

Washington Apple Health (Medicaid)

Mental Health Services Billing Guide

August 1, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please [email](#) us about the broken link.

About this guide*

This publication takes effect **August 1, 2022**, 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.

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.

Refer also to HCA's [ProviderOne billing and resource guide](#) for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's [provider alerts webpage](#).

To access provider documents, go to HCA's [provider billing guides and fee schedules webpage](#).

Where can I download HCA forms?

To download an HCA form, see HCA's [Forms & Publications](#) webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Telemedicine and coronavirus (COVID-19)	Added references to the information and policy on telehealth, telemedicine, and COVID-19 available on HCA's website	HCA clarified its telehealth and telemedicine policy and created audio-only procedure code lists, consolidating them on HCA's website.
Drug monitoring	Changed the 4 th bullet to read, "Must be provided during a face-to-face <u>an in-person</u> visit with the client unless it is part of a qualified telemedicine visit.	To clarify how the service must be provided

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Resources Available

Topic	Resources
Obtaining prior authorization or a limitation extension	<p>Online submission: Providers may submit prior authorization (PA) and limitation extension requests online through direct data entry into ProviderOne. See HCA's prior authorization webpage for details.</p> <p>Fax/Written: Providers who do not use the online submission may fax their written request to 866-668-1214, along with the following information:</p> <ul style="list-style-type: none"> • A completed, TYPED <i>General Information for Authorization form</i>, HCA 13-835. This request form must be the initial page when you submit your request. • A completed <i>Fax/Written Request Basic Information form</i>, HCA 13-756, and all the documentation listed on this form and any other medical justification. <p>To download forms, see "Where can I download HCA forms?"</p>
Obtaining Apple Health forms	See HCA's Forms & Publications webpage.
Definitions	Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.
Contacting Provider Enrollment	See the Apple Health Billers and Providers Contact Us page.
Becoming a provider or submitting a change of address or ownership	See the Apple Health Billers and Providers webpage.
Finding out about payments, denials, claims processing, or HCA-managed care organizations	See the Apple Health Billers and Providers webpage.
Electronic billing	See the Apple Health Billers and Providers webpage.
Finding provider billing guides, fee schedules, and other HCA documents	See the Apple Health Billers and Providers webpage.
Third-party liability other than HCA managed care	See the Apple Health Billers and Providers webpage.

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Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter [182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

Agency – See **Behavioral health agency**.

Assessment – See WAC [182-538D-0200](#).

Behavioral Health Administrative Service Organization (BH-ASO) – An entity selected by HCA to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

Behavioral health agency – An entity licensed by the Department of Health to provide behavioral health services under Chapter [71.05](#), [71.24](#), or [71.34](#) RCW.

Behavioral Health Services Only (BHSO) – The program in which enrollees receive only behavioral health benefits through a managed care delivery system.

Early and periodic screening, diagnosis and treatment (EPSDT) – See WAC [182-500-0030](#).

Expedited prior authorization (EPA) – See WAC [182-500-0030](#).

Fee-for-service (FFS) – See WAC [182-500-0035](#).

Integrated Managed Care – The program under which a managed care organization provides:

- Physical health services funded by Medicaid; and
- Behavioral health services funded by Medicaid and other available resources provided for in chapters [182-538B](#), [182-538C](#), and [182-538D](#) WAC.

Hospital – See WAC [182-500-0045](#).

Institution for mental diseases (IMD) – See WAC [182-500-0050](#).

Licensed behavioral health agency – See **Behavioral health agency**.

Licensed mental health professional (LMHP) – See WAC [246-809 010](#). For more information, see the [Note box](#) following the Inpatient mental health services coverage table.

Managed care organization (MCO) – See WAC [182-500-0070](#).

Medically necessary – See WAC [182-500-0070](#).

Mental health outpatient services - Services rendered by independently licensed or certified providers who do not access the Provider Entry Portal for billing services that are listed in Part I of this guide.

National correct coding initiative (NCCI) – See WAC [182-500-0075](#).

National Provider Identifier (NPI) – See WAC [182-500-0075](#).

Outpatient – See WAC [182-500-0080](#).

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Post stabilization care – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, to improve or resolve the patient’s condition. For the purposes of the mental health program, emergency services end when patient is ready to discharge from the emergency room and either be released or admitted to an inpatient psychiatric facility.

Prior authorization – See WAC [182-500-0085](#).

Provider – See WAC [182-500-0085](#).

Psychiatric hospital – See WAC [182-550-1050](#).

Psychiatric residential treatment facility (PRTF) – A nonhospital residential treatment center licensed by DOH, and certified by HCA or HCA’s designee to provide psychiatric inpatient services to Medicaid-eligible individuals age twenty-one and younger. A PRTF must be accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) or any other accrediting organization with comparable standards recognized by Washington State. A PRTF must meet the requirements in [42 C.F.R. 483, Subpart G](#), regarding the use of restraint and seclusion.

Specialized mental health services - Services rendered to fee-for-service clients through a licensed and certified Community Mental Health Center (CMHC) enrolled through the Provider Entry Portal (PEP). Clients must have one of the Recipient Aid Categories (RAC) listed in Part II of this guide and cannot be enrolled in integrated managed care or behavioral health services only.

Third-party liability (TPL) – See WAC [182-503-0540](#).

Program Overview

This billing guide describes mental health benefits administered through the Health Care Authority (HCA) that are available to Apple Health clients.

This billing guide is divided into four parts:

Part I describes:

- The set of mental health outpatient services for clients with less complex treatment needs covered by the client's integrated managed care organizations (MCOs) and fee-for-service (FFS).
- Inpatient psychiatric services covered by FFS.

Part II describes:

- The specialized mental health services available to eligible FFS clients with more complex treatment needs and not enrolled in an integrated managed care plan or a managed care plan's behavioral health services only (BHSO) program.
- How fee-for-service clients must be in one of the recipient aid categories (RACs) listed in Part II of this guide. These mental health services are in addition to the mental health outpatient services covered by the client's MCO or FFS program in Part I. Part II is available only if all the following criteria apply:
 - The client is FFS and in one of the RACs in Part II
 - The client is not enrolled in a BHSO or integrated managed care program. See [How are services administered?](#)
 - The provider is a licensed and certified behavioral health agency that is enrolled in the provider entry portal (PEP)

Part III describes:

- Freestanding Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA's Division of Behavioral Health and Recovery (DBHR). **This information does not apply to any other facility.**

Part IV describes:

- How to bill a freestanding treatment and evaluation center.

To determine which services are covered by which payer and who to bill, see [How do providers identify the correct payer?](#)

What services are covered?

Apple Health clients have coverage for behavioral health services dependent on their eligibility coverage. These services may include:

- Mental health services, including crisis, outpatient, and professional services
- Mental health services provided by DOH-licensed behavioral health agencies
- Psychiatric inpatient hospitalization

When may a behavioral health agency bill for take-home naloxone?

A behavioral health agency may bill when an individual receives take-home naloxone from an:

- Inpatient setting upon discharge
- Outpatient clinic

Naloxone must be billed on a separate claim. See the [Prescription Drug Program Billing Guide](#) for more information.

National correct coding initiative

HCA follows the [National Correct Coding Initiative \(NCCI\) policy](#). The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HCA to control improper coding that may lead to inappropriate payment. HCA bases coding policies on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Procedure code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

Medically Unlikely Edits (MUEs) - Part of the NCCI policy are MUEs. MUEs are the maximum unit of service per HCPC or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a "Medically Unlikely Edit." Not all HCPCS or CPT codes are assigned an MUE. HCA adheres to the CMS MUEs for all codes.

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HCA may have units of service edits that are more restrictive than MUEs.

HCA may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system.

Partnership Access Line (PAL) for child mental health

PAL toll-free number (866) 599-7257

The Partnership Access Line (PAL) is a telephone-based child mental health consultation system for Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services.

The PAL team is available to any primary care provider in Washington State. Washington's primary care providers are encouraged to call the PAL toll free number (866) 599-7257 as often as needed. PAL provides rapid consultation responses during business hours (Monday-Friday, 8:00 a.m. to 5:00 p.m.) for any type of children's mental health issue that arises with any child. For more information, see the [Partnership Access Line](#) webpage. Primary care providers are encouraged to call the PAL toll-free number (866) 599-7257 as often as needed.

PAL Family Referral Assistance Line

PAL Family Referral Line is (833) 303-5437

PAL services include Washington's Mental Health Referral Assist Service. This program facilitates referrals to children's mental health services and other resources for parents and guardians with concerns related to the mental health of their child. Facilitation activities include assessing the level of services needed by the child within one to two weeks of receiving a call from a parent or guardian and identifying mental health professionals who are in network health with the child's health plan and accepting new patients. This service coordinates contact between the family and mental health provider and provides post-referral reviews to determine if the child still has unmet needs. The PAL Family Referral Line is (833) 303-5437.

PAL for Moms

The PAL for Moms line is 877-725-4666

PAL for Moms provides psychiatric consultation to health care providers on any mental health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g., pregnancy loss, infertility). PAL for Moms is staffed to respond to calls between 9:00 a.m. and 5:00 p.m. on weekdays. The PAL for Moms line is 877-725-4666.

Psychiatry Consultation Line

The University of Washington Psychiatry Consultation Line (PCL) helps eligible providers who are seeking clinical advice regarding adult patients (age 18 and older) with mental health and/or substance abuse disorders. The program is fast, free, and connects community providers to psychiatrists at the University of Washington (UW).

Providers call 877-WA-PSYCH (877-927-7924) and after a short intake with a UW health navigator, are connected to a UW psychiatrist. At the conclusion of the conversation, the UW psychiatrist sends a brief written documentation of the recommendations to the caller via email.

PCL is staffed 8 a.m. - 5 p.m., Monday through Friday (closed on federal and UW holidays), but providers can call at any time. If calling outside of business hours, providers can leave a message, which will be returned within one working day. The PCL is staffed 24/7.

For more information, [email](#) the PCL or visit the University of Washington [Clinical Care and Consultation webpage](#).

Additional mental-health-related services

The following covered services are explained in other HCA billing instructions and rules:

- [Applied Behavior Analysis \(ABA\) Program Billing Guide](#)
- Alcohol or substance misuse counseling (screening, brief interventions, and referral to treatment) (SBIRT) (See the [Physician-Related Services/Health Care Professional Services Billing Guide](#))
- Collaborative Care Model Guidelines (See the [Physician-Related Services/Health Care Professional Services Billing Guide](#))
- Health and behavior codes when provided by a physician or licensed behavioral health provider. Health and behavior codes (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) are used when the primary [diagnosis](#) is medical and the provider is addressing the behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems. The focus of the assessment is not mental health but on the biopsychosocial factors important to physical health problems and treatments. (See the [Physician-Related Services/Health Care Professional Services Billing Guide](#))
- Screening children for mental health and caregiver depression screening (See [Early and Periodic Screening Diagnosis and Treatment \(EPSDT\) Program Billing Guide](#))
- [Substance Use Disorder Program Billing Guide](#) (Fee-for-Service, Non-Behavioral Health Administrative Services Organization (BH-ASO), or Behavioral Health Services Only (BHSO))
- Tobacco cessation counseling (See the [Physician-Related Services/Health Care Professional Services Billing Guide](#))

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Note: For providers providing evidence-based practice (EBP), including the Positive Parenting Program (Triple P), see [evidence-based practices](#) in this guide.

How are services administered?

Mental health services are available through:

- Licensed professionals with individual Core Provider Agreements who accept payment on a fee-for-service (FFS) basis for providing services to people not enrolled with an integrated managed care organization (MCO) who need mental health outpatient services, as determined by an independently licensed and certified provider.
- Inpatient psychiatric services covered by FFS.
- MCOs under contract with HCA's Apple Health Managed Care program to provide integrated health care service for enrollees, which includes all levels of behavioral health services except crisis services.
- MCOs under their BHSO contract-provide:
 - Specialized mental health care services through a BHSO for FFS clients. Services are provided by a community mental health center. The mental health claim must be billed with a billing taxonomy 261QM0801X or 251S00000X.
Exception: FQHCs and Tribal Health Clinics must refer to respective program specific billing guides for direction on taxonomy billing requirements.
 - For mental health outpatient services, bill HCA as described in [Part I](#) of this guide.
- See [How do providers identify the correct payer?](#)
- The contracted regional behavioral health administrative service organization (BH-ASO) provides all crisis services for Apple Health clients and provides all behavioral health services for non-Apple Health clients regardless of ability to pay, within available resources. See [How do providers identify the correct payer?](#)

Telemedicine and Coronavirus (COVID-19)

Refer to the [Health Care Authority's Provider Billing Guides and Fee Schedules webpage](#), under Telehealth, for more information on the following:

- Telehealth policy, under *Clinical policy and billing for COVID-19*
- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

See the Health Care Authority's [Information about novel coronavirus \(COVID-19\) webpage](#) for updated information regarding COVID-19.

Client Eligibility

Most Apple Health clients are enrolled in an HCA-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 MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA'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.

How do I verify a client's eligibility?

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 HCA will not pay for.

If a client's benefit package indicates "Suspended – Inpatient Hospital Services Only" for the date of service, it means that the Jail Booking and Reporting System shows that the client was incarcerated for the date of service. Apple Health covers inpatient hospital services only for the suspension dates. All other services during the suspension timeframe are covered by the jail or state hospital. For more information or instructions on how to make corrections if the client was not incarcerated, see HCA's [Medicaid suspension webpage](#).

Client Eligibility Spans					
Insurance Type Code ▲▼	Recipient Aid Category (RAC) ▲▼	Benefit Service Package ▲▼	Eligibility Start Date ▲▼	Eligibility End Date ▲▼	ACES Coverage Group ▲▼
MC: Medicaid	8500	SBP - Institutionalized Dates	04/**/2018	12/**/2999	
MC: Medicaid	1201	ABP	04/**/2018	12/**/2999	N05
MC: Medicaid	1201	Suspended - Inpatient Hosp. Svc. Only	04/**/2018	04/**/2018	N05
MC: Medicaid	1201	ABP	06/**/2016	04/**/2018	N05

View Page: 1 Viewing Page: 1

Message(s): This is the Clients eligibility as of this date, based on information available at this time

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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 HCA's [ProviderOne Billing and Resource Guide](#).

Note: A client's coverage can change at any time, so check eligibility at each visit.

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 HCA'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](#).
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 the [Washington Healthplanfinder's website](#) or call the Customer Support Center.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

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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](#).

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. 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. Providers must check eligibility to determine enrollment for the month of service.

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.

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.

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](#).
 - 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."
 - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's [Apple Health Managed Care webpage](#).

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the 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. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. 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

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's [Apple Health managed care webpage](#) and scroll down to "Changes to Apple Health managed care."

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 HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

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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 Only (BHSO). For details, see HCA's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) [American Indian/Alaska Native webpage](#).

How can I verify a patient's coverage for mental health services?

Providers must verify the client's coverage in ProviderOne to bill correctly for furnishing mental health services.

This billing guide is divided into the following sections:

- **Part I:** Services for clients enrolled in an integrated managed care plan, BHSO, or fee-for-service
- **Part II:** Specialized mental health services for fee-for-service clients
- **Part III:** Inpatient psychiatric civil commitments for 90+ days
- **Part IV:** How to bill a freestanding evaluation and treatment center

Use the following lists and ProviderOne screen shots below to identify the provider guide section appropriate for your client. The lists provide the names of MCOs and MCO BHSOs as they appear in ProviderOne when viewing Managed Care Information. The screen shots demonstrate which organization is responsible for a client's medical benefits and behavioral health benefits.

The following list of the integrated managed care plans (as they appear in ProviderOne) cover physical health and mental health:

- AMG Fully Integrated Managed Care
- CCC Fully Integrated Managed Care
- CHPW Fully Integrated Managed Care
- Coordinated Care Healthy Options Foster Care

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- MHC Fully Integrated Managed Care
- UHC Fully Integrated Managed Care

The following list of the BHSO plans offered by the managed care organizations (as they appear in ProviderOne) cover behavioral health services only.

