

Chapter 182-545 WAC **THERAPIES**

Last Update: 3/27/19

WAC

182-545-200	Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy).
182-545-400	Habilitative services.
182-545-900	Neurodevelopmental centers.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-545-300	Occupational therapy. [WSR 11-14-075, recodified as § 182-545-300, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. WSR 10-13-167, § 388-545-300, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.] Repealed by WSR 11-21-066, filed 10/17/11, effective 11/17/11. Statutory Authority: RCW 41.05.021.
182-545-500	Physical therapy. [WSR 11-14-075, recodified as § 182-545-500, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. WSR 10-13-167, § 388-545-500, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.] Repealed by WSR 11-21-066, filed 10/17/11, effective 11/17/11. Statutory Authority: RCW 41.05.021.
182-545-700	Speech/audiology services. [WSR 11-14-075, recodified as § 182-545-700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-545-700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. WSR 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.] Repealed by WSR 11-21-066, filed 10/17/11, effective 11/17/11. Statutory Authority: RCW 41.05.021.

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the medicaid agency, as defined in WAC 182-500-0010, to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible clients:

- (a) A physiatrist;
- (b) A licensed occupational therapist;
- (c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
- (d) A licensed physical therapist;
- (e) A physical therapist assistant supervised by a licensed physical therapist;
- (f) A licensed speech-language pathologist; and
- (g) A licensed optometrist to provide vision occupational therapy only.

(2) Clients covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter.

(3) Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through their agency-contracted MCO.

(4) The agency pays for outpatient rehabilitation when the services are:

- (a) Covered;
- (b) Medically necessary;
- (c) Within the scope of the eligible person's medical care program;
- (d) Ordered by:
 - (i) A physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP); or

(ii) An optometrist, if the ordered services are for occupational therapy only.

(e) Within currently accepted standards of evidence-based medical practice;

(f) Authorized, as required within this chapter, under chapters 182-501 and 182-502 WAC and the agency's published billing instructions;

(g) Begun within thirty calendar days of the date ordered;

(h) Provided by one of the health professionals listed in subsection (1) of this section;

(i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions; and

(j) Provided as part of an outpatient treatment program:

(i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC;

(iii) In a neurodevelopmental center, as described in WAC 182-545-900; or

(iv) For children with disabilities, age two or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(5) For eligible clients age twenty and younger, the agency covers unlimited outpatient rehabilitation.

(6) For clients age twenty-one and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for clients age twenty-one and older must:

(a) Restore, improve, or maintain the person's level of function that has been lost due to medically documented injury or illness; and

(b) Include an ongoing management plan for the client or the client's caregiver to support timely discharge and continued progress.

(8) For eligible clients age twenty-one and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per person, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge; and

(C) Twenty-four units of occupational therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The client's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual cognitive or functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual cognitive or functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Swallowing deficits due to injury or surgery to the face, head, or neck;

(XI) Spinal cord injury that occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per person, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to twenty-four additional units of physical therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(c) Speech therapy, per person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

- (B) The person's diagnosis is any of the following:
- (I) Brain injury, which occurred within the past twenty-four months, with residual cognitive or functional deficits;
 - (II) Burns of internal organs such as nasal oral mucosa or upper airway;
 - (III) Burns of the face, head, and neck - Second or third degree only;
 - (IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;
 - (V) Muscular-skeletal disorders such as complex fractures that require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;
 - (VI) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre));
 - (VII) Speech deficit due to injury or surgery to the face, head, or neck;
 - (VIII) Speech deficit that requires a speech generating device;
 - (IX) Swallowing deficit due to injury or surgery to the face, head, or neck; or
 - (X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.
- (d) Durable medical equipment (DME) needs assessments, two per person, per year.
- (e) Orthotics management and training of upper or lower extremities, or both, two program units, per person, per day.
- (f) Orthotic or prosthetic use, two program units, per person, per year.
- (g) Muscle testing, one procedure, per person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.
- (h) Wheelchair needs assessment, one per person, per year.
- (9) For the purposes of this chapter:
- (a) Each fifteen minutes of timed procedure code equals one unit; and
 - (b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.
- (10) For expedited prior authorization (EPA):
- (a) A provider must establish that:
 - (i) The person's condition meets the clinically appropriate EPA criteria outlined in this section; and
 - (ii) The services are expected to result in a reasonable improvement in the person's condition and achieve the person's therapeutic individual goal within sixty calendar days of initial treatment;
 - (b) The appropriate EPA number must be used when the provider bills the agency;
 - (c) Upon request, a provider must provide documentation to the agency showing how the person's condition met the criteria for EPA; and
 - (d) A provider may request expedited prior authorization once per year, per person, per each therapy type.
- (11) If the client does not meet the EPA clinical criteria in this section, the agency uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

(12) The agency evaluates limitation extension (LE) requests regarding scope, amount, duration, and frequency of covered health care services under WAC 182-501-0169. Providers may submit LE requests for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) A new qualifying condition arises after the initial six visits are used.

(13) Duplicate services for outpatient rehabilitation are not allowed for the same person when both providers are performing the same or similar procedure(s).

(14) The agency does not pay separately for outpatient rehabilitation 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.

(15) The agency does not reimburse a health care professional for outpatient rehabilitation 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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 18.35.040. WSR 18-09-052, § 182-545-200, filed 4/13/18, effective 5/14/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-03-042, § 182-545-200, filed 1/14/16, effective 2/14/16. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (Public Law 111-148). WSR 14-07-042, § 182-545-200, filed 3/12/14, effective 4/12/14. Statutory Authority: RCW 41.05.021. WSR 11-21-066, § 182-545-200, filed 10/17/11, effective 11/17/11.]

