97530	Therapeutic activities	20.70	20.70
97532	Cognitive skills development	13.88	13.88
97533	Sensory Integration	15.02	15.02
97535	Self care mngmt training	18.43	18.43
97537	Community/work reintegration	15.02	15.02
97703	Prosthetic checkout	16.15	16.15
0002M*	Custom splints (cockup and/or dynamic)	47.76	47.76

*State-unique code

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Billing

What is the time limit for billing?

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

- **For eligible clients:** Bill MAA 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 on the date of service:** Bill MAA within 365 days from the Retroactive¹ or Delayed² certification period.
- **MAA will not pay if:**
 - ✓ The service or product is not covered by MAA;
 - ✓ 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 MAA allows for the service or product; or
 - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

¹ **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person is 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 MAA 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 MAID 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 MAA for those services.