- AMG Behavioral Health Services Only
- CCW Behavioral Health Services Only
- CHPW Behavioral Health Services Only
- MHC Behavioral Health Services Only
- UHC Behavioral Health Services Only

Use Part I: Services for clients enrolled in an integrated managed care plan or BHSO of this billing guide for the following examples:

Enrolled in Integrated Managed Care

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	06/**/2019	12/**/2999	N05	999999999		
MC: Medicaid	1203	CNP	09/**/2014	02/**/2014	N11	999999999		

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Message(s): This is the Clients eligibility as of this date, based on information available at this time

Managed Care Information							
Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC	08/**/2019	02/**/2065
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC	07/**/2019	07/**/2019
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC	01/**/2019	02/**/2019
HM: Health Maintenance Organization	MC: Capitated	King County Behavioral Health Org	105020602	(800) 790-8049		01/**/2017	12/**/2018
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options	105010201	(800) 869-7165		10/**/2014	12/**/2018

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Message(s):

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Enrolled in a BHSO

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	01/**/2014	12/**/2999	N05	999999999		

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Message(s): This is the Clients eligibility as of this date,based on information available at this time

Managed Care Information							
Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	AMG Behavioral Health Services Only	201599811	(800) 600-4441		03/**/2020	12/**/2999

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Message(s):

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Enrolled in a PCCM

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1014	CNP	10/**/2019	12/**/2999	D01	999999999		
MC: Medicaid	1019	CNP	12/**/2015	09/**/2019	D02	999999999		

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Message(s): This is the Clients eligibility as of this date,based on information available at this time

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Enrolled in a PCCM

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	DAVID C WYNECOOP MEMORIAL CLI	100743200	509-258-4517		12/**/2015	12/**/2999

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Message(s):

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Enrolled in FFS

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	04**/2019	12**/2999	N05	999999999		

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Message(s): This is the Clients eligibility as of this date,based on information available at this time

Information Source Data
<p>Name: WA State DSHS</p> <p>Identification Code Qualifier: PI: Payor Identification</p> <p>Primary Identifier: 77045</p> <p>Contact Name: WA State DSHS Provider Relations</p> <p>Communications Number: (800) 562-3022</p>

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Use PART II: Specialized mental health services for fee-for-service clients of this billing guide for the following examples:

FFS Medical – FFS Behavioral

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	01/**/2014	12/**/2999	N05	999999999		

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Message(s): This is the Clients eligibility as of this date, based on information available at this time

PCCM Medical – FFS Behavioral

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	01/**/2014	12/**/2999	N05	999999999		

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Message(s): This is the Clients eligibility as of this date,based on information available at this time

Managed Care Information							
Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	NATIVE HEALTH OF SPOKANE	100781700	(509) 483-7535		06/**/2017	12/**/2045

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Message(s):

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How do providers identify the correct payer?

Provider can use the [How do providers identify the correct payer?](#) table to identify the payer for a service based on the service type and the client's health care coverage.

This Mental Health Services billing guide is not applicable to the services in the table marked with an asterisk (*). Contact the managed care organization for information and instructions regarding provider credentialing, benefits, prior authorization requirements, and billing.

Part I: Services for clients enrolled in an integrated managed care plan, BHSO, or are fee-for-service

Part I describes mental health outpatient services and inpatient psychiatric professional services covered by managed care organizations (MCOs) or fee-for-service (FFS) rendered by independently licensed or certified providers without access to Provider Entry Portal.

Crisis services

Crisis mental health services are provided upon request, 24-hours a day, seven days a week, and are available to anyone who needs them regardless of ability to pay. To find telephone numbers for crisis intervention services, see the [State Mental Health Crisis Lines](#).

Tribal health clinics providing crisis services should refer to the [Tribal Health Services Billing Guide](#).

Note: The behavioral health administrative service organization (BH-ASO) provides all crisis services for Apple Health clients and non-Apple Health clients. See the Behavioral Health Administrative Services Organizations (BH-ASO) [contact chart](#) for the phone numbers for crisis situations, general questions, or authorizations.

Professional services delivered in an outpatient setting

Provider requirements

Who is eligible to provide and bill for mental health outpatient services covered by fee-for-service (FFS)?

To be eligible to provide and bill HCA fee-for-service (FFS) for mental health outpatient treatment services, all mental health professionals must meet all the following:

- Be independently licensed by the Department of Health.
- Be in good standing without restriction.
- Have a current core provider agreement (CPA) with HCA and a national provider identifier (NPI). For more information about completing the CPA, see the [Provider Enrollment](#) webpage for new providers.

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Who is eligible to provide and bill for mental health outpatient services to clients age 18 and younger?

Note: This section applies to clients up to the day of their 18th birthday.

Except for licensed psychiatrists and psychologists, qualified health care professionals who treat clients up to age 18 and younger must Submit a *Mental Health Professionals Attestation* form HCA 13-951.

Which professional services can be billed in an outpatient setting?

Note: For clients enrolled in an HCA-contracted managed care organization (MCO) who are receiving outpatient mental health services, providers must follow the policies and referral procedures of the MCO.

If you are treating or evaluating a fee-for-service client who appears to need more intense services than you can provide, contact the client's MCO-BHSO to make a referral for an intake evaluation.

When performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate E&M code and the appropriate psychiatric add-on CPT® code (e.g., CPT® code +90833).

HCA covers the services below to treat conditions that fall within the current ICD diagnosis code range for mental health. For billing purposes, providers must use the most specific code available.

Outpatient mental health services coverage table

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

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
+90785	Psytx complex interactive		X	X	X	X		

Legend -Codes and Other Descriptions

+ = Add-on code

* = Includes independently licensed Social Workers, Marriage and Family Therapists, and Mental Health Counselors

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day, without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
90791***	Psych diagnostic evaluation		X	X	X	X	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year For more information about psychiatric diagnostic interview exams of infants and young children, see Mental Health Assessments for Young Children	

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
90792***	Psych diag eval w/med srvc		X	X			One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year For more information about psychiatric diagnostic interview exams of infants and young children, please see Mental Health Assessment for Young Children	
90832	Psytx w pt 30 minutes	30 min	X	X	X	X		
+90833	Psytx w pt w e/m 30 min	30 min	X	X	X	X		

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
90834	Psytx w pt 45 minutes	45 min	X	X	X	X		
+90836	Psytx w pt w e/m 45 min	45 min	X	X	X	X		
90837	Psytx w pt 60 minutes	60 min	X	X	X	X		
+90838	Psytx w pt w e/m 60 min	60 min	X	X				
90845	Psychoanalysis		X				Not CMHC	
90846	Family psytx w/o pt 50 min	50 min	X	X	X	X		
90847	Family psytx w/pt 50 min	50 min	X	X	X	X		
90849	Multiple family group psytx	40 min	X	X	X	X	Not in POS 24	
90853	Group psychotherapy	60 min	X	X	X	X		
90865	Narcosynthesis		X				Exclude POS 24	

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
90867	Tcranial magn stim tx plan		X	X			One per client, per year; outpatient only	
90868	Tcranial magn stim tx deli		X	X			30 visits in 7-week period followed by 6 taper treatments; outpatient only	
90869	Tcran magn stim redetermine		X	X			One per client, per year; outpatient only	
90870	Electroconvulsive therapy		X					
96110	Developmental screen w/score		X	X		X		
96112	Devel tst phys/qhp 1 st hr		X	C	C	X		
96113	Devel tsxt phys/qhp ea addl		X	C	C	X		

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
96116	Neurobehavioral status exam		X			X		
96121	Nubhvl xm phy/qhp ea addl hr	60 min	X			X		
96130	Psycl tst eval phys/qhp 1 st	60 min	X			X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96131	Psycl tst eval phys/qhp ea	60 min	X			X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
96132	Nrpsyc tst eval phys/qhp 1 st	60 min	X			X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	PA for 20yrs and older
96133	Nrpsyc tst eval phys/qhp ea	60 min	X			X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	PA for 20 and older
96136	Psycl/nrpsyc tst phy/qhp 1 st	30 min	X			X	See limits under 96130 or 96132	PA for Neuropsych age 20 and older
+96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X			X	See limits under 96130 or 96132	PA for Neuropsych age 20 and older

Legend -Codes and Other Descriptions

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** = Use this code when a technician or computer is used to administer the test selected by the professional

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C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
96138	Psycl/nrpsyc tech 1 st	30 min	**			**	See limits under 96130 or 96132	PA for Neuropsych age 20 and older
+96139	Psycl/nrpsyc tst tech ea	30 min	**			**	See limits under 96130 or 96132	PA for Neuropsych age 20 and older
96146	Psycl/nrpsyc tst auto result		**			**	See limits under 96130 or 96132	PA for Neuropsych age 20 and older
99281	Emergency dept visit		X	X				
99282	Emergency dept visit		X	X				
99283	Emergency dept visit		X	X				
99284	Emergency dept visit		X	X				
99285	Emergency dept visit		X	X				
99218	Initial observation care	30 min	X	X				

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99219	Initial observation care	50 min	X	X				
99220	Initial observation care	70 min	X	X				
99226	Subsequent observation care	35 min	X	X				
99241	Office consultation	15 min	X	X				
99242	Office consultation	30 min	X	X				
99243	Office consultation	40 min	X	X				
99244	Office consultation	60 min	X	X				
99245	Office consultation	80 min	X	X				
99202	Office o/p new sf 15-29 min	15-29 min	X	X				
99203	Office o/p new low 30-44 min	30-44 min	X	X				
99204	Office o/p new mod 45-59 min	45-59 min	X	X				

Legend -Codes and Other Descriptions

+ = Add-on code

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C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99205	Office o/p new hi 60-74 min	60-74 min	X	X				
99211	Office o/p est minimal prob		X	X				
99212	Office o/p est sf 10-19 min	10-19 min	X	X				
99213	Office o/p est low 20-29 min	20-29 min	X	X				
99214	Office o/p est mod 30-39 min	30-39 min	X	X				
99215	Office o/p est hi 40-54 min	40-54 min	X	X				
99304	Nursing facility care init	25 min	X	X				
99305	Nursing facility care init	35 min	X	X				
99306	Nursing facility care init	45 min	X	X				
99307	Nursing fac care subseq	10 min	X	X				
99308	Nursing fac care subseq	15 min	X	X				

Legend -Codes and Other Descriptions

+ = Add-on code

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** = Use this code when a technician or computer is used to administer the test selected by the professional

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C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99309	Nursing fac care subseq	25 min	X	X				
99310	Nursing fac care subseq	35 min	X	X				
99315	Nursing fac discharge day	30 min or less	X	X				
99316	Nursing fac discharge day	30 min or longer	X	X				
99324	Domicil/r-home visit new pat	20 min	X	X				
99325	Domicil/r-home visit new pat	30 min	X	X				
99326	Domicil/r-home visit new pat	45 min	X	X				
99327	Domicil/r-home visit new pat	60 min	X	X				
99328	Domicil/r-home visit new pat	75 min	X	X				
99334	Domicil/r-home visit est pat	15 min	X	X				
99335	Domicil/r-home visit est pat	25 min	X	X				

Legend -Codes and Other Descriptions

+ = Add-on code

* = Includes independently licensed Social Workers, Marriage and Family Therapists, and Mental Health Counselors

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day, without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99336	Domicil/r-home visit est pat	40 min	X	X				
99337	Domicil/r-home visit est pat	60 min	X	X				
99339	Domicil/r-home care supervis	15-29 min	X	X				
99340	Domicil/r-home care supervis	30 min or longer	X	X				
99341	Home visit new patient	20 min	X	X				
99342	Home visit new patient	30 min	X	X				
99343	Home visit new patient	45 min	X	X				
99344	Home visit new patient	60 min	X	X				
99345	Home visit new patient	75 min	X	X				
99347	Home visit est patient	15 min	X	X				
99348	Home visit est patient	25 min	X	X				

Legend -Codes and Other Descriptions

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99349	Home visit est patient	40 min	X	X				
99350	Home visit est patient	60 min	X	X				
+99354	Prolng svc o/p 1 st hour	1 st hr	X	X	X	X		
+99355	Prolng svc o/p ea addl 30	Each 30 min beyond 1 st hr	X	X	X	X		
99367	Team conf w/o/ pat by phys	30 min or longer	X	X				
99441	Phone e/m phys/qhp 5-10 min	10 min	X	X				
99442	Phone e/m phys/qhp 11-20 min	11-20 min	X	X				
99443	Phone e/m phys/qhp 21-30 min	21-30 min	X	X				

Legend -Codes and Other Descriptions

+ = Add-on code

* = Includes independently licensed Social Workers, Marriage and Family Therapists, and Mental Health Counselors

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day, without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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Services delivered outpatient for treatment-resistant depression

(CPT® 90867, 90868, 90869, 90870)

Treatment-resistant depression is defined as depression that is unresponsive to trial therapy at a maximum tolerated dose for 4-12 weeks of one antidepressant from two of the following five classes:

- Selective Serotonin Reuptake Inhibitors (SSRI)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
- Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)
- Norepinephrine/Dopamine Reuptake Inhibitor (NDRI)
- Serotonin Antagonist Reuptake Inhibitor (SARI)

Failed trials require a level of compliance considered adequate by the provider and may include failures that did not meet the duration requirement due to adverse events or reactions.

HCA covers the following two non-pharmacologic treatments for treatment-resistant depression for clients age 19 and older.

- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Electroconvulsive Therapy (ECT)

HCA pays for rTMS as follows:

- Documentation exists supporting other treatments have been unsuccessful
- Limited to 30 visits in a seven-week period followed by six taper treatments
- Must be ordered and performed by a psychiatrist or a P-ARNP
- Must be performed in outpatient settings only

HCA does not consider rTMS to be medically necessary when:

- Psychotic symptoms are present in the current depressive episode
- Conductive, ferromagnetic, or other magnetic-sensitive metals are implanted in the client's head which are nonremovable and are within 30 cm of the TMS magnetic coil (e.g., cochlear implants, implanted electrodes/stimulators, aneurysm clips or coil, stents, and bullet fragments).
- The client is diagnosed with Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder
- Other neurological conditions exist (e.g., epilepsy, Parkinson's disease, multiple sclerosis, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the central nervous system, or any other degenerative neurologic condition)
- Used as a maintenance therapy

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- The client is an active substance user

HCA pays for ECT when documentation exists supporting other treatments have been unsuccessful and treatment is provided by a psychiatrist.

For outpatient ECT services, bill the MCO or FFS based on the client's enrollment.

Billing for professional services in an emergency room setting for a client who is transferred to another facility for an inpatient psychiatric admission

See [How do providers identify the correct payer?](#)

Outpatient psychiatric services and limitations

See the [Mental Health Services Coverage Table](#) for covered mental health services. HCA pays for only one psychiatric diagnostic interview exam (CPT® codes 90791 or 90792) per client, per provider, per calendar year. For more information about psychiatric diagnostic interview exams for young children, see [Mental Health Assessments for Young Children](#).

Drug monitoring

Drug monitoring refers to a brief office visit for the sole purpose of monitoring or changing drug prescriptions. Drug monitoring (use the appropriate E/M code) is used in the treatment of mental psychoneurotic and personality disorders. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a drug monitoring visit is the use of medication for relief of the client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that require discussion beyond minimal psychotherapy, the focus of the service is broader and is considered psychotherapy rather than drug monitoring.

Drug monitoring:

- May be billed as one psychiatric medication management service per client, per day, in an outpatient setting when performed by one of the following:
 - Psychiatrist
 - P-ARNP
 - PMHNP-BC
- May be billed when prescribing medication and when reviewing the effects of the prescribed medication.
- Is intended for use for clients whose condition is being managed primarily by psychotropic medications.
- Must be provided during an in-person visit with the client unless it is part of a qualified telemedicine visit.
- Is not allowed in an inpatient hospital (POS 21).

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Documentation requirements for drug monitoring

The medical record must be clear, concise, and complete. A checklist by itself is not accepted as complete documentation. The treating provider must document in the medical record that drug monitoring was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated drug monitoring. These requirements are in addition to those in [WAC 182-538D-0200](#).

Documentation of medical necessity for drug monitoring must address all the following information in the client's medical record in legible format:

- Date and time
- Diagnosis – update at least annually
- Interim medication history
- Current symptoms and problems, including any physical symptoms
- Problems, reactions, and side effects, if any, to medications or ECT
- Current mental status exam
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcomes

Note: When a client sees a psychiatrist, P-ARNP, or a PMHNP-BC for psychiatric care and only drug monitoring is necessary, the practitioner may bill for either drug monitoring or an evaluation and management (E&M) visit for that date of service.

Alternatively, when a psychiatrist, P-ARNP, or a PMHNP-BC provides psychotherapy and drug monitoring, the practitioner may bill an E&M visit and a qualifying psychotherapy service on that date of service.

In accordance with the National Correct Coding Initiative (NCCI), drug monitoring and an E&M or psychotherapy service cannot be billed on the same day of service, by the same provider. For additional information, see [NCCI](#).

Outpatient developmental testing

HCA pays for developmental testing (CPT® codes 96112 and 96113) when conducted by a licensed health care professional certified to administer and interpret the identified test.

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What psychological testing does HCA cover?

HCA covers psychological testing **after** a detailed diagnostic evaluation if:

- The client's history and symptomatology are not clearly attributable to a specific psychiatric diagnosis and psychological testing would aid in the differential diagnosis of behavioral and psychiatric conditions. The psychological testing questions must be questions that could not otherwise be answered during:
 - A psychiatric or diagnostic evaluation.
 - Observation during therapy.
 - An assessment for level-of-care determinations at a mental health or substance-abuse facility.
- The client has tried various medications and psychotherapies but has not progressed and continues to be symptomatic. All the following criteria must be met:
 - The number of hours or units requested for testing does not exceed the reasonable time necessary to address the clinical questions with the identified measures.
 - The testing techniques are validated for the proposed diagnostic question or treatment plan.
 - The testing techniques do not represent redundant measurements of the same cognitive, behavioral, or emotional domain.
 - The testing techniques are both validated for the age and population of the member.
 - The instruments must meet all the following:
 - Be the most current version of the instrument.
 - Have empirically substantiated reliability, validity, standardized administration, and clinically relevant normative data needed to assess the diagnostic question or treatment planning goals.

