



MENTAL HEALTH SERVICES
Provider Guide

July 1, 2014

Washington State
Health Care Authority

About this guide*

This publication takes effect July 1, 2014, and supersedes earlier guides to this program.

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.

What has changed?

| Subject | Change | Reason for Change |
|---|--------------------------------------|-------------------|
| Place of service | Changed attestation process | PN 14-50 |
| Evidence-based medicine | Added new section and EPA code table | PN 14-50 |

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

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*This publication is a billing instruction.

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Resources

| Topic | Resources |
|---|--|
| Obtaining prior authorization or a limitation extension | <p>For all requests for prior authorization or limitation extension, submit:</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>Fax your request to: 866-668-1214.</p> |
| Obtaining Medicaid forms | See Medicaid Forms . |
| Definitions and Abbreviations | See the agency's Medical Assistance Glossary . |
| Becoming a provider or submitting a change of address or ownership | See the agency's Resources Available web page. |
| Contacting Provider Enrollment | |
| Finding out about payments, denials, claims processing, or agency managed care organizations | |
| Electronic or paper billing | |
| Finding Medicaid provider guides, provider notices, fee schedules, and other agency documents | |
| Third-party liability other than agency managed care | |

Program Overview

[\(WAC 182-531-1400\)](#)

This document describes the set of benefits managed by the Health Care Authority (agency) and available to those clients who do not meet the regional support network (RSN) access to care standards (ACS) and who are therefore not receiving care through the RSN community mental health clinic. Providers must transfer clients who meet the ACS to an RSN for care. More information about RSNs is available from the Department of Social and Health Services (DSHS), [Division of Behavioral Health and Recovery](#).

What services are covered?

The agency covers the following:

- Mental health services for all clients
- Mental health services by psychologists, licensed mental health counselors, independent clinical social workers, advanced social workers, and marriage and family therapists
- Psychiatric services by psychiatrists and psychiatric advanced registered nurse practitioners (P-ARNPs) for all clients
- Psychological testing by psychologists for all clients

Additional mental-health related services

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

- [Applied behavior analysis services](#)
(See [WSR 14-10-011](#))
- Alcohol or substance misuse counseling (SBIRT)
(See the [Physician-Related Services Medicaid Provider Guide](#))
- Tobacco cessation counseling
(See the [Physician-Related Services Medicaid Provider Guide](#))

Note: For providers providing evidence-based medicine (EBM), including Triple P, see [Evidence-based medicine](#) in this guide.

How are services administered?

Mental health services are available through:

- Professionals with individual Core Provider Agreements who will accept payment on a fee-for-service (FFS) basis for providing services to individuals not enrolled with a managed care organization (MCO) and whose condition does not meet the RSN access to care standards (ACS).
- Managed Care Organizations (MCOs) which are under contract with the agency's Division of Health Care Services' Apple Health Managed Care program to provide health care services for individuals whose condition does not meet the RSN ACS and who are enrolled in and receiving care from an MCO.
- Regional Support Networks (RSNs), which are under contract with the Department of Social and Health Services' Division of Behavioral Health and Recovery, serve individuals whose condition meets the RSN ACS. A memorandum of understanding between DSHS and the single State Medicaid Agency (the Health Care Authority) allows DSHS to contract with RSNs.

Who may provide mental health services?

The following licensed mental health professionals may bill the agency for mental health services on a fee-for-service basis:

- Psychiatrists
- Psychologists
- Advanced registered nurse practitioners (ARNPs)
- Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
- Independent clinical social workers or licensed advanced social workers
- Mental health counselor
- Marriage and family therapists

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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 the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Washington Apple Health. For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

Note: Patients who are not Washington 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 at: www.wahealthplanfinder.org.
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 www.wahealthplanfinder.org or call the Customer Support Center.

Are managed care enrollees eligible?

Yes. Managed care organization (MCO) enrollees are eligible for mental health services. When verifying eligibility for mental health services using ProviderOne, if the client is enrolled in an agency MCO, managed care enrollment will be displayed on the client benefit inquiry screen. All services for MCO enrollees must be requested directly through the MCO enrollee's primary care provider. (See WAC [182-538-060](#) and [182-531-0950](#).)

All mental health services covered under an MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

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

Provider Eligibility

How do I enroll to provide mental health services?

To enroll you must:

- Obtain a national provider identifier (NPI) from the federal government.
- Complete a core provider agreement.
- Send all of the above to Provider Enrollment. For more information, contact Provider Enrollment (see [Resources Available](#) web page).

To provide services to children, all providers except psychologists and psychiatrists must:

- Write and sign a letter attesting to a minimum of two years' experience in providing mental health services to children, youth, and their families as described in this guide (the letter does not need to be notarized). If you are already an enrolled provider, you must send in this additional information to bill for these services.

