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Update: Uniform Coding for Habilitative and Rehabilitative Services

Background

With the passing of the Affordable Care Act (ACA) in 2010, rehabilitative and habilitative services and devices became one of the ten required Essential Health Benefits (EHBs) required to be covered by healthcare plans. More recently, federal regulations further clarified how these benefits should be covered by defining rehabilitative and habilitative services, requiring parity in coverage limits and requiring separate visit limits for each.[1]

Effective Jan. 1, 2017, visit limits for rehabilitative and habilitative services must not be combined. Therefore, Blue Cross Blue Shield (BCBS) Plans that impose visit limits on their members' rehabilitative and habilitative benefits need to track the services separately for all members, including members accessing care in another Plan's service area, to ensure visit limits are not combined.

Providers that submit claims for habilitative services may need to make a change to their billing practices to support compliance with requirements.

Updated Provider Guidance for Uniform Coding for Habilitative Services

Providers should use the available Healthcare Common Procedure Coding System (HCPCS) modifier SZ (Habilitative Services) when billing habilitative services on claims for BCBS members.

This billing requirement applies to both professional (CMS-1500) and outpatient facility (UB-04) claims. For electronic professional claims, the modifier is coded in the SV1 segment and for electronic facility claims, the modifier is coded in the SV2 segment. Without the (SZ) modifier, the service will be considered rehabilitative. Providers' use of the code modifier allows BCBS Plans to be able to track habilitative and rehabilitative services separately, in order to comply with EHB requirements of the ACA regulations.

[1] See the regulation at 45 CFR § 156.115.

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Current Procedural Terminology (CPT®) codes and CMS' Healthcare Common Procedure Coding System (HCPCS) Level II codes are defined for rehabilitative services (see Appendix). Many of the procedure codes used for rehabilitative services are also used for habilitative services, which do not have a separate set of procedure codes. In 2014, the HCPCS modifier SZ (Habilitative Services) was created for providers to accurately specify when habilitative services are billed. Use of the (SZ) modifier is supported by the situational rule for HIPAA-adopted claim transactions which requires modifiers for procedure codes when they clarify or improve the reporting accuracy of the associated procedure code.

Commonly Asked Questions

- **Do rehabilitative services and habilitative services have legal definitions?**

Yes. Federal regulations include the following definitions for habilitative and rehabilitative services:

Habilitative services. Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/ or outpatient settings.

Rehabilitative services. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.[2]

- **How do I submit claims billed for rehabilitative and habilitative services?**

These claims should be submitted to your local BCBS Plan in the same manner that you currently submit claims with other types of services for other BCBS members.

- **Do I need to make changes to my current billing practices?**

Because the HCPCS code modifier (SZ) was created in 2014, you may already bill with the modifier for habilitative services claims. If you do not currently bill with the (SZ) modifier for habilitative services, you may need to change billing practices to include the modifier on these services to ensure the correct information is received by the member's BCBS Plan and claim can be adjudicated properly.

- **I do not currently bill habilitative services using the SZ modifier. When should I start including this modifier on submitted claims?**

[2] See preamble in the 2016 Notice of Benefit and Payment Parameters (80 FR 10749).

The federal regulation went into effect on January 1, 2017. You should begin billing habilitative services with the SZ modifier as soon as possible.

- **Do all BCBS members have habilitative and rehabilitative benefits?**

You should always verify a member's eligibility and benefits, including applicable pre-authorization requirements, using the information provided on the member's ID card.Though the services are considered Essential Health Benefits (EHBs), not all types of health care plans are required to cover EHBs and actual benefits vary by BCBS Plan.

- **Whom do I contact if I have questions?**

If you have questions, please contact your Premera Provider Network Executive or Provider Network Associate.

Appendix – Additional Resources

- Department of Health and Human Services Notice of Benefit and Payment Parameters for 2016 – Final Rule
- CMS Uniform Codes for Therapy Services