Note: HCA does not cover neuropsychological testing (NPT) or psychological testing (PT) if the client is actively abusing a substance, having acute withdrawal symptoms, or has recently entered recovery because test results may be invalid.

Psychological testing and evaluation services

- Psychological assessments must include a complete diagnostic history, examination, and assessment. Testing cognitive processes, visual motor responses, and abstract abilities is accomplished by combining several testing procedures.
- Evaluation services must always be performed by the qualified professional prior to test administration and may be billed on separate days.
- To receive reimbursement for the testing and evaluation, the psychologist must keep a report in the client's file that contains all the components of a psychological assessment including test results and interpretation of results.
- Use CPT® codes 96130 and 96131 when billing for psychological evaluation services from a psychologist or physician. Test selection, clinical decision making, and test interpretation are now billed under 96130 and 96131.
- Use CPT® codes 96136 and 96137 billing for test administration and scoring by a psychologist or physician.
- Use CPT® codes 96138 and 96139 for test administration and scoring by a qualified technician.
- Psychological testing is limited to twelve units of any combination of CPT® codes 96130, 96131, 96136, 96137, 96138 or 96139 without prior authorization (PA) per client, per lifetime.

Neuropsychological testing evaluation services

- Neuropsychological testing evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation and interactive feedback to the patient, family member(s) or caregiver(s).
 - Use CPT® codes 96132 for the first hour of neuropsychological evaluation and 96133 for each additional hour provided on the same day.
 - Use CPT® codes 96136 for the first 30 minutes of testing and scoring by a psychologist or neuropsychologist and 96137 for each additional 30 minutes of testing and scoring provided on the same day.
 - Use CPT® code 96138 for the first 30 minutes of test administration and scoring by a technician, and 96139 for each additional 30 minutes a technician is administering and scoring tests on the same day.
 - HCA reimburses for neuropsychological testing (CPT® codes 96132, 96133, 96136, and 96137) when the provider is currently licensed in Washington State to practice psychology or clinical neuropsychology.
 - No prior authorization (PA) for neuropsychological testing is required if billing 15 units or less of any combination of neuropsychological testing codes.
 - If the child is in school, the provider must complete detailed review of the individualized education plan (IEP) outlining all the following:
 - The specific clinical issues in the IEP that have not been sufficiently addressed
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- The aspects of the child's rehabilitation that are not improving
- Specific additional benefits that neuropsychological testing will provide the client, describing what the IEP is already addressing, and how the proposed testing will improve the treatment plan
- Other psychological testing that has been done
- Relevant consultations from psychiatrists, neurologists, developmental pediatricians, etc.

Neuropsychological testing of people age 20 or older requires all the following information:

- The client's current diagnoses
- If available, a copy of the reports produced by the testing for HCA to review
- For neuropsychological testing that has been done in the past:
 - Documentation of the provider's review of reports produced by the testing
 - Documentation of the provider's review of the results of the previous testing(s)
- An explanation detailing the essential medical knowledge that is expected to be gained from neuropsychological testing
- Specific details documenting how the results of neuropsychological testing will improve the day-to-day care of this client

Note: HCA no longer requires providers who bill for neuropsychological testing to be board-certified; however, upon request, providers must be able to furnish credentials that demonstrate their expertise. If the client does not meet the criteria listed in this section, HCA requires prior authorization (PA) for the testing.

Providers

HCA pays only “qualified” providers for administering neuropsychological testing to eligible HCA clients. To be “qualified,” providers must be both of the following:

- Currently licensed in Washington State to practice psychology or clinical neuropsychology
- One of the following:
 - Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology
 - Have adequate education, training, and experience as defined by having completed all the following:
 - A doctoral degree in psychology from an accredited university training program
 - An internship, or its equivalent, in a clinically relevant area of professional psychology
 - The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences (these two years must include supervision by a clinical neuropsychologist)

Billing and Payment Limits

This section describes four groups of criteria that apply to billing in certain circumstances.

To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met.

For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.

Group 1

All the following must be met:

- The patient to be evaluated has, or is suspected to have, an acquired injury to the brain because of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy.
- The patient is age 20 or older.
- The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder.
- The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living).
- Testing will be used only in conjunction with functionally based rehabilitation, not “cognitive” rehabilitation.

Group 2

The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following:

- Client or family complaints
- A head CT (computed tomography scan)
- A mental status examination or other medical examination

This suspected diagnosis is not confirmed or able to be differentiated from the following:

- Normal aging
- Mild concussion
- Depression
- Focal neurological impairments

A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.

Group 3

The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help with either of the following:

- Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language
- Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors)

Group 4

The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post-transplant protocol to prevent organ rejection).

What mental health services does HCA cover for youth?

- All age-appropriate mental health services are available to children
- Depression screening is required for youth 12 through 18yrs. Suggested tools and billing instructions can be found in the [Early and Periodic Screening, Diagnosis and Treatment Billing Guide](#).

What mental health services does HCA cover for transgender clients?

Mental health treatment can be provided to a transgender client, the client's spouse, parent, guardian, or child, or a person with whom the client has a child in common, if the treatment is directly related to the client's care, is medically necessary and is in accordance with WAC [182-531-1400](#).

See the [Apple Health webpage](#) for resources that may be helpful for providing healthcare services to transgender people.

For more information about covered services for transgender health, see the [Physician-Related Services/Health Care Professional Services Billing Guide](#).

What mental health outpatient services does HCA cover for young children (birth through age five)?

Mental health treatment can be provided to children from birth through age five and the children's parents or guardians if the treatment is directly related to the child's care, is medically necessary, and is in accordance with the WAC [182-531-1400](#).

Providers must bill mental health services for a newborn or child under the newborn or child's ProviderOne client ID.

Note: HCA covers depression screening for caregivers of infants ages six months and younger. This screening should be billed under the infant's ProviderOne client ID when done by the infant's provider. For suggested tools and billing instructions, see the [Early and Periodic Screening, Diagnosis and Treatment Billing Guide](#).

Mental health assessments for young children

About this section

This section of the billing guide applies to mental health services for children from birth through five years of age. **This information does not apply for any other age group.**

Under [RCW 74.09.520](#), for children from birth through age five, HCA allows otherwise eligible reimbursement for up to five sessions per client, per provider, per calendar year, to complete a mental health assessment (Psychiatric Diagnostic Evaluation). HCA also allows reimbursement for mental health assessments in home or community settings, including reimbursement for provider travel through a separate A-19 payment process only.

Apple Health mental health providers must use the current version of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™)* for mental health assessments and diagnoses for children from birth through five years of age.

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Note: For more information, visit [HCA's Mental Health Assessment for Young Children provider webpage](#).

Billing for multi-session mental health assessments for young children

Providers conducting mental health assessments (i.e., Psychiatric Diagnostic Evaluation) with children from birth through age five may conduct up to five sessions per client, per provider, within a calendar year. Providers must submit claims using the appropriate Psychiatric Diagnostic Evaluation CPT® codes for each session conducted with the child or the child's family for the purpose of the mental health assessment.

Note: For clients age five and younger, a **limitation extension** is required to provide more than five mental health assessment sessions, per provider, per calendar year.

For clients age six and older, a **limitation extension** is required to provide more than one mental health assessment session, per provider, per calendar year.

Reimbursement for provider travel

Provider travel is eligible for reimbursement when providers conduct a mental health assessment for children from birth through age five in the home or in a community setting. Provider travel is reimbursed by mileage, using current mileage reimbursement rates from the Office of Financial Management. The following information must be included on any submitted claims to qualify for provider travel reimbursement.

Component	Mental health assessment	For child birth through age five	In home or community setting
Claim Requirement	CPT® Code: <ul style="list-style-type: none"> 90791 90792 	Client DOB: <ul style="list-style-type: none"> Less than or equal to 72 months before the date of service (younger than 6 years) 	Place of Service (POS) Code: <ul style="list-style-type: none"> 03: School 04: Homeless Shelter 12: Home 99: Other Place of Service

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Note: Claims with a U8 modifier, which identify services provided to Wraparound Intensive Services (WISe) participants by qualified WISe practitioners, are NOT eligible for mental health assessment for young children provider travel reimbursement. For more information, see [Wraparound with Intensive Services \(WISe\) monthly case rate](#).

For clients enrolled in fee-for-service, providers should refer to the Fee-for-Service Mental Health Assessments for Young Children A-19 and Instructional Cover Sheet for guidance on submitting A-19 invoices and receiving reimbursement. For more information, see the [Mental Health Assessment for Young Children webpage](#).

Note: For clients enrolled in an HCA-contracted managed care organization (MCO), providers must follow the policies and procedures of the MCO regarding provider travel reimbursement.

Diagnosis for Young Children

The DC:0-5™ is the internationally accepted system for developmentally appropriate assessment and diagnosis of young children's mental health; however, other diagnostic manuals are often still necessary in our current behavioral health system. For Apple Health clinicians, federal Medicaid guidance requires that all claims be submitted with an ICD (International Classification of Disease) code. HCA has published an interim Apple Health "DC: 0 - 5™ crosswalk," a reference guide for clinicians that helps convert DC: 0 - 5™ diagnoses to associated ICD diagnostic codes and DSM diagnoses. For more information, see the [Mental health Assessment for Young Children webpage](#).

Note: For initial assessment sessions when a diagnosis cannot be made or is unknown, use F99 "Mental disorder, not otherwise specified". For the final assessment session, providers must use the most appropriate diagnosis code available.

How are providers reimbursed for aged, blind, or disabled (ABD) evaluation services?

Providers must be enrolled with ProviderOne to claim and receive payment for ABD Evaluation Services. See the DSHS [Medical Evaluation and Diagnostic Procedures](#) webpage.

Medical evidence reimbursements are solely for the cost of obtaining medical evidence of an impairment that limits work activity, and for the purposes of an Aged, Blind, or Disabled (ABD) disability determination. See the DSHS [Medical Evidence Reimbursement](#) webpage.

For information regarding reimbursement for psychological evaluations and testing these DSHS Community Services Division (CSD) [Mental Incapacity Evaluation](#) Services webpage.

When is out-of-state outpatient care covered?

Out-of-state mental health care requires [prior authorization](#) (PA).

Note: Out-of-state mental health care is not covered for clients under the MCS eligibility program, unless the services are provided in a bordering city listed in WAC [182-508-0005](#).

HCA covers emergency and nonemergency out-of-state health care services provided to eligible Apple Health clients when the services are:

- Within the scope of the client's health care program.
- Allowed to be provided outside the state of Washington by specific program.
- Medically necessary.

When HCA pays for covered health care services furnished to an eligible Apple Health client outside the state of Washington, its payment is payment in full according to [42 C.F.R. § 447.15](#).

Where can I view the fee schedules?

See the following fee schedules for more information:

- [Early and Periodic Screening Diagnosis and Treatment \(EPSDT\) Fee Schedule](#)
- [Mental Health Services Fee Schedule](#)
- [Physician-Related/Professional Services Fee Schedule](#).

Prior authorization and expedited prior authorization

Authorization is HCA's approval for certain, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement.

Prior Authorization (PA), Expedited prior authorization (EPA) and limitation extensions (LE) are forms of prior authorization.

What is prior authorization (PA)?

Prior authorization (PA) is HCA or HCA designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients. When PA is applicable, it is a precondition for provider reimbursement. Expedited prior authorization (EPA) is a form of prior authorization.

What is the expedited prior authorization (EPA) process?

HCA or its designee's expedited prior authorization (EPA) process is designed to eliminate the need for written/fax authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling the provider to use HCA's designated "EPA" number when appropriate.

Note: EPA does not apply to [out-of-state](#) care.

Billing with an EPA number

For electronic billing, enter the EPA in the Prior Authorization section. For more information about entering EPA numbers, see the [Direct data entry of an institutional claim](#) or [Medical provider workshop](#) webinars.

Note: When the client's situation does not meet published criteria for EPA, formal written PA is necessary.

EPA guidelines

Clinical 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 will be denied.

EPA documentation

The billing provider must document how EPA criteria were met in the client's file and make this information available to HCA or HCA's designee upon request.

For managed care clients, see [How do providers identify the correct payer?](#)

EPA billing requirements for evidence and research-based practices

Evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively “EBPs”) include programs such as cognitive behavioral therapy (CBT) and the Positive Parenting Program (Triple P). HCA is required by law to collect data on EBPs in Washington State. Providers who provide these services to clients under age 18 should include the appropriate EPA number from the following table when billing for EBP.

EPA Numbers Representing Evidence-Based Practice

Anxiety

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	<ul style="list-style-type: none"> • CBT4 CBT training (Coping Cat) (151) • Centre for Emotional Health (Cool Kids) (151) • Effective Child Therapy/ Society of Clinical Child & Adolescent Psychology (151) • Harborview CBT + Learning Collaborative (151) • The Reach Institute (CATIE trainings) (151) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (151) 	870001555
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Cool Kids (032)	870001556
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Coping Cat (035)	870001557
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Coping Cat/Koala book-based model (157)	870001558

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Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Coping Koala (158)	870001559
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Managing and Adapting Practice (MAP) (175)	870001560
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote) (151)	Modularized Approach to therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) (085)	870001561
Parent cognitive behavioral therapy (CBT) for young children with anxiety (187)		870001562

Attention Deficit Hyperactivity Disorder

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Behavioral parent training (BPT) for children with ADHS	Barkley Model (003)	870001563
Behavioral parent training (BPT) for children with ADHS	New Forest Parenting Program (181)	870001564
Multimodal Therapy (MMT) for children with ADHD (091)		870001565

Depression

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)	<ul style="list-style-type: none"> Acceptance and Commitment Therapy (ACT) for children with depression (153) Effective Child Therapy/Society of Clinical Child & Adolescent Psychology (153) Harborview CBT + Learning Collaborative (153) The Reach Institute (CATIE trainings) (153) Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type (below) (153) 	870001566
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)	Coping with Depression – Adolescents (159)	870001567
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)	Managing and Adaptive Practice (MAP) (175)	870001568
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH – ADTC) (085)	870001569
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)	Treatment for Adolescents with Depression Study (197)	870001570
Blues Program (group CBT prevention program for high school students at risk for depression) (149)		870001571

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Disruptive Behavior (Oppositional Defiant Disorder or Conduct Disorder)

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	<ul style="list-style-type: none"> Coping Power Program (148) Harborview CBT + Learning Collaborative (148) Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (148) Stop Now and Plan (SNAP) (148) The Reach Institute (CATIE trainings) (148) 	870001572
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Helping the Noncompliant Child (171)	870001573
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Incredible Years: Parent Training (073)	870001574
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Incredible Years: Parent Training + child training (076)	870001575
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Managing and Adapting Practice (MAP) (175)	870001576
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) (085)	870001577

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Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Parent Child Interaction Therapy (PCIT) for children with disruptive behavior problems (186)	870001578
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Parent Management Training – Oregon Model (treatment population) (188)	870001579
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Triple –P Positive Parenting Program: Level 4, Group (139)	870001580
Behavior parent training (BPT) for children with disruptive behavior disorders (148)	Triple – P Positive Parenting Program: Level4, Individual (140)	870001581
Brief Strategic Family Therapy (BSFT) (010)		870001582
Choice Theory/Reality Therapy (164)		870001583
Families and Schools Together (FAST) (046)		870001584

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Serious Emotional Disturbance

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Dialectical Behavior Therapy (DBT) for adolescent self-harming behavior (160)		870001585
Multisystem Therapy (MST) for youth with serious emotional disturbance (SED) (180)		870001586
Intensive Family Preservation (HOMEBUILDERS) for youth with serious emotional disturbance (SED) (172)		870001587

Trauma

Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	<ul style="list-style-type: none"> • Harborview CBT + Learning Collaborative (155) • The Reach Institute (CATIE trainings) (155) • Teaching Recovery Techniques (TRT) (155) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (155) 	870001588
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Classroom—based intervention for war-exposed children (013)	870001589
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Cognitive Behavioral Intervention for Trauma in Schools (016)	870001590

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Treatment Category	Specific Treatment and Approved Trainings	EPA Number
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Enhancing Resiliency Among Students Experiencing Stress (ERASE – Stress) (162)	870001591
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	KID – NET Narrative Exposure Therapy for children (079)	870001592
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Managing and Adapting Practice (MAP) (175)	870001593
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH – ADTC) (085)	870001594
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Trauma Focused CBT for children (136)	870001595
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)	Trauma Grief Component Therapy (137)	870001596
Child – Parent Psychotherapy (163)		870001597
Eye Movement Desensitization and Reprocessing (EMDR) for child trauma (043)		870001598

Allowable CPT® codes to use with evidence-based practices: 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, and 90853

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What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides. Note: A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA criteria list for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service. The written request must state all the following forms of authorization:

- The name and ProviderOne Client ID of the client
- The provider's name, ProviderOne Client ID, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

HCA limits the amount, frequency, or duration of certain services and reimburses up to the stated limit without requiring PA. HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits.