WAC 182-545-400 Habilitative services. (1) Habilitative services assist the client in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition. To the extent practical, habilitative services maximize the client's ability to function in the client's environment.

(2) Eligibility is limited to clients who are enrolled in the Washington apple health alternative benefits plan defined in WAC 182-501-0060. Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for habilitative services through their MCO.

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

(a) Physiatrists;

(b) Occupational therapists;

(c) Occupational therapy assistants supervised by a licensed occupational therapist;

(d) Physical therapists;

(e) Physical therapy assistants supervised by a licensed physical therapist;

(f) Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech-Language-Hearing Association; and

- (g) Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate.
- (4) The agency pays for habilitative services that are:
- (a) Covered within the scope of the client's alternative benefits plan under WAC 182-501-0060;
- (b) Medically necessary;
- (c) Within currently accepted standards of evidence-based medical practice;
- (d) Ordered by a physician, physician assistant, or an advanced registered nurse practitioner;
- (e) Begun within thirty calendar days of the date ordered;
- (f) Provided by one of the health care professionals listed in subsection (3) of this section;
- (g) Authorized under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published provider guides;
- (h) Billed under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published provider guides; and
- (i) Provided as part of a habilitative treatment program:
- (i) In an office or outpatient hospital setting;
- (ii) In the home, by a home health agency as described in chapter 182-551 WAC; or
- (iii) In a neurodevelopmental center, as described in WAC 182-545-900.
- (5) For billing purposes under this section:
- (a) Each fifteen minutes of timed procedure code equals one unit.
- (b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.
- (c) Duplicate services for habilitative services are not allowed for the same client when both providers are performing the same or similar procedure on the same day.
- (d) The agency does not pay 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.
- (6) The limitations in subsection (7) of this section do not apply to eligible clients under age twenty-one.
- (7) For eligible clients age twenty-one and older, the agency covers habilitative services that include an ongoing management plan for the client or the client's caregiver to support continued client progress. The agency limits habilitative services as follows:
- (a) Occupational therapy, per client, per year:
- (i) Without authorization:
- (A) One occupational therapy evaluation;
- (B) One occupational therapy reevaluation at time of discharge;
- and
- (C) Twenty-four units of occupational therapy (which equals approximately six hours).
- (ii) With expedited prior authorization (EPA), up to twenty-four additional units of occupational therapy may be available when the therapy is required as part of an initial botulinum toxin injection protocol for spasticity or dystonia and botulinum toxin has been authorized by the agency.
- (b) Physical therapy, per client, per year:
- (i) Without authorization:
- (A) One physical therapy evaluation;
- (B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy (which equals approximately six hours).

(ii) With EPA, up to twenty-four additional units of physical therapy may be available when the therapy is required as part of an initial botulinum toxin injection protocol for spasticity or dystonia and botulinum toxin has been authorized by the agency.

(c) Speech therapy, per client, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy (which equals approximately six hours).

(ii) With EPA, up to six additional units of speech therapy may be available when:

(A) The therapy is required as part of an initial botulinum toxin injection protocol for spasticity or dystonia and botulinum toxin has been authorized by the agency; or

(B) The client has a speech deficit which requires a speech generating device.

(d) Two durable medical equipment needs assessments, per client, per year. The agency covers devices and other durable medical equipment for habilitative purposes under chapter 182-543 WAC.

(e) Two program units of orthotics management and training of upper and lower extremities, per client, per day.

(f) Two program units for the provider to assess prosthetic or orthotic use, per client, per year.

(g) One muscle testing procedure, per client, per day.

(h) One wheelchair-needs assessment, per client, per year.

(8) The agency evaluates requests for habilitative services that exceed the limitations in this section under WAC 182-501-0169, for clients age twenty-one and older. For clients age nineteen and twenty, the agency evaluates such requests for medical necessity under chapter 182-534 WAC. The agency requires prior authorization for additional units when:

(a) The criteria for EPA do not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) The provider requests it as a medically necessary service.

(9) The agency does not cover the following:

(a) Day habilitation services designed to provide training, structured activities, and specialized services to adults;

(b) Services to assist basic needs;

(c) Vocational services;

(d) Custodial services;

(e) Respite care;

(f) Recreational care;

(g) Residential treatment;

(h) Social services; and

(i) Educational services of any kind.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-08-027, § 182-545-400, filed 3/27/19, effective 4/27/19; WSR 16-04-026, § 182-545-400, filed 1/25/16, effective 3/1/16.]

WAC 182-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed by the agency;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services for which a neurodevelopmental center may be reimbursed.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, the agency requires a neurodevelopmental center to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to the agency; and

(c) Have an approved core provider agreement with the agency.

(3) Clients age twenty or younger may receive outpatient rehabilitation and habilitative services (occupational therapy, physical therapy, and speech therapy) in agency-approved neurodevelopmental centers.

(4) The agency reimburses neurodevelopmental centers for providing the following services to clients:

(a) Outpatient rehabilitation and habilitative services as described in chapter 182-545 WAC; and

(b) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in the agency's provider guides.

(5) To be reimbursed, neurodevelopmental centers must meet the agency's billing requirements in WAC 182-502-0020, 182-502-0100, and 182-502-0150.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-04-026, § 182-545-900, filed 1/25/16, effective 3/1/16. Statutory Authority: RCW 41.05.021. WSR 11-21-066, § 182-545-900, filed 10/17/11, effective 11/17/11. WSR 11-14-075, recodified as § 182-545-900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-545-900, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.09.080, 74.09.520 and 74.09.530. WSR 01-20-114, § 388-545-900, filed 10/3/01, effective 11/3/01.]