See [Resources Available](#) for the fax number and specific information (including forms) that must accompany the request for LE.

HCA evaluates requests for LE under the provisions of WAC [182-501-0169](#).

How do I obtain written authorization?

Send your request to HCA's Authorization Services Office. For more information on requesting authorization, see HCA's [ProviderOne Billing and Resource Guide](#).

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see HCA's [Paper Claim Billing Resource](#).

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's [Billers and Providers](#) webpage, under Webinars. See [Direct data entry of an institutional claim](#) or [Medical provider workshop](#) for professional claims.

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 guidelines for billing professional services?

- Providers must bill using the most appropriate procedure code for the total time spent on direct patient care during each visit.

HCA pays for one psychiatric diagnostic evaluation for a client, per provider, per calendar year, unless a significant change in the client's circumstances makes an additional evaluation medically necessary. For clients age 20 and younger, additional evaluations may be covered if medically necessary, regardless of whether a significant change in the client's circumstances has occurred under WAC 182-501-0165. The provider must request a limitation extension from HCA prior to the evaluation to exceed the limit. For more information about psychiatric diagnostic interview exams of young children, see [Mental Health Assessment for Young Children](#).

- HCA pays for one or more individual or family/group psychotherapy visits per day (with or without the client), per client, when medically necessary.
- For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.

Professional services delivered in an inpatient setting

Note: For eligible Apple Health fee-for-service clients who are not enrolled in an integrated managed care plan or a BHSO and who have high needs, refer to [Part II: Specialized mental health services for fee-for-service clients](#).

For clients in an integrated managed care plan, follow any PA procedures required by the MCO or the MCO's BHSO in which they are enrolled for behavioral health services.

For more information, see:

- [Inpatient hospital psychiatric admissions](#)
- [How can I verify a patient's coverage for mental health services?](#)
- [How do providers identify the correct payer?](#)

Professional services provided to an FFS-covered client during a psychiatric admission paid for by an MCO's BHSO

HCA covers professional inpatient mental health services when provided by a psychiatrist, P-ARNP, PMHNP-BC, or a psychologist, in conjunction with the prescribing provider, to FFS Apple Health-covered clients or clients determined Apple Health-eligible as a result of this admission, for both voluntary and involuntary psychiatric admissions under chapters [71.34](#) and [71.05](#) RCW.

- HCA pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. HCA considers services rendered during rounds to be direct client care services and may include up to one-hour individual psychotherapy, family/group therapy, and electroconvulsive therapy.
- One ECT or narcosynthesis per client, per day only when performed by a psychiatrist.

Professional services during a psychiatric inpatient admission for people who are not eligible for Apple Health

Note: The services are paid with state-only funds. These people are not eligible for any program administered by Apple Health.

HCA covers the inpatient professional mental health services delivered by psychiatrists, P-ARNPs, PMHNP-BCs, or psychologists, in conjunction with the prescribing provider, for people residing in Washington state who are admitted under chapters [71.34](#) and [71.05](#) RCW, and are not Apple Health clients or Apple Health-eligible.

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Billing for inpatient professional services

Physicians, P-ARNPs, and psychologists may bill HCA for all psychiatric services provided according to the following guidelines:

- Each person must be examined and evaluated by a licensed physician or P-ARNP within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony during an involuntary admission.

When billing for an evaluation under these circumstances, do both of the following:

- Enter SCI=I in the Claim Note section of the electronic professional claim for involuntary or SCI=V for voluntary admissions.
 - Provide documentation that the client was admitted to an inpatient facility.
- A day's rounds, along with any one of the following, constitute direct client care:
 - Narcosynthesis
 - Brief (up to one hour) individual psychotherapy
 - Multiple/family group therapy
 - Group therapy
 - ECT
 - If an Apple Health client requires psychiatric hospitalization while out of state, the hospital must obtain authorization from the appropriate payer representative. See [How can I verify a patient's coverage for mental health services?](#) for more information.
 - HCA does not pay for services provided to Medical Care Services (MCS) program clients who are out of state, unless the services are provided in a bordering city listed in WAC [182-501-0175](#).
 - **During an involuntary admission:**
 - A court may request another physician or P-ARNP evaluation.
 - HCA pays for physician or P-ARNP evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client.
 - Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT® code 99075) for time spent doing court testimony. Additional costs for court testimony are paid from the ITA administrative fund.
 - ITA applies only within the borders of Washington State. Neither HCA nor the BH-ASO pays for involuntary inpatient services for non-Apple Health clients provided outside of the state of Washington.

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Note: For general information about admissions under the Involuntary Treatment Act (ITA), see [Involuntary Treatment Act admissions](#).

Inpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
+90785	Psytx complex interactive		X	X			
90791***	Psych diagnostic evaluation		X	X	X	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year	
90792***	Psych diag eval w/med srvc		X	X		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year	
90832	Psytx w pt 30 minutes	30 min	X	X	X		
+90833	Psytx w pt w e/m 30 min	30 min	X	X	X		
90834	Psytx w pt 45 minutes	45 min	X	X	X		

Legend - Codes and Other Descriptions

+ = Add-on code

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
+90836	Psytx w pt w e/m 45 min	45 min	X	X	X		
90837	Psytx w pt 60 minutes	60 min	X	X	X		
+90838	Psytx w pt w e/m 60 min	60 min	X	X	X		
90845	Psychoanalysis		X		X		
90846	Family psytx w/o pt 50 min	50 min	X	X	X		
90847	Family psytx w/pt 50 min	50 min	X	X	X		
90849	Multiple family group psytx	40 min	X	X	X		
90853	Group psychotherapy	60 min	X	X	X		
90865	Narcosynthesis		X				
90870	Electroconvulsive therapy		X				
96112	Developmental Testing 1 st	60 min	X	C	X		
96113	Developmental Testing ea. add'l hr.	60 min	X	C	X		

Legend - Codes and Other Descriptions

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*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
96116	Neurobehavioral status exam		X		X		
96121	Nubhvl xm phy/qhp ea addl hr	60 min	X		X		
96130	Psych testeval Physician/qhp 1 st hr.	60 min	X		X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96131	Psycl tst eval phys/qhp ea	60 min	X		X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96132	Neuropsych Test./Eval. 1 st hr	60 min				15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA for 20yrs and older

Legend - Codes and Other Descriptions

+ = Add-on code

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
96133	Neuropsych Test./Eval ea. add'l hr.	60 min	X		X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA 20 and older
96136	Psycl/nrpsyc tst phy/qhp 1st	30 min	X		X	See limits under 96130 and 96132	EPA/PA for Neuropsych age 20 and older
+96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X		X	See limits under 96130 and 96132	EPA/PA for Neuropsych age 20 and older
96138	Psycl/nrpsyc tech 1 st	30 min	**		**	See limits under 96130 and 96132	EPA/PA for Neuropsych age 20 and older
+96139	Psycl/nrpsyc tst tech ea	30 min	**		**	See limits under 96130 and 96132	EPA/PA for Neuropsych age 20 and older
96146	Psycl/nrpsyc tst auto result		**		**	See limits under 96130 and 96132	EPA/PA for Neuropsych age 20 and older
99218	Initial observation care	30 min	X	X			

Legend - Codes and Other Descriptions

+ = Add-on code

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
99219	Initial observation care	50 min	X	X			
99220	Initial observation care	70 min	X	X			
99221	Initial hospital care	30 min	X	X			
99222	Initial hospital care	50 min	X	X			
99226	Subsequent observation care	35 min	X	X			
99231	Subsequent Hospital Care	15 min	X	X			
99232	Subsequent Hospital Care	25 min	X	X			
99233	Subsequent Hospital Care	35 min	X	X			
99251	Inpatient consultation	20 min	X	X			
99252	Inpatient consultation	40 min	X	X			
99253	Inpatient consultation	55 min	X	X			
99254	Inpatient consultation	80 min	X	X			

Legend - Codes and Other Descriptions

+ = Add-on code

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
99255	Inpatient consultation	110 min	X	X			
99239	Hospital discharge day	30 min +	X	X			
+99356	Prolng svc i/p/obs 1 st hour	1st hour	X	X		18 yrs and younger	
99357	Prolng svc i/p/obs ea addl	30 min	X	X		18 yrs and younger	
99367	Team conf w/o pat by phys	30 min or longer	X	X			

Note:

- LMHPs are not eligible for reimbursement in an inpatient setting.
- HCA does not cover psychiatric sleep therapy.
- Claims for inpatient rounds must be charged using one of the inpatient CPT® codes in this section.

Legend - Codes and Other Descriptions

+ = Add-on code

** = Use this code when a technician or computer is used to administer the test selected by the professional

*** = A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day without prior authorization

C = The code is conditional; see [Outpatient developmental testing](#).

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Services delivered inpatient for treatment-resistant depression

(CPT® 90870)

Treatment-resistant depression is defined as depression that is unresponsive to trial therapy at a maximum tolerated dose for 4-12 weeks of one antidepressant from two of the following five classes:

- Selective Serotonin Reuptake Inhibitors (SSRI)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
- Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)
- Norepinephrine/Dopamine Reuptake Inhibitor (NDRI)
- Serotonin Antagonist Reuptake Inhibitor (SARI)

Failed trials require a level of compliance considered adequate by the provider and may include failures that did not meet the duration requirement due to adverse events or reactions.

HCA pays for ECT for individuals age 19 and older when all the following are met:

- Documentation exists supporting other treatments have been unsuccessful
- Provided by a psychiatrist

For inpatient ECT services for integrated managed care clients, bill the managed care organization.

Part II: Specialized mental health services for fee-for-service clients

Specialized mental health services are rendered through a licensed and certified community mental health center (CMHC) enrolled through the Provider Entry Portal (PEP). Clients must have one of the Recipient Aid Categories (RAC) listed in this section and cannot be enrolled in integrated managed care or behavioral health services only.

Note: Part II specialized mental health services that are provided by a community mental health center to clients who have BHSO coverage listed under their eligibility are billed to the appropriate BHSO. The mental health claims billed to the BHSO must be billed with a billing taxonomy 261QM0801X or 251S00000X. Mental health outpatient services rendered by independently licensed or certified providers for BHSO clients are billed as FFS claims and follow Part I of this billing guide.

Recipient Aid Categories (RACs)		
1014-1023	1039*	1046-1047 1048-1049*
1052-1055	1059*	1061*
1065-1074	1083-1084*	1086*
1088-1089*	1091*	1101-1111
1121-1122	1124*	1126*
1134	1146-1153	1162-1169
1174-1175	1194**	1196-1207
1209	1211-1213	1214-1216**
1217-1225	1236-1269	1274-1278***

If the client requires specialized mental health services but does not have one of the RAC codes listed above, refer to the BH-ASO.

RAC codes with an asterisk (*) indicate those individuals who may have a spenddown.

RAC codes with a double asterisk (**) indicate an effective date of April 1, 2021.

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RAC codes with a triple-asterisk (***) indicate an effective date of April 1, 2022.

For more information about spenddown including the step-by-step process and contact information, see the [ProviderOne Billing and Resource Guide](#).

Provider eligibility

Who is eligible to provide and bill for these specialized mental health services?

To be eligible to provide and bill HCA for specialized mental health services described above, the provider must meet all the following:

- Be licensed and certified by the Department of Health to provide the services
- Be in good standing without restriction
- Have a current core provider agreement (CPA) and national provider identifier (NPI). For more information about completing the CPA, see the [Provider Enrollment](#) webpage for new providers
- Be registered with the Provider Network through the provider entry portal (PEP). See the [Contractor and provider resources](#) webpage

Crisis services

Crisis mental health services are provided upon request, 24-hours a day, seven days a week, and are available to anyone who needs them regardless of ability to pay. To find telephone numbers for crisis intervention services, see the [State Mental Health Crisis Lines](#).

Crisis services provided for Apple Health clients who are not enrolled in an integrated managed care plan are eligible for FFS billing when the provider meets the above qualifications.

Tribal health clinics providing crisis services should refer to the [Tribal Health Services Billing Guide](#).

Professional services

HCA covers professional services for medically necessary specialized mental health services, including services rendered at a free-standing evaluation and treatment center, using CPT® and HCPCS codes on a professional claim form or 837P. For more information about coverage, services, and codes, see the [Contractor and provider resources](#) webpage. All providers must comply with the documentation requirements in [WAC 246-341-0640](#).

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What are the general guidelines for billing professional services?

- Providers must bill using the most appropriate procedure code for the total time spent on direct patient care during each visit.
- For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.

How do specialized mental health providers bill claims for professional services?

For general billing information, see the instructions in HCA's [ProviderOne Billing and Resource Guide](#).

All specialized mental health providers must bill as follows:

- Report modifier TG as the first modifier for specialized mental health services.
- Use billing taxonomy 261QM0801X.
- Do not bill with individual servicing provider NPIs. Bill with the clinic NPI and taxonomy only.
- Do not report specialized mental health services on the same claim form as Part I services.

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.

For professional charges during a psychiatric inpatient admission, see [professional services delivered in an inpatient setting](#) in Part I of this guide.

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Crisis Services	H2011	Crisis intervention service, per 15 minutes	TG
Crisis Services	H0030	Behavioral health hotline service	TG
Day Support	H2012	Beh. health day treatment, per hour	TG
Family Treatment	90846	Family psytx w/o pt 50 min	TG
Family Treatment	90847	Family psytx w/pt 50 min	TG
Group Treatment Services	90849	Multiple family group psytx	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Group Treatment Services	90853	Group psychotherapy	TG
High Intensity Treatment	H0040	Assertive comm treatment program, per diem	TG
High Intensity Treatment	H2022	Comm-based wrap-around service, per diem	TG
High Intensity Treatment	H2033	Multisystemic therapy for juveniles, per 15 minutes	TG
High Intensity Treatment	S9480	Intensive outpt psychiatric services, per diem	TG
Individual Treatment	90832	Psytx w pt 30 minutes	TG
Individual Treatment	90833	Psytx w pt w e/m 30 min	TG
Individual Treatment	90834	Psytx w pt 45 minutes	TG
Individual Treatment	90836	Psytx w pt w e/m 45 min	TG
Individual Treatment	90837	Psytx w pt 60 minutes	TG
Individual Treatment	90838	Psytx w pt w e/m 60 min	TG
Individual Treatment	90889	Preparation of report	TG
Individual Treatment	99354	Prolng svc o/p 1 st hour	TG
Individual Treatment	99355	Prolng svc o/p ea addl 30	TG
Individual Treatment	H0004	Beh health counseling and therapy, per 15 minutes	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Individual Treatment	H0036	Comm psychiatric supportive treatment, face-to-face, per 15 minutes	TG
Individual Treatment	H0046	Mental health services not otherwise specified	TG
Individual Treatment	H2014	Skills training and development, per 15 minutes	TG
Individual Treatment	H2015	comprehensive community support services, per 15 minutes	TG
Individual Treatment	H2017	Psychosocial rehabilitation services, per 15 minutes	TG
Intake Evaluation	90791	Psych diagnostic evaluation	TG
Intake Evaluation	90792	Psych diag eval w/med svcs	TG
Intake Evaluation	99202	Office o/p new sf 15-29 min	TG
Intake Evaluation	99203	Office o/p new low 30-44 min	TG
Intake Evaluation	99204	Office o/p new mod 45-59 min	TG
Intake Evaluation	99205	Office o/p new hi 60-74 min	TG
Intake Evaluation	99304	Nursing facility care init	TG
Intake Evaluation	99305	Nursing facility care init	TG
Intake Evaluation	99306	Nursing facility care init	TG
Intake Evaluation	99324	Domicil/r-home visit new pat	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Intake Evaluation	99325	Domicil/r-home visit new pat	TG
Intake Evaluation	99326	Domicil/r-home visit new pat	TG
Intake Evaluation	99327	Domicil/r-home visit new pat	TG
Intake Evaluation	99328	Domicil/r-home visit new pat	TG
Intake Evaluation	99341	Home visit new patient	TG
Intake Evaluation	99342	Home visit new patient	TG
Intake Evaluation	99343	Home visit new patient	TG
Intake Evaluation	99344	Home visit new patient	TG
Intake Evaluation	99345	Home visit new patient	TG
Intake Evaluation	99354	Prolng svc o/p 1 st hour	TG
Intake Evaluation	99355	Prolng svc o/p ea addl 30	TG
Intake Evaluation	99356	Prolng svc i/p/obs 1 st hour	TG
Intake Evaluation	99357	Prolng svc i/p/obs ea addl	TG
Intake Evaluation	H0031	Mental health assessment, by non-physician	TG
Medication Management	96372	Ther/proph/diag inj sc/im	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Medication Management	99211	Office o/p est minimal prob	TG
Medication Management	99212	Office o/p est sf 10-19 min	TG
Medication Management	99213	Office o/p est low 20-29 min	TG
Medication Management	99214	Office o/p est mod 30-39 min	TG
Medication Management	99215	Office o/p est hi 40-54 min	TG
Medication Management	99307	Nursing fac care subseq	TG
Medication Management	99308	Nursing fac care subseq	TG
Medication Management	99309	Nursing fac care subseq	TG
Medication Management	99310	Nursing fac care subseq	TG
Medication Management	99334	Domicil/r-home visit est pat	TG
Medication Management	99335	Domicil/r-home visit est pat	TG
Medication Management	99336	Domicil/r-home visit est pat	TG
Medication Management	99337	Domicil/r-home visit est pat	TG
Medication Management	99347	Home visit est patient	TG
Medication Management	99348	Home visit est patient	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Medication Management	99349	Home visit est patient	TG
Medication Management	99350	Home visit est patient	TG
Medication Management	T1001	Nursing assessment/evaluation	TG
Medication Monitoring	H0033	Oral medication admin, direct observation	TG
Medication Monitoring	H0034	Medication training and support, per 15 minutes	TG
Mental Health Services Provided in a Residential Setting	H0018	Behavioral health; short term residential, w/o room and board, per diem	TG
Mental Health Services Provided in a Residential Setting	H0019	Behavioral health; long term residential, w/o room and board, per diem	TG
Peer Services	H0038	Self-help/peer services, per 15 minutes	TG
Psychological Assessment	96112	Devel tst phys/qhp 1st hr	TG
Psychological Assessment	96113	Devel tst phys/qhp ea addl	TG
Psychological Assessment	96130	Psycl tst eval phys/qhp 1st	TG
Psychological Assessment	96131	Psycl tst eval phys/qhp ea	TG
Psychological Assessment	96132	Nrpsyc tst eval phys/qhp 1st	TG

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State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Psychological Assessment	96133	Nrpsyc tst eval phys/qhp ea	TG
Psychological Assessment	96136	Psycl/nrpsyc tst phy/qhp 1st	TG
Psychological Assessment	96137	Psycl/nrpsyc tst phy/qhp ea	TG
Psychological Assessment	96138	Psycl/nrpsyc tech 1st	TG
Psychological Assessment	96139	Psycl/nrpsyc tst tech ea	TG
Rehabilitation Case Management	H0023	Behavioral health outreach service	TG
Special Population Evaluation	T1023	Screening for appropriateness for spec program	TG
Stabilization Services	S9484	Crisis intervention mental health services, per hour	TG
Stabilization Services	S9485	Crisis intervention mental health services, per diem	TG
Therapeutic Psychoeducation	H0025	Beh health prevention education service	TG
Therapeutic Psychoeducation	H2027	Psychoeducational service, per 15 minutes	TG
Therapeutic Psychoeducation	S9446	Patient education, nonphysician provider, group, per session	TG
Community Behavioral Health Service Per Month	T1041	Monthly Case Rate provided for WISe per youth, per month	TG, U8

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What specialized mental health services does HCA cover for young children (birth through age five)?

Specialized mental health treatment may be provided to children from birth through age five and the children's parents or guardians if the treatment is directly related to the child's care and is medically necessary. Providers must bill mental health services for a newborn or child under the newborn or child's ProviderOne client ID.

Note: HCA covers depression screening for caregivers of infants ages six months and younger. This screening should be billed under the infant's ProviderOne client ID when done by the infant's provider.

Mental Health Assessments for Young Children

About this section

This section of the billing guide applies to mental health services for children from birth through age five. **This information does not apply to any other age group.**

As directed by [RCW 74.09.520\(11\)](#), HCA pays for the following related to mental health and assessment and diagnosis of children from birth through five years of age:

- Up to five sessions, per client, per provider, per calendar year, to complete a mental health assessment (i.e., Intake Evaluation).
- Mental health assessments in home or community settings, including reimbursement for provider travel.

Additionally, Apple Health mental health providers must use the current version of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™)* for mental health assessments and diagnoses of children from birth through age five.

Note: For more information, see [HCA's Mental Health Assessment for Young Children provider webpage](#).

Billing for multi-session mental health assessments for young children

Providers conducting a mental health assessment (i.e., Intake Evaluation) with children from birth through age five may conduct up to five sessions per client within a calendar year. Providers must submit claims using the appropriate Intake Evaluation CPT®/HCPCS codes for each of the sessions conducted with the child and the child's family for the purpose of the intake evaluation.

Note: For clients age five or younger, a [limitation extension](#) is required for more than five mental health assessment sessions, per provider, per calendar year.

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For clients age six and older, a **limitation extension** is required to provide more than one mental health assessment session, per provider, per calendar year.

Reimbursement for Provider Travel

HCA pays for provider travel when providers conduct a mental health assessment for children from birth through age five in the home or in a community setting. Provider travel is paid by mileage, using current mileage reimbursement rates from the Office of Financial Management. The following information must be present on any submitted claims to qualify the **claims** for provider travel reimbursement.

Component	Mental health assessment	For child birth through age five	In home or community setting
Claim Requirement	CPT®/HCPCS Code: <ul style="list-style-type: none"> 90791 90792 H0031 	<ul style="list-style-type: none"> Client DOB: Less than or equal to 72 months before the date of service (younger than 6 years) 	<ul style="list-style-type: none"> Place of Service (POS) Code: 03: School 04: Homeless Shelter 12: Home 99: Other Place of Service

Note: Claims with a U8 modifier, which identify services provided to Wraparound Intensive Services (WISe) participants by qualified WISe practitioners, are NOT eligible for MHAYC provider travel reimbursement. For more information, please refer to [Wraparound with Intensive Services \(WISe\) monthly case rate](#).

For clients enrolled in fee-for-service, refer to the Fee-for-Service Mental Health Assessments for Young Children A-19 and Instructional Cover Sheet for guidance on submitting A-19 invoices and receiving payment. See the [Mental Health Assessment for Young Children webpage for more information](#).

Note: For clients enrolled in an HCA-contracted managed care organization (MCO), providers must follow the policies and procedures of the MCO regarding provider travel reimbursement.

Diagnosis for young children

The DC:0-5™ is the internationally accepted system for developmentally appropriate assessment of young children's mental health; however, other diagnostic manuals are often still necessary in our current behavioral health system. For Apple Health clinicians, federal Medicaid guidance requires that all claims be submitted with an ICD (International Classification of Disease) code. HCA has published an interim Apple Health "DC: 0 - 5™ crosswalk," a reference guide for clinicians that helps to convert DC: 0 - 5™ diagnoses to associated ICD diagnostic codes and DSM diagnoses. For more information, see the [Mental Health Assessment for Young Children webpage](#).

Note: When a mental health diagnosis cannot be made or is unknown during the multi-session assessment process, use F99 "Mental disorder, not otherwise specified". When a provider has adequate information to provide a diagnosis, providers must use the most specific ICD-10 code available.

Wraparound with Intensive Services (WISe) monthly case rate

Wraparound with Intensive Services (WISe) is a range of services for eligible Apple Health clients age 20 or younger with mental disorders causing severe disruptions in behavior and requiring:

- Coordinating services and support across multiple domains (i.e., mental health system, juvenile justice, child protection/welfare, special education, developmental disabilities).
- Intensive care collaboration.
- Ongoing intervention to stabilize the child and family to prevent more restrictive or institutional placement.

WISe team members accommodate families by working evenings and weekends, and responding to crises 24 hours a day, seven days a week. Services are based on the client's needs and the Cross System Care Plan developed by the Child and Family Team.

Approved WISe providers are eligible to receive a monthly case rate. The WISe case rate is allowed each month for each client enrolled in WISe. The case rate is in addition to the reimbursement schedule for services provided and billed within the same time period.

How do approved providers bill claims with the WISE case rate?

For general billing information, see the instructions in HCA's [ProviderOne Billing and Resource Guide](#). All approved WISE providers must bill as follows:

- Continue to bill as usual for services provided to child receiving WISE. Bill all services using the TG modifier followed by the U8 modifier.
- Using the information in the [chart](#), bill the monthly case rate for WISE: once per month, per child, starting with the first date of service on a single claim.
- For information about billing and Health Insurance Portability and Accountability Act (HIPAA), see the [HIPAA Electronic Data Interchange \(EDI\)](#).

Intensive Residential Treatment Team Program

Intensive Residential Treatment teams (IRT) is a Medicaid-funded range of service components that includes individualized, intensive, coordinated, comprehensive, culturally competent, and outreach-based services for adults:

- Age 21 years and older living in ALTSA-licensed adult family homes and assisted living facilities; and
- Who have a mental disorder that causes severe disruptions in functioning and has resulted in a recent need of hospitalization.

IRT services are delivered by a multi-disciplinary, mental health staff who work as a team and provide most of the treatment, rehabilitation, and support services clients need to achieve their goals. The team provides services with an extended availability and a greater number of contacts than available for most outpatient services. Services are provided to the client where they live, and the team coordinates with the facility the client lives in to better work with the client.

- Inclusions:
 - Criteria for entry to this program are specified on the [IRT webpage](#).
 - Bill with taxonomy 261QM0801X on 837P format. Services are provided by staff who are members of an IRT team and are billed by an approved agency. Services are limited to once per client, per calendar month with the applicable HCPCS code S0311, and modifier HK.
 - Services are provided by staff who are members of an IRT team and are billed by an approved agency. Services are limited to once per client, per calendar month with the applicable HCPCS code S0311, and modifier HK.
- The following services are excluded from IRT programs:
 - Day Support
 - High Intensity Treatment

New Journeys

New Journeys is an evidence-informed, Coordinated Specialty Care treatment model for older youth and young adults who are experiencing a first episode of psychosis. New Journeys is more intensive than regular outpatient services. This treatment model is curated specifically to meet the needs of those in the early stages of psychosis when they are first diagnosed. Treatment goals focus on functional recovery and are defined by what is meaningful to the youth and their family. Routine outcome monitoring or measurement-based care is used by teams throughout care to inform youth and families of progress, improve outcomes, and to drive practice improvements.

Entry to New Journeys is specified in the HCA/DBHR [New Journeys Policy, Program, and Procedure Manual](#) and defined specifically by age and diagnoses.

New Journeys services must be billed as follows:

- Use billing taxonomy: 261QM0801X on 837p format
- Use HCPCS code T2022 and modifier HT- Limit 1 per client, per calendar month, for 1-6 months
- Use HCPCS code T2023 and modifier HT -Limit 1 per client, per calendar month, for 7 - 24 months
- Each set of services is limited to once per client, per lifetime
- There is a client age restriction of at least age 15 through age 40 (under age 41)

For more information, see the [New Journeys Fact Sheet and the New Journeys website](#).

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see HCA's [Paper Claim Billing Resource](#).

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's [Billers and Providers](#) webpage, under Webinars. See [Direct data entry of an institutional claim or Medical provider workshop](#) for professional claims.

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.

Where can I view the fee schedules?

See the following fee schedules for more information:

- [Specialized Mental Health Services Fee Schedule](#)

Note: The reimbursement rate for these specialized mental health services may differ from reimbursement in other mental health FFS programs, based on the acuity of the client.

Professional mental health services delivered in an inpatient hospital setting on an 837P

Prior authorization (PA) is **not** required for eligible fee-for-service clients who are not enrolled in an integrated managed care plan.

HCA covers professional inpatient mental health services when provided by a psychiatrist, P-ARNP, or PMHNP-BC, or psychologist in conjunction with the prescribing provider.

- HCA pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. HCA considers services rendered during rounds to be direct client care services and may include up to one-hour individual psychotherapy, family/group therapy, and electroconvulsive therapy.
- One ECT or narcosynthesis per client, per day only when performed by a psychiatrist.

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How do I bill the professional services in an emergency room setting for a client who is transferred to another facility for an inpatient psychiatric admission?

See [How do providers identify the correct payer?](#)

Professional services for involuntarily admitted clients

For Involuntary Treatment Act (ITA) admissions under chapters [71.34](#) and [71.05](#) RCW, HCA covers the inpatient professional mental health services delivered by psychiatrists, P-ARNPs, or PMHNP-BCs to clients covered by an MCO, except for clients who reside in the integrated managed care region. See [How do providers identify the correct payer?](#)

To bill for psychiatric services under the ITA follow these guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or P-ARNP within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT® code 90791 or 90792.

When billing for an evaluation under these circumstances, do both of the following:

- Enter SCI=I in the Claim Note section of the electronic professional claim.
- Provide documentation that the client was admitted to an inpatient facility.
- A day's rounds, along with any one of the following, constitute direct client care:
 - Narcosynthesis
 - Brief (up to one hour) individual psychotherapy
 - Multiple/family group therapy
 - Group therapy
 - ECT
- A court may request another physician or P-ARNP evaluation.
- HCA pays for physician or P-ARNP evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client.
- Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT® code 99075) for time spent doing court testimony.
- HCA does not cover services provided outside the State of Washington under the Involuntary Treatment Act (chapter [71.05](#) RCW and [chapter 182-538D WAC](#)), including services provided in designated bordering cities.

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If the person is not receiving Apple Health or not Apple Health-eligible, see [Professional services for ITA individuals who are not receiving or not eligible for Apple Health](#) for assistance with how to bill for these professional services.

When is out-of-state outpatient care covered?

(WAC [182-501-0182](#))

Out-of-state mental health care requires [prior authorization](#) (PA).

HCA covers emergency and nonemergency out-of-state health care services provided to eligible Apple Health clients when the services are:

- Within the scope of the client's health care program.
- Allowed to be provided outside the state of Washington by specific program.
- Medically necessary.

When HCA pays for covered health care services furnished to an eligible Apple Health client outside the state of Washington, its payment is payment in full according to [42 C.F.R. § 447.15](#).

Part III: Inpatient psychiatric civil commitments for 90+ days

About this section

This section of the billing guide applies to freestanding Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA's Division of Behavioral Health and Recovery (DBHR). **This information does not apply to any other facility.**

The identified population are clients mandated by court process for a civil commitment stay that is 90 to 180 days (reference [Washington State Budget Proviso Language from Section 204 Q of the enacted 2018 Budget](#), Chapters 246-320 and 246-322 WAC, and RCW 71.05).

Note: More information on substance use disorders (SUD) is available on [HCA's billing guides and fee schedules webpage](#).

HCA pays for inpatient bed capacity in free-standing E&T facilities, psychiatric hospitals, and E&T units in acute care hospitals that provide inpatient psychiatric care, as defined in Chapters 246-320 and 246-322 WAC. (See individual contract-specific language for the pre-determined number of beds.) For services not identified in these two WAC chapters, see the [Physicians Related Services/Health Care Professional Services Billing Guide](#) or the [Pharmacy Special Services Fee Schedule](#).

The Department of Health (DOH) must license and certify all contracted facilities in accordance with Chapters 246-320, 246-322, and 246-341 WAC and facilities must meet the general conditions of payment criteria in WAC 182-502-0100.

Recoupment of payments

HCA recoups any inappropriate payments made to contracted facilities providing 90- to 180-day civil commitment beds.

Billing for professional services

For 90- to 180-day HCA-contracted beds, bill the appropriate Managed Care Organization or Behavioral Health Administrative Service Organization. For fee-for-service clients, see [Part II: Specialized mental health services for fee-for-service clients](#).

Authorizations for inpatient psychiatric admissions civil commitments 90 days or longer

The contracted requesting facility must [email](#) the DBHR representative using the contracted facility's secure email system to report the change in stay from a 14-day court order to a 90+ day court order within 48 hours of admission. At this time, the contracted requesting facility requests an end to the initial authorization from the original provider, and the DBHR representative creates a new pre-authorization in ProviderOne for the new episode of care. The DBHR representative then provides the facility with a pre-authorization number. The contracted requesting facility must include a portable document format (PDF) version of the **court documentation** clearly showing that the individual is legally committed for 90+ days in either the email or faxed afterward to the DBHR representative at 360-763-4702. Court documentation **must not contradict** the facility's location.

For example, if a specific facility is mentioned, then the documentation must reflect the facility the individual is in. If a facility is not specifically identified, the individual may transfer to a facility in their home county if deemed clinically appropriate.

When an individual is admitted into a contracted bed, the contracted site must [email](#) HCA a completed Admission/Demographic form containing the following information. HCA requires this form for everyone admitted to a 90- or 180-day state contracted civil commitment bed, so HCA can create the prior authorization in the Provider One system. This form is provided to the facility when it becomes a contracted site:

- Facility name
- Facility NPI number
- Client's full name (confirm correct spelling)
- Client's date of birth (DOB)
- Client's home city
- Client's ProviderOne ID number (ending with "WA")
- Primary psychiatric ICD-DM diagnosis (e.g., F20.9)
- Insurance provider name (e.g., Molina, CHPW, etc.)
- Additional insurance if any (e.g., Medicare or private insurance)
- If no insurance coverage, submit an ITA eligibility segment for the length of stay
- Date of admit to long-term bed
- Type of court order (e.g., 90-day, 180-day, etc.)
- Anticipated end/discharge date

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Note: You must complete the form using Microsoft Word. Otherwise, the system will not recognize the information submitted. Do not leave any section empty.

A current civil commitment or additional court order(s), or both, must accompany the Admission/Demographic form.

Email all communications to HCA. If a communication contains personal health information (PHI), use the contracted facility's secure email system.

If an individual who is to be admitted to a 90- or 180-day bed has Medicaid coverage that is inactive, contracted facilities must take steps to re-activate the individual's Medicaid coverage. Medicaid coverage is imperative to ensure that individuals may access outpatient services upon discharge to ensure their success upon returning to their community. Work with individuals' community service office (CSO) to help individuals have their Medicaid coverage re-activated.

If Medicare coverage is a factor, include this information in the authorization request. Add an Involuntary Treatment Act (ITA) segment to the request if the individual does not have either active Medicaid or has dual Medicare/Medicaid coverage.

Discharge Documents

When an individual is discharged from a contracted bed, the contracted facility must **email** HCA a completed Discharge form, indicating the discharge occurred. This form is provided to the facility when it becomes a contracted site. Discharge information on the form must include all the following:

- Facility name
- Facility NPI number
- Authorization Number
- Client's full name (confirm correct spelling)
- Client's Provide One ID number
- Discharge Date
- Discharge ICD Diagnosis (e.g., F25.0)
- Discharge setting type: e.g., assisted living facility, apartment, adult family home, etc.
- Discharge location address
- Legal Status Upon Discharge (e.g., 90- day conditional release, other)

Note: You must complete the form using Microsoft Word. Otherwise, the system will not recognize the information submitted. Do not leave any section empty.

If applicable, current **additional** court order(s) may accompany the Discharge Form.

Billing for Part III services

Medicaid Billing

Acute Care Hospitals

Under the prior authorization (PA), acute care hospitals contracted for the 90+-day inpatient care bill for inpatient services the same as they do for shorter stays.

Acute care hospitals must bill Medicare and any other third-party insurance before billing Medicaid. HCA allows retroactive billing for charges not covered by Medicare or third-party insurance.

The following specific claim instructions relate to billing services on an electronic institutional claim form (837i):

Name	Entry
Taxonomy	282N0000X
Revenue Code	0124

Acute care hospitals may bill inpatient psychiatric claims for these services every 30 days but must not bill these claims as separate 30-day claims. Acute care hospitals must adjust the initial claim submitted for the first 30 days and resubmit it to include the additional 30 days/additional days until the client is discharged.

Acute care hospitals must still bill all other inpatient services in 60-day intervals.

HCA reimburses for Medicare crossover claims according to WAC [182-502-0110](#). See [Appendix J: Medicare crossover claim payment methodology](#).

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Psychiatric Hospitals

Under the PA, psychiatric hospitals contracted for the 90+-day inpatient care bill for inpatient services the same as they do for shorter stays.

Psychiatric hospitals must bill Medicare and any other third-party insurance before billing Medicaid. HCA allows retroactive billing for charges not covered by Medicare or third-party insurance.

The following specific claim instructions relate to billing services on an electronic institutional claim form (837i):

Name	Entry
Taxonomy	283Q0000X
Revenue Code	0124

Psychiatric hospitals may bill inpatient psychiatric claims for these services every 30 days but must not bill these claims as separate 30-day claims. Adjust the initial claim submitted for the first 30 days and resubmit it to include the additional 30 days/additional days until the client is discharged. **Psychiatric hospitals must still bill all other inpatient services in 60-day intervals.**

HCA reimburses for Medicare crossover claims according to WAC [182-502-0110](#). See [Appendix J: Medicare crossover claim payment methodology](#).

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Free-Standing Evaluation and Treatment Centers (E&Ts)

Under the PA, free-standing E&Ts contracted for the 90+-day inpatient care bill for inpatient services in Provider One.

Medicare does not cover services billed by freestanding E&T facilities. Free-standing E&Ts must document in the client's record that this benefit is not covered by Medicare, bill Medicaid as primary, and give this information to the DBHR representative authorizing the client's stay.

As identified in this guide, the daily per diem rate includes all the following:

- An evaluation
- Stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other mental health professionals
- Discharge planning involving the individual, family, and significant others to ensure continuity of mental health care

The following specific claim instructions relate to billing services on an electronic institutional claim form (837i):

Name	Entry
Taxonomy	320800000X
Claim Note	SCI=I
Revenue Code	1001
Bill Type	86x

Note: Enter dates at the line level

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

No Identified Insurance

Providers must request an ITA segment for the following:

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- Individuals with Active Apple Health—QMB-only coverage
- Individuals who are not eligible for Apple Health
- Individuals with Medicare-only coverage
- Individuals whose private insurer has denied coverage

The contracted requesting facility must [email](#) HCA the admitted individual's information using the Admission/Demographic form and indicate that ITA coverage needs to be put into effect. This form is provided to the facility when it becomes a contracted site.

Billing for individuals not eligible for Medicaid who have Commercial/Private Insurance

Community Hospitals & Free-Standing E&T's

As with Medicare and Medicaid dual eligibility, contact the appropriate payer.

Part IV: Institutional Facility Charges Billed on 837I Format

How do I bill freestanding evaluation and treatment services provided to eligible Apple Health clients not enrolled in an integrated managed care plan who are in one of the RAC codes found in Part II?

HCA covers freestanding evaluation and treatment services provided by Community Mental Health Centers that are eligible to bill for specialized mental health services under this section of the billing guide. At a minimum, these services include:

- An evaluation
- Stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other mental health professionals
- Discharge planning involving the individual, family, and significant others to ensure continuity of mental health care

Use the 837i (institutional) format to bill freestanding evaluation and treatment services with the following information on the claims.

- When a client is admitted into an evaluation and treatment facility and their Apple Health coverage changes mid-stay (i.e., fee-for service to managed care), the bill must be split based on the client's coverage at the time of the service.
 - Example: A client is enrolled in fee-for-service during admission and their coverage changes the next month to a managed care plan. The facility must split the billing as follows:
 - Bill fee-for-service for the first month of service
 - Bill the appropriate managed care plan after that

Note: Checking a client's eligibility each month is highly recommended.

See the [Inpatient Hospital Billing Guide](#) for information about billing for noncovered and covered days.

EPA for inpatient evaluation and treatment -

EPA Code	Service Name	Criteria
870001612	Voluntary Admissions for fee-for-service clients	<p>Voluntary Admissions for Fee-for-Service Clients Use this EPA when the patient agrees to admission for treatment.</p> <p>Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all of the following:</p> <ul style="list-style-type: none"> • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility <p>Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> • Legal status • Principal covered diagnosis • Place of service

EPA Code	Service Name	Criteria
870001613	Involuntary Admissions for fee-for-service clients	<p>Use this EPA when the patient has been detained through the Involuntary Treatment Act.</p> <p>Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all of the following:</p> <ul style="list-style-type: none"> • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility <p>Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> • Legal status • Principal covered diagnosis • Place of service

Services requiring EPA

The following services require EPA:

EPA Code	Service Name	CPT®/HCPCS/Dx/Revenue Code	Criteria
870001610	Inpatient psychiatric hospital involuntary detention	Revenue Code: 0114, 0124, 0134, 0144, 0154, 0204	Refer to Billing for inpatient hospital psychiatric care Effective January 1, 2020
870001611	Inpatient psychiatric hospital voluntary	Revenue Code: 0114, 0124, 0134, 0144, 0154, 0204	Refer to Billing for inpatient hospital psychiatric care Effective January 1, 2020

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Institutional (facility) charges

Inpatient hospital psychiatric care criteria

Inpatient psychiatric care for all Apple Health clients, including managed care enrollees (i.e., those on Medicaid and state programs), must be all the following:

- Medically necessary (as defined in WAC [182-500-0070](#))
- Admissions where psychiatric needs are the focus of treatment
- Approved (ordered) by the professional in charge of the hospital or hospital unit
- Services provided in a psychiatric hospital must have psychiatric diagnosis and be in APR DRG 740-760

Provider requirements

This section of the billing guide **does not** apply to any of the following:

- Freestanding Evaluation and Treatment (E&T) facilities, except for those contracted with the state for long-term care
- Children's Long-Term Inpatient Program (CLIP) facilities
- Eastern State Hospital
- Western State Hospital
- Residential treatment facilities

HCA pays for hospital inpatient psychiatric care, as defined in [WAC 182-550-2600](#) under inpatient psychiatric facility prospective payment rules when provided by any of the following:

- Free-standing psychiatric hospitals determined by HCA to meet the federal definition of an Institution for Mental Diseases (IMD), which is: "a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services"
- Medicare-certified, distinct psychiatric units
- Hospitals that provide active psychiatric treatment (see [WAC 182-550-2600](#)) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician, including single-bed certifications for ITA admissions and voluntary admissions that occur in an emergency circumstance under the direction of the designated crisis responder (DCR) or written order of the emergency physician
- State-designated pediatric psychiatric units
- Facilities with state-contracted long-term beds

Hospitals providing **involuntary** hospital inpatient psychiatric care must be **licensed and certified** by DOH in accordance with chapter 246-341 WAC and must meet the general conditions of payment criteria in WAC [182-502-0100](#).

If a person is detained for involuntary care and a bed is not available in a facility certified by DOH, the state psychiatric hospitals (under the authority of DSHS) may, at their discretion, issue a **single bed certification** which serves as temporary certification allowing for inpatient admission to occur in that setting.

Voluntary treatment

Clients eligible for Apple Health

The MCO or MCO's BHSO representative may authorize and pay for voluntary hospital inpatient psychiatric hospitalization services provided to clients who are receiving or have applied and are eligible for Apple Health programs (e.g., Categorically Needy Program). For more information on Apple Health programs, see HCA's [ProviderOne Billing and Resource Guide](#).

HCA's representative (MCO or MCO's BHSO) pays for services provided to clients who are enrolled in Apple Health.

Clients not eligible for Apple Health

The BH-ASO pays for these services if a person is not eligible for Apple Health. See [How do providers identify the correct payer?](#) to determine the payer for an Apple Health client or a person who is not eligible for Apple Health.

The BH-ASO representative also authorizes voluntary services provided to clients who are in crisis and do not qualify for any Apple Health program. These inpatient stays are paid for with state funds.

Any patient without active eligibility must have a ProviderOne Client ID. The admitting hospital:

- Contacts the BH-ASO representative for authorization
- Requests the BH-ASO to create a voluntary-based eligibility segment
- Provides the BH-ASO representative with the following information:
 - **Requesting Facility Name**
 - **Client ProviderOne Number** (If already in system)
 - **Client Name:** First, Last, Middle Initial
 - **Client Legal Gender**
 - **Client Date of birth**
- **Social Security Number** (if available)
- **Washington county of residence** (If unavailable County of residence, provide out of state address, if applicable)
- **A brief summary of services and care to date** (if possible)
- **To and from dates of admittance** (if possible)

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Note: The BH-ASO must submit a ticket to ProviderOne to create an eligibility segment to include all the information above for both ITA and Voluntary.

Age of consent for voluntary inpatient hospital psychiatric care

Age group or members	Criteria
Minors age 12 and younger	May be admitted to treatment only with the permission of the minor's parent/legal guardian.
Minors age 13 and older	May be admitted to treatment with the permission of any of the following: <ul style="list-style-type: none"> • The minor and the minor's parent/guardian • The minor without parental consent • The minor's parent/legal guardian without the minor's consent through the Parent Initiated Treatment process
Age 18 years and older	May be admitted to treatment only with the client's voluntary and informed, written consent. In cases where the client has a legal guardian, the guardian's consent is required.
Members of Indian Tribes	The age of consent of the associated tribe supersedes the other requirements listed.

Involuntary treatment

Clients eligible for Apple Health

Only people age 13 and older (see "Age of consent for voluntary inpatient hospital psychiatric care" above) may be detained in an inpatient community hospital setting under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters [71.05](#) and [71.34](#) RCW. HCA's representative (MCO or MCO's BHSO) pays for services provided to clients who are Apple Health-enrolled or eligible.

Clients not eligible for Apple Health

The BH-ASO pays for these services if the person is not eligible for Apple Health. See [How do providers identify the correct payer?](#) to determine the payer for any Apple Health client or any person who is not eligible for Apple Health.

The representative also authorizes services that are provided to clients detained under ITA law when the client either refuses to apply for, or does not qualify for, any Apple Health program. These inpatient stays are paid for with state funds.

An ITA patient without active eligibility must have a ProviderOne Client ID.

The admitting hospital:

- Contacts the BH-ASO
- Requests the BH-ASO to create an ITA-based eligibility segment; and
- Provides the BH-ASO representative with the following information:
 - **Requesting Facility Name**
 - **Client ProviderOne Number** (If already in system)
 - **Client Name:** First, Last, Middle Initial
 - **Client Legal Gender**
 - **Client Date of birth**
 - **Social Security Number** (if available)
 - **Washington county of residence** (If unavailable County of residence, provide out of state address, if applicable)
 - **A brief summary of services and care to date** (if possible)
 - **To and from dates of admittance** (if possible)

Note: The BH-ASO must submit a ticket to ProviderOne to create an eligibility segment to include all the information above for both ITA and voluntary treatment.

Consent for involuntary admissions

Involuntary admissions occur in accordance with ITA in chapters [71.05](#) and [71.34](#) RCW. Therefore, no consent is required. Only people age 13 and older are subject to the provisions of these laws.

Authorization requirements for inpatient hospital psychiatric care

Note: To determine the correct payer (MCO, MCO's BHSO or BH-ASO), [See How do providers identify the correct payer?](#)

Requirements for clients enrolled in an MCO or MCO's BHSO

Contact the MCO.

Note: Information indicating which MCO or MCO's BHSO is associated with an active recipient is available in the managed care section of the Client Benefit Inquiry Screen in ProviderOne or through HCA's Interactive Voice Response System at 1-800-562-3022.

Services provided to blind and disabled clients in a certified public expenditure (CPE) hospital must be billed FFS to HCA through ProviderOne. To process those claims, the CPE hospital must obtain prior authorization from the MCO and submit that information to HCA in the *Claim Note* field on the claim.

Medicare/Medicaid dual eligibility

For the purposes of this section, "Medicare dual eligibility" refers to cases when a client has health care coverage under both Medicare and Apple Health. In such cases, the following applies:

- If the client is enrolled with a BHSO, contact the BHSO for authorization requirements for secondary payment.
- If the client is not enrolled in an MCO, see expedited prior authorization.
- If the client with Medicare dual eligibility has exhausted the Medicare lifetime benefit at admission or during the hospital stay, contact the appropriate payer.

Commercial (private) insurance

As with Medicare and Medicaid dual eligibility, contact the appropriate payer.

Changes in status

There may be more than one authorization needed during an episode of hospitalization. A request for authorization is required when there has been a change in a client's legal status, principal diagnosis, or change of hospital indicated below. The appropriate payer representatives must respond to hospital requests for authorization within the timelines below:

- **Change in legal status:** If a client's legal status changes from involuntary to voluntary, contact the appropriate payer within 24 hours.
- **Change in Principal Diagnosis:** The situations below outline different scenarios and corresponding expectations when a change in principal diagnosis occurs. Contact the appropriate payer.
 - If a client is authorized for hospital inpatient psychiatric care, is discharged, admitted to medical care, and then discharged from the medical care and readmitted to psychiatric care during their hospitalization, the appropriate payer representative must be notified of the initial discharge from psychiatric care and a new authorization may be required for the readmission to psychiatric care for that day forward.
- **Change in Hospital of Service (transfer):** If the client is to be transferred from one hospital to another hospital during inpatient psychiatric care, the hospital from which the client is being transferred must contact the appropriate payer representative regarding authorization for services to be provided in the new hospital 24 hours prior to the change in hospital of service (transfer). A subsequent authorization may be issued if the stay is approved. Hospitals must ensure that when a client who has been involuntarily detained and is transferred from one facility to another, the client's current medical, psychiatric, and copies of any ITA or court papers must accompany the client. The appropriate payer representative is required to provide a determination on the request within 24 hours of receipt of the request.

Notification of discharge

For clients who have been authorized for inpatient care by the MCO, the MCO's BHSO, or the BH-ASO representative, follow requirements of the appropriate payer.

Authorization denials and enrollee rights of appeal

Follow requirements of the appropriate payer.

Enrollees may request an administrative hearing conducted by HCA after receiving notice that an adverse benefit determination by the appropriate payer has been upheld. If the appropriate payer fails to comply with the notice and timing requirements in [42 CFR 438.408](#), the enrollee is considered to have exhausted the appeals process and may request an administrative hearing conducted by HCA.

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The appropriate payer representative cannot deny extension requests for adults who are detained under the Involuntary Treatment Act (ITA) law unless another less-restrictive alternative is available. The hospitals and the appropriate payer representatives are encouraged to work together to find less-restrictive alternatives for these clients. However, all alternative placements must be ITA-certified (either as a facility or through the single bed certification). Additionally, since the ITA court papers indicate the name of the facility in which the client is to be detained, the court must be approached for a change of detention location if a less restrictive placement is found (see [Billing instructions specific to involuntary treatment](#)).

- **Retrospective certification for admission to inpatient psychiatric care**

(PA): The PA subsystem is also used for retrospective certifications and provides the appropriate payer representative's authorization for:

- Authorized days (covered REV code units).
- Administrative days, if applicable (paid at the administrative day rate).
- Non-authorized days (noncovered) for the **extended** stay.

Retrospective authorization may occur if the client becomes eligible for Apple Health after admission or in rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the client is admitted or admitted and discharged. The appropriate payer representative on behalf of HCA has the authority to render authorization decisions for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in WAC [182-550-2600](#).

- For retrospective certification requests **prior to discharge**, the hospital must submit a request for authorization for the current day and days forward. For these days, the appropriate payer representative must respond to the hospital or hospital unit within 2 hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e., admission date to the day before the appropriate payer representative was contacted), the hospital must submit a separate request for authorization. The appropriate payer representative must provide a determination within 30 days upon receipt of the required clinical documentation for the days prior to notification.
- For retrospective certification requests **after the discharge**, the hospital must submit a request for authorization as well as provide the required clinical information to the appropriate payer representative within 30 days of discharge. The appropriate payer representative must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

- **Administrative days:** The appropriate payer representative may issue approval for administrative days only when all the following conditions are true:
 - The client has a legal status of “voluntary.”
 - The client no longer meets medical necessity criteria.
 - The client no longer meets intensity of service criteria.
 - Less restrictive alternatives are not available, posing a barrier to safe discharge.
 - The hospital and appropriate payer representative mutually agree to the appropriateness of the administrative day.

Agencies may bill the negotiated administrative day rate payment, as well as payment for pharmacy services and pharmaceuticals.

- **Extensions for youth waiting for children’s long-term inpatient program (CLIP):** The appropriate payer representative cannot deny an extension request for a child or youth who has been detained under ITA and is waiting for a CLIP admission unless another less-restrictive alternative is available. As previously noted, use of administrative days may be considered in voluntary cases only.
 - **Voluntary:** For a child waiting for admission to CLIP, who is in a community psychiatric hospital on a voluntary basis, the appropriate payer representative may authorize or deny extensions or authorize administrative days. Hospitals and appropriate payer representatives are encouraged to work together to find less restrictive alternatives for these children.
 - **Involuntary:** For a youth waiting for admission to CLIP, who is in a community psychiatric hospital on an involuntary basis, extensions may not be denied, and the appropriate payer representative may not authorize administrative days. The hospitals and appropriate payer representatives are encouraged to work together to find less restrictive alternatives available to meet the treatment needs for these youths. However, any less-restrictive placements would need to be ITA-certified (either as a facility or through the single bed certification). Additionally, since the ITA court papers indicate the name of the facility in which the youth is to be detained, the court would need to be approached for a change of detention location if a less-restrictive placement is found.

Additional requirements

In addition to timely requests for authorization and provision of required client information as indicated, admission must be determined to be **medically necessary** for treatment of a **covered principal diagnosis code** (see Diagnostic Categories).

- For Inpatient Hospital Psychiatric Admissions, “Medically Necessary or Medical Necessity” is defined as follows:
 - Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND**
 - Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a physician (according to [WAC 182-500-0070](#)); **AND**
 - The services can reasonably be expected to improve the client’s level of functioning or prevent further regression of functioning; **AND**
 - The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association) and warrants extended care in the most intensive and restrictive setting; **OR**
 - The client was evaluated and met the criteria for emergency involuntary detention (chapter [71.05](#) or [71.34](#) RCW); **OR**
 - The client was evaluated and met the criteria for emergency involuntary detention (chapter [71.05](#) or [71.34](#) RCW) but agreed to inpatient care and was admitted on a voluntary basis.
- **Provision of required clinical data:** For the appropriate payer representative to make medical necessity determination, the hospital must provide the requisite HCA-**required clinical data** for initial and extended authorizations. While appropriate payer representatives may use different formats for collection of this clinical data, the data set that is required is the same regardless of which appropriate payer representative is certifying the need for inpatient psychiatric care.

Institutional charges for inpatient hospital psychiatric admissions on an 837i

Inpatient hospital psychiatric care criteria

Inpatient psychiatric care for all Apple Health clients, including managed care enrollees (i.e., those on Medicaid and state programs), must be all the following:

- Medically necessary (as defined in [WAC 182-500-0070](#))
- For a principal covered diagnosis (see Diagnostic Categories)
- Approved (ordered) by the professional in charge of the hospital or hospital unit

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Provider requirements

This section **does not** apply to any of the following:

- Children’s Long-Term Inpatient Program (CLIP) facilities
- Eastern State Hospital
- Western State Hospital
- Residential treatment facilities

HCA pays for hospital inpatient psychiatric care, as defined in chapters [246-320](#) and [246-322 WAC](#), only when provided by one of the following Department of Health (DOH) **licensed hospitals or units**:

- Free-standing psychiatric hospitals determined by HCA to meet the federal definition of an Institution for Mental Diseases (IMD), which is: “a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services”
- Medicare-certified, distinct psychiatric units
- Hospitals that provide active psychiatric treatment (see [WAC 246-322-170](#)) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician
- State-designated pediatric psychiatric units

Hospitals providing **involuntary** hospital inpatient psychiatric care must be **licensed and certified** by DOH in accordance with [chapter 246-341 WAC](#) and must meet the general conditions of payment criteria in [WAC 182-502-0100](#).

If a person is detained for involuntary care and a bed is not available in a facility certified by DOH, the state psychiatric hospitals (under the authority of DSHS) may, at their discretion, issue a **single bed certification** which serves as temporary certification allowing for inpatient admission to occur in that setting.

Voluntary treatment

For clients who are not enrolled in an integrated managed care plan, voluntary inpatient hospital psychiatric treatment is eligible for payment based on the determination of medical necessity by the admitting clinician and subject to retrospective review by HCA.

Age of consent for voluntary inpatient hospital psychiatric care:

Age/Member	Criteria
Minors age 12 and younger:	May be admitted to treatment only with the permission of the minor's parent/legal guardian.
Minors age 13 and older:	May be admitted to treatment with the permission of any of the following: <ul style="list-style-type: none"> • The minor and the minor's parent/guardian • The minor without parental consent • The minor's parent/legal guardian without the minor's consent through the Parent Initiated Treatment process
Age 18 years and older:	May be admitted to treatment only with the client's voluntary and informed, written consent. In cases where the client has a legal guardian, the guardian's consent is required.
Members of Indian Tribes:	The age of consent of the associated tribe supersedes the requirements above.

Involuntary treatment

Only people age 13 and older (see "Age of consent for voluntary inpatient hospital psychiatric care" above) may be detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters [71.05](#) and [71.34](#) RCW. HCA pays for services provided to clients who are enrolled in Apple Health.

Consent for involuntary admissions

Involuntary admissions occur in accordance with ITA in chapters [71.05](#) and [71.34](#) RCW. Therefore, no consent is required. Only people age 13 and older are subject to the provisions of these laws.

General authorization requirements for fee-for-service inpatient hospital psychiatric care

If an Apple Health FFS client is not enrolled in an integrated managed care plan and has one of the [RAC codes](#) listed at the beginning of this section, and the stay requires inpatient psychiatric services, the hospital may submit a claim for medically necessary inpatient care using one of the EPA numbers shown below.

Each claim for inpatient psychiatric care must include an EPA number. In addition, SCI=I or SCI=V (reflecting involuntary or voluntary legal status) must be noted in the *Billing Note* section of the electronic institutional claim.

Note: HCA's [ProviderOne Billing and Resource Guide](#) provides information on how to "Check Status of an Authorization."

Billing inpatient psychiatric services for eligible fee-for-service clients not enrolled in an MCO or a MCO's Behavioral Health Services Only (BHSO)

EPA Code	Service Name	Criteria
870001610	Involuntary Treatment Act Admissions for Fee-for-Service Clients	<p>Use this EPA when the patient is detained under the Involuntary Treatment Act (ITA) in chapters 71.05 and 71.34 RCW</p> <p>Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following:</p> <ul style="list-style-type: none"> • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the hospital or hospital unit <p>Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> • Legal status • Principal covered diagnosis • Hospital of service

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EPA Code	Service Name	Criteria
870001611	Voluntary Admissions for Fee-for-Service Clients	<p>Use this EPA when the patient agrees to admission for treatment.</p> <p>Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following:</p> <ul style="list-style-type: none"> • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the hospital or hospital unit <p>Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> • Legal status • Principal covered diagnosis • Hospital of service

Authorized (covered) days: Authorized days are determined by the appropriate payer representative utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim must match authorized days in the ProviderOne PA record.

Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	\$xx.xx	
0xx4		\$xx.xx

Hospitals must bill any **administrative days** and associated covered charges for services rendered on these days with revenue code **0169** on a separate claim.

Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144, 0154, or 0204.

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Per coding standards, hospitals must report **all current ICD diagnosis codes at the highest level of specificity.**

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Medicare/Medicaid dual eligibility and commercial (private) insurance

A client is "dual eligible" when they have coverage through Medicare or a commercial insurance plan and Apple Health. In such cases, HCA will coordinate benefits based on applicable adjudication rules.

- **Administrative days:** administrative days are eligible for payment when all the following conditions are true:
 - The client has a legal status of "voluntary."
 - The client no longer meets medical necessity criteria.
 - The client no longer meets intensity of service criteria.
 - Less restrictive alternatives are not available, posing a barrier to safe discharge.
 - The hospital determines the appropriateness of the administrative day.

When administrative days are authorized, HCA reimburses for the administrative day rate, as well as for pharmacy services and pharmaceuticals.

Additional requirements

Admission must be determined to be **medically necessary** for treatment of a **covered principal diagnosis code** (see Diagnostic Categories).

- For Inpatient Hospital Psychiatric Admissions, "Medically Necessary," or "Medical Necessity" is defined as follows:
 - Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND**
 - Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC [246-322-170](#)); **AND**

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- The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning; **AND**
- The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association) that is considered a principal covered diagnosis (see Diagnostic Categories) and warrants extended care in the most intensive and restrictive setting; **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (chapter 71.05 or 71.34 RCW); **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (chapter 71.05 or 71.34 RCW) but agreed to inpatient care.

Referral to the children's long-term inpatient program (CLIP): Children and youth ages 6-17 can be referred to CLIP voluntarily or via a 180-day Involuntary Treatment Act (ITA) court. When the court determines that a 180-day commitment to inpatient care in a state-funded facility is necessary for a juvenile, the committing hospital must notify the CLIP Administration of the court's decision *by the end of the next working day following the court hearing* (RCW 71.34). Once the Committee is notified, authorization for additional care can be issued by the appropriate payer representative. For additional information, refer to the [CLIP Administration webpage](#).

HCA **does not** reimburse for services provided in a juvenile detention facility.

- **Initial notification:** The committing hospital must notify the CLIP Administration by the end of the next working day of the 180-day court commitment to state-funded long-term inpatient care.

The following information is required:

- Referring staff, organization, and telephone number
 - Client's first name and date of birth
 - Beginning date of 180-day commitment and initial detention date
 - Client's county of residence
- **Discharge summary and Review of Admissions:** Within two weeks of transfer from the hospital to a CLIP program, a copy of the completed discharge summary must be submitted by the hospital to the CLIP Administration and to the facility where the child is receiving treatment. **All referral materials** should be sent to the CLIP Administration at the following address:

Children's Long-Term Inpatient Program (CLIP)
2142 10th Avenue W
Seattle, WA 98119
206.298.9654

*All referral materials can also be **emailed** to the CLIP program. Any information being sent via email that includes PHI must be sent via secure email.

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Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter [71.34 RCW](#), hospitals must provide the appropriate payer representative access to review the care of any minor (regardless of source of payment) who has been admitted upon application of the child's parent or legal guardian. For the purposes of the Review of Admissions, all information requested must be made available to the appropriate payer representative. The representative must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- **Referral packet:** A referral packet concerning the ITA-committed child must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
 - A certified copy of the court order and the 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist
 - A diagnosis by a psychiatrist, including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association
 - An admission evaluation including:
 - Medical evaluation
 - Psychosocial evaluation
 - The hospital record face sheet
 - Other information about medical status including:
 - Laboratory work
 - Medication records
 - Consultation reports
 - An outline of the child's entire treatment history
 - All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility
 - A brief summary of child's progress in treatment to date, including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment

- **Submitting other background information for CLIP referrals:** During the 20 days following the 180-day commitment hearing, the committing hospital must arrange to have the following background information submitted to the CLIP Administration. Submit all the following information prior to admission to the CLIP program:
 - Written formulation/recommendation of the local intersystem team responsible for the child's long-term treatment plan. The plan should include family's involvement, and detail of treatment history, as well as less restrictive options being considered
 - HCA case records, including placement history form, individualized service plans (ISPs), court orders, etc. Include legal history regarding juvenile arrests, convictions, probation/parole status.
 - Complete records from all hospitalizations, including admission and discharge summaries, treatment plans, social history evaluations, consultations, and all other assessments (do not include daily progress notes)
 - Treatment summaries and evaluations from all foster or residential placements, and all-day treatment and outpatient treatment summaries
 - If not contained in other documents, a comprehensive social history, including developmental and family history
 - School records, including special services assessments, transcripts, psychological evaluations, current IEP, current level of functioning
 - Immunization record, copy of social security card and birth certificate
- **Interfacility transfer reports:** When a youth who has been involuntarily detained is transferred from one facility to another, an interfacility or hospital transfer report detailing the child's current medical, psychiatric, and legal status (for both ITA commitment and custody) must accompany that child as well as a certified copy of the court order. For general information, visit the [Children's Long-Term Inpatient Program for Washington State \(CLIP\)](#) webpage.

Note: See the [Clinical data required for initial certification](#) and [Clinical data required for extension certification](#) requests.

- **Referral to the children's long-term inpatient program (CLIP):** Children and youth ages 6-17 can be referred to CLIP voluntarily or via a 180-day Involuntary Treatment Act (ITA) court. When the court determines that a 180-day commitment to inpatient care in a state-funded facility is necessary for a juvenile, the committing hospital must notify the CLIP Administration of the court's decision *by the end of the next working day following the court hearing* (RCW 71.34). Once the Committee is notified, authorization for additional care can be issued by the appropriate payer representative. For additional information, refer to the [CLIP Administration webpage](#).

Note: HCA **does not** reimburse for services provided in a juvenile detention facility.

- **Initial notification:** The committing hospital must notify the CLIP Administration by the end of the next working day of the 180-day court commitment to state-funded long-term inpatient care. The following information is required:
 - Referring staff, organization, and telephone number
 - Client's first name and date of birth
 - Beginning date of 180-day commitment and initial detention date
 - Client's county of residence
 - A copy of the minor's certified 180-day court order
- **Discharge summary and Review of Admissions:** Within two weeks of transfer from the hospital to a CLIP program, a copy of the completed discharge summary must be submitted by the hospital to the CLIP Administration and to the facility where the child is receiving treatment. **All referral materials** should be sent to the CLIP Administration at the following address:

Children's Long-Term Inpatient Program (CLIP)
2142 10th Avenue W
Seattle, WA 98119
TTY: 206-588-2985
Fax: 206-859-6432

All referral materials can also be **emailed** to the CLIP program. Any information being sent via email that includes PHI, must be sent via secure email.

Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter [71.34 RCW](#), hospitals must provide the appropriate payer representative access to review the care of any minor (regardless of source of payment) who has been admitted upon application of his/her parent or legal guardian. For the purposes of the Review of Admissions, all information requested must be made available to the appropriate payer representative. The appropriate payer representative must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- **Referral packet:** A referral packet concerning the ITA committed child must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
 - A certified copy of the court order and the 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist
 - A diagnosis by a psychiatrist, including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association
 - An admission evaluation including:
 - Medical evaluation
 - Psychosocial evaluation
 - The hospital record face sheet
 - Other information about medical status including:
 - Laboratory work
 - Medication records
 - Consultation reports
 - An outline of the child's entire treatment history
 - All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility
 - A brief summary of child's progress in treatment to date, including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment
- **Submitting other background information for CLIP referrals:** During the 20 days following the 180-day commitment hearing, the committing hospital must arrange to have the following background information submitted to the CLIP Administration. Submit all the following information prior to admission to the CLIP program:
 - Written formulation/recommendation of the local intersystem team responsible for the child's long-term treatment plan. The plan should include family's involvement, and detail of treatment history, as well as less restrictive options being considered.
 - HCA case records, including placement history form, individualized service plans (ISPs), court orders, DYCF Comprehensive Family Assessments court reports, etc. Include legal history regarding juvenile arrests, convictions, probation/parole status.

- Complete records from all hospitalizations, including admission and discharge summaries, treatment plans, social history evaluations, consultations, and all other assessments (do not include daily progress notes)
- Treatment summaries and evaluations from all foster or residential placements, and all-day treatment and outpatient treatment summaries
- If not contained in other documents, a comprehensive social history, including developmental and family history
- School records, including special services assessments, transcripts, psychological evaluations, current IEP, current level of functioning
- Immunization record, copy of social security card and birth certificate
- **Interfacility transfer reports** - When a youth who has been involuntarily detained is transferred from one facility to another, an interfacility or hospital transfer report detailing the child's current medical, psychiatric, and legal status (in terms of both ITA commitment and custody) must accompany that child as well as a certified copy of the court order. For general information, visit the [Children's Long-Term Inpatient Program for Washington State \(CLIP\)](#) webpage.

Billing for inpatient hospital psychiatric care

General billing of institutional claims for inpatient hospital psychiatric care

Note: Providers must submit inpatient psychiatric claims to the client's managed care organization (MCO or the MCO's BHSO) for processing and payment, not ProviderOne. However, if the client is admitted to a CPE-designated hospital and the client is a Healthy Options-Blind/Disabled (HOBD) client, the provider must bill ProviderOne and follow the instructions in this section.

All the following must occur for hospitals to be paid for providing inpatient hospital psychiatric care:

- Hospitals must contact the appropriate payer so that they may construct a valid prior authorization (PA) record for voluntary or involuntary hospital inpatient psychiatric admission in accordance with HCA's [Inpatient Hospital Services Billing Guide](#).
- For **all** hospital inpatient psychiatric admissions, including clients with Medicare dual eligibility (when the client's Medicare lifetime benefit has been exhausted) as well as clients with commercial or private insurance with Apple Health as a secondary payer (when the primary insurance is exhausted), the hospital must obtain authorization from the appropriate payer representative.

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For fee-for-service clients, each claim for inpatient psychiatric care must include an **expedited prior authorization (EPA) number**. For clients with managed care eligibility, bill the appropriate MCO. The appropriate payer representative that authorized the hospital admission must provide an authorization number. To receive payment, hospitals must ensure the authorization number appears in the *Prior Authorization Number* field of the claim. In addition, SCI=I or SCI=V (reflecting involuntary or voluntary legal status) must be noted in the *Billing Note* section of the electronic institutional claim.

- Hospitals must bill a new claim and use the appropriate EPA number depending on voluntary or involuntary status.
- A new authorization or EPA must be used when there is a change in any of the below:
 - Legal status
 - Principal covered diagnosis
 - Hospital of service
- An episode of inpatient care may require more than one certification or authorization record. To allow concurrent review, if the inpatient care requires additional days of care, authorization must be requested at least one day before the current authorization ends.

Note: HCA's [ProviderOne Billing and Resource Guide](#) provides information on how to "Check Status of an Authorization."

- **Authorized (covered) days:** Authorized days are determined by the appropriate payer representative utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim must match authorized days in the ProviderOne PA record.
- Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	\$xx.xx	
0xx4		\$xx.xx

- Hospitals must bill any **administrative days** and associated covered charges for services rendered on these days with revenue code **0169** on a separate claim.
- Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144, 0154, or 0204.

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- Per coding standards, hospitals must report **all current ICD diagnosis codes at the highest level of specificity.**

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

EPA for billing inpatient psychiatric services for eligible fee-for-service clients not enrolled in an MCO or a MCO's Behavioral Health Services Only (BHSO)

EPA Code	Service Name	Criteria
870001610	Involuntary Treatment Act Admissions for Fee-for-Service Clients	<p>Use this EPA when the patient is detained under the Involuntary Treatment Act (ITA) under chapters 71.34 and 71.05 RCW</p> <p>Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following:</p> <ul style="list-style-type: none"> Medically necessary (as defined in WAC 182-500-0070) Admissions where psychiatric needs are the focus of treatment Less restrictive placements are not available Approved (ordered) by the professional in charge of the hospital or hospital unit <p>Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> Legal status Principal covered diagnosis Hospital of service

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EPA Code	Service Name	Criteria
870001611	Voluntary Admissions for Fee-for-Service Clients	<p>Use this EPA when the patient agrees to admission for treatment.</p> <p>Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following:</p> <ul style="list-style-type: none"> • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the hospital or hospital unit <p>Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776</p> <p>A new authorization or EPA must be used when there is a change in any of the below:</p> <ul style="list-style-type: none"> • Legal status • Principal covered diagnosis • Hospital of service

Claims for psychiatric services when the principal diagnosis falls outside of the appropriate payer psychiatric diagnosis range

For certain psychiatric diagnosis codes, coding rules require the associated neurological or medical condition be coded first. Such claims are reviewed and manually processed for payment when:

- An inpatient psychiatric admission to the hospital occurs on an involuntary or voluntary basis.
- The admission is authorized by an appropriate payer representative on behalf of HCA.
- The principal diagnosis on the hospital claim is a medical diagnosis.

Splitting claims

When the focus of care shifts from medical to psychiatric services or from psychiatric to medical services, psychiatric services and acute medical services must be billed on separate claims.

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Billing instructions specific to involuntary treatment

- HCA will process claims for services provided to detained clients who have applied for Apple Health and were denied if the BH-ASO representative submits a ticket to ProviderOne for the creation of an ITA-related eligibility segment (previously called ITA-Q).
- **Out-of-state hospitals** must obtain authorization from the appropriate payer representative for all **Apple Health** clients. Neither HCA nor the appropriate payer representative pays for inpatient services for non-Apple Health clients if provided outside of the State of Washington. All claims for admissions to **out-of-state hospitals** are paid as **“voluntary legal status”** as the Involuntary Treatment Act applies only within the borders of Washington State.
- For all clients involuntarily detained under chapter [71.34](#) or [71.05](#) RCW, HCA does not provide payment for hospital inpatient psychiatric care past the **20th calendar day** from the date of initial detention *unless* a length of stay extension certification request is authorized by the BH-ASO representative.

Note: To be paid, all claims must be accurate, complete, and include the required documents as indicated in this section. Incorrectly or partially completed claims, or claims not associated with a valid PA record, will be denied, and will require resubmission, which will delay payment.

How do I bill for clients covered by Medicare Part B only (No Part A), or who have exhausted Medicare Part A benefits prior to the stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill HCA for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on HCA 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect HCA to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect HCA to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*

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Description	DRG	Per Diem	RCC	CPE	CAH
Report the Part B payment on the claim in the other payer field "Medicare Part B"	Yes	Yes	Yes	Yes	Yes
Include a claim note**	Yes	Yes	Yes	Yes	Yes

* HCA pays line item by line item on some claims (RCC, CPE, and CAH). HCA does not pay for line items that Medicare has already paid. HCA pays by the stay (DRG claims) or the day (Per Diem) on other claims. HCA calculates the payment and then subtracts what Medicare has already paid. HCA recoups what it paid as secondary on the Medicare claim.

**The claim note should be one of the following:

- SCI=I No Part A benefits
- SCI=V No Part A benefits
- SCI=I Part A benefits exhausted prior to stay
- SCI=V Part A benefits exhausted prior to stay

What HCA pays the hospital:

DRG Paid Claims:

DRG allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

Per Diem Paid Claims:

Per diem allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

RCC, CPE and CAH claims:

Allowed amount for line items covered by HCA (line items usually covered by Medicare under Part A if client were eligible).

How do I bill for clients when Medicare coverage begins during an inpatient stay or Medicare Part A has been exhausted during the stay?

Providers bill for clients when Medicare coverage begins, or Medicare Part A has been exhausted during an inpatient stay using the steps below. These instructions are also available in the [ProviderOne Billing and Resource Guide](#).

1. Bill Medicare
 - Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3 states:
“The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other people for days of care preceding entitlement except for days exceeding the outlier payment.”
2. HCA must have a paid/billed inpatient crossover claim in the system.
3. After the inpatient crossover claim is paid, bill the primary claim for the entire stay to HCA on an 837I transaction:
 - If billing ratio of costs-to-charges (RCC), certified public expenditures (CPE), or are a critical access hospital (CAH), list the Medicare covered day's charges as non-covered.
 - If billing DRG or per diem, list all services (do not list noncovered services).
4. If Part A is exhausted during the stay, bill Medicare for the Part B charges.
5. HCA may pay an amount using the following formula:
 - HCA's allowed amount for the entire stay minus Medicare's payment minus HCA's crossover payments
6. Add the following claim note:
 - “Part A Benefits exhausted during stay;” or
 - “Medicare Part A coverage began during the stay;” or
 - Enter the Part A start date or the date benefits are exhausted in the “occurrence” fields using occurrence Code “A3”.
7. Attach Part A and Part B Medicare explanation of benefits (EOMB)
8. These claims can be very complex and are addressed on a case-by-case basis and sometimes it is necessary for HCA to contact the biller for additional information.

Billing for medical admissions with psychiatric principal diagnosis

If a client had a medical admission for non-psychiatric care and the principal diagnosis is a psychiatric diagnosis contained in Chapter 5, Mental Behavioral and Neurodevelopmental Disorders of the ICD CM, the claim will be reviewed prior to a payment decision. Providers must submit the claim with adequate documentation to support payment as a medical necessity (i.e., history and physical, discharge summary, and physician orders).

Note: If the client is covered by a managed care organization (MCO), the required documentation and claim must be submitted to the client's MCO. Do not send these claims to HCA.

Recoupment of payments

HCA recoups any inappropriate payments made to hospitals for unauthorized days or for authorized days that exceeded the actual date of discharge.

Noted Exceptions

- The requirements in this section do not apply to three-day and five-day detoxification program admissions associated with HCA. See the [Hospital-Based Inpatient Detoxification Billing Guide](#).
- For people admitted involuntarily under chapter [71.05](#) or [71.34](#) RCW, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities do not apply.
- For people with Medicare and Medicaid dual eligibility, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities does not apply until the lifetime Medicare benefit has been exhausted.

Clinical data required for initial certification

In addition to the information required for the PA record, the hospital must also provide the following data elements when seeking initial certification and authorization.

History

- Risk Factors by HX - Prior hospitalizations, CLIP, foster care, suicide attempts, ER use, legal system involvement, homelessness, substance abuse TX, and enrollment in MH system.

Presenting Problems

- Mental Status - Diagnosis, thought content, risk of harm to self or others, behavioral presentation.

- Co-Morbidity Issues - Substance abuse HX/current, toxicity screen results, developmental disability, medical issues.
- Other System Issues - Jail hold, other legal issues, DDD/MH Cross System Crisis Plan.

Actions Taken to Prevent Hospitalization

- Less Restrictives - Involvement of natural supports, outpatient services including medication management, CM, PACT team, WRAP-Around, etc. Consultation with Crisis Plan, DD/MH Cross-System Crisis Plan, or Advanced Directive.
- Rule Outs - Malingering, medical causes, toxicity, hospitalization in lieu of homelessness or inability to access outpatient services.

Anticipated Outcomes for Initial Stay

- Proposed TX Plan - Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of hospitalization.
- Discharge Plan - Anticipated length of stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

Clinical data required for extension certification

In addition to the information required for the PA record, hospitals must also provide the following data elements when seeking an extension certification and authorization.

Course of Care

- Treatment Rendered - *All* inpatient services rendered since admission (medical and psychiatric tests, therapies, and interventions performed including type and frequency) and client response to treatment thus far.
- Changes - Changes in diagnoses, legal status, TX plan, or discharge plan.

Current Status

- Mental Status - Diagnoses Axis I-V, thought content, risk of harm to self or others, behavioral presentation.
- Medical Status - Diagnoses, labs, behavioral presentation, withdrawal.

Anticipated Outcomes for Continued Stay

- Proposed TX Plan - Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of continued stay and justification of why a less restrictive alternative is not appropriate at this time.
- Discharge Plan - Anticipated length of continued stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

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Inpatient psychiatric civil commitments for 90 days or longer

Part III applies to free-standing Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA. **This information does not apply to any other facility.** See [Part III: Inpatient psychiatric civil commitments for 90+ days](#) for more information.

General billing of institutional claims for inpatient hospital psychiatric care for clients who are not enrolled in an integrated managed care plan

All the following must occur for hospitals to be paid for providing inpatient hospital psychiatric care for clients who are not enrolled in an integrated managed care plan:

- To receive payment, each claim for inpatient psychiatric care must include SCI=I or SCI=V (reflecting involuntary or voluntary legal status) and must be noted in the *Billing Note* section of the electronic institutional claim.
- Hospitals must bill any **administrative days** and associated covered charges for services rendered on these days with revenue code **0169** on a separate claim. When a patient is on administrative days, the provider may bill for pharmacy services and pharmaceuticals in addition to the administrative day rate.
- Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144 or 0204.
- Per coding standards, hospitals must report **all ICD diagnosis codes at the highest level of specificity.**

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"SCI=V" for voluntary

"SCI=I" for involuntary

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Claims for psychiatric services when the principal diagnosis falls outside the psychiatric diagnosis range

For certain psychiatric diagnosis codes, coding rules require the associated neurological or medical condition be coded first. Such claims are reviewed and manually processed for payment when:

- An inpatient psychiatric admission to the hospital occurs on an involuntary or voluntary basis.
- The principal diagnosis on the hospital claim is a medical diagnosis.

Splitting claims

When the focus of care shifts from medical to psychiatric services or from psychiatric to medical services, psychiatric services and acute medical services must be billed on separate claims.

Note: To be paid, all claims must be accurate, complete, and include the required documents as indicated in this section. Incorrectly or partially completed claims will be denied and will require resubmission, which will delay payment.

How do I bill for clients covered by Medicare Part B only (No Part A), or who have exhausted Medicare Part A benefits prior to the stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill HCA for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on HCA 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect HCA to reduce the hospital stay payment by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect HCA to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*
Report the Part B payment on the claim in the other payer field "Medicare Part B"	Yes	Yes	Yes	Yes	Yes
Include a claim note**	Yes	Yes	Yes	Yes	Yes

* HCA pays line item by line item on some claims (RCC, CPE, and CAH). HCA does not pay for line items that Medicare has already paid. HCA pays by the stay (DRG claims) or the day (Per Diem) on other claims. HCA calculates the payment and then subtracts what Medicare has already paid. HCA recoups what it paid as secondary on the Medicare claim.

**The claim note should be one of the following:

- No Part A benefits
- Part A benefits exhausted prior to stay

What HCA pays the hospital

DRG Paid Claims:

DRG allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

Per Diem Paid Claims:

Per diem-allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

RCC, CPE and CAH claims:

Allowed amount for line items covered by HCA (line items usually covered by Medicare under Part A if client were eligible).

How do I bill for clients when Medicare coverage begins during an inpatient stay or Medicare Part A has been exhausted during the stay?

Providers bill for clients when Medicare coverage begins, or Medicare Part A has been exhausted during an inpatient stay using the steps below. These instructions are also available in the [ProviderOne Billing and Resource Guide](#).

1. Bill Medicare
 - Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3 states:
"The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other people for days of care preceding entitlement except for days in excess of the outlier payment."
2. HCA must have a paid/billed inpatient crossover claim in the system.
3. After the inpatient crossover claim is paid, bill the primary claim for the entire stay to HCA:
 - If billing ratio of costs-to-charges (RCC), certified public expenditures (CPE), or are a critical access hospital (CAH), list the Medicare covered day's charges as non-covered.
 - If billing DRG or per diem, list all services (do not list noncovered services).
4. If Part A is exhausted during the stay, bill Medicare for the Part B charges.
5. HCA may pay an amount using the following formula:
 - HCA's allowed amount for the entire stay minus Medicare's payment minus HCA's crossover payments
6. Add the following claim note:
 - "Part A Benefits exhausted during stay;" or

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- "Medicare Part A coverage began during the stay;" or
 - Enter the Part A start date or the date benefits are exhausted in the "occurrence" fields using occurrence Code "A3".
7. Attach Part A and Part B Medicare explanation of benefits (EOMB)
 8. These claims can be very complex and are addressed on a case-by-case basis. Sometimes it is necessary for HCA to contact the biller for additional information.

Billing when Medicare Part A benefits are exhausted during the stay

If a client's Medicare coverage ends while receiving inpatient psychiatric care (due to limits on psychiatric inpatient coverage in IMDs), use an occurrence code with qualifier A3 and provide the last Medicare Part A payable date. Enter "Medicare benefits exhausted during stay" in claim comments field.

Billing for medical admissions with psychiatric principal diagnosis

If a client had a medical admission for non-psychiatric care and the principal diagnosis is a psychiatric diagnosis contained in Chapter 5, Mental Behavioral and Neurodevelopmental Disorders of the ICD CM.), the claim will be reviewed prior to a payment decision. Providers must submit the claim with adequate documentation to support payment as a medical necessity (i.e., history and physical, discharge summary, and physician orders).

Note: If the client is covered by an MCO, the required documentation and claim must be submitted to the client's MCO. Do not send these claims to HCA.

Recoupment of payments

HCA recoups any inappropriate payments made to hospitals.