Who is eligible to provide mental health services?

To be eligible to provide and bill the agency fee-for-service for mental health services, all mental health professionals must:

- Complete the enrollment requirements listed above.
- Be licensed by the Department of Health.
- Be in good standing without restriction.
- Have a minimum of two years' experience in the diagnosis and treatment of children, youth, and their families. The experience may be a combination of pre- and post-licensure and may include supervised internships completed as part of a master's degree curriculum. The equivalent of one year of full-time experience must be under the supervision of a mental health professional trained in child and family mental health.

The exemptions to the minimum experience requirement are licensed psychologists and licensed psychiatrists.

Coverage

The agency covers medically necessary psychotherapy, including therapy services and family therapy visits, using the following CPT codes. Additional coverage, services, and codes are discussed in separate sections of this guide, which are organized by provider type. All providers must comply with the documentation requirements in WAC [388-865-0610](#).

Eligible providers who are approved to provide mental health services may bill one psychiatric or psychological service per day, per client, which includes the evaluation and management service.

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

| Mental Health Services Coverage Table | | | | | | | | |
|--|-----------------------------|----------|-----------------|-------|-------------|---|--------|-------|
| CPT Code | Short Description | Psych MD | P-ARNP PMHNP-BC | LMHP* | Psych Ph.D. | Limits | EPA/PA | Hours |
| +90785** | Psytx complex interactive | X | X | X | X | | | 1.00 |
| 90791*** | Psych diagnostic evaluation | X | X | X | X | One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year | | 1.00 |
| 90792*** | Psych diag eval w/med srvc | X | X | | | One psychiatric diagnostic interview exam | | 1.00 |

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| Mental Health Services Coverage Table | | | | | | | | |
|---------------------------------------|-----------------------------|----------|-----------------|-------|-------------|---|--------|-------|
| CPT Code | Short Description | Psych MD | P-ARNP PMHNP-BC | LMHP* | Psych Ph.D. | Limits | EPA/PA | Hours |
| | | | | | | allowed per client, per provider, per calendar year | | |
| 90832 | Psytx pt&/family 30 minutes | X | X | X | X | | | 0.50 |
| +90833** | Psytx pt&/fam w/e&m 30 min | X | X | | | | | 0.50 |
| 90834 | Psytx pt&/family 45 minutes | X | X | X | X | | | 1.00 |
| +90836** | Psytx pt&/fam w/e&m 45 min | X | X | | | | | 1.00 |
| 90837 | Psytx pt&/family 60 minutes | X | X | X | X | | | 1.00 |
| +90838** | Psytx pt&/fam w/e&m 60 min | X | X | | | | | 1.00 |
| 90845 | Psychoanalysis | X | | | | | | |
| 90846 | Family psytx w/o patient | X | X | X | X | | | |
| 90847 | Family psytx w/patient | X | X | X | X | | | 1.00 |
| 90849 | Multiple family | X | X | X | X | | | |

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| Mental Health Services Coverage Table | | | | | | | | |
|---------------------------------------|-------------------------------|----------|-----------------|-------|-------------|--|---|-------|
| CPT Code | Short Description | Psych MD | P-ARNP PMHNP-BC | LMHP* | Psych Ph.D. | Limits | EPA/PA | Hours |
| | group psytx | | | | | | | |
| 90853 | Group psychotherapy | X | X | X | X | | | 1.00 |
| 90865 | Narcosis | X | | | | | | |
| 90870 | Electroconvulsive therapy | X | | | | | | |
| 96101 | Psych testing by psych/phys | | | | X | See Psychological Assessment and testing | Limit of two. PA if over limit of two for outpatient only | |
| 96101 UC | | | | | | | EPA# 870001315 | |
| 96110 | Developmental screen | | | | X | | | |
| 96111 | Developmental test extend | | | | X | One per client, per provider, per calendar year | | |
| 96116 | Neurobehavioral status exam | | | | X | | PA | |
| 96118 | Neuropsych test by psych/phys | | | | X | EPA, PA if EPA does not apply | EPA#: 870001207 | |
| 96119 | Neuropsych testing by tech | | | | X | EPA, PA if EPA does not apply | EPA#: 870001207 | |

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| Mental Health Services Coverage Table | | | | | | | | |
|---|---------------------------|----------|-----------------|-------|-------------|-----------------------|--------|-------|
| CPT Code | Short Description | Psych MD | P-ARNP PMHNP-BC | LMHP* | Psych Ph.D. | Limits | EPA/PA | Hours |
| M0064 | Visit for drug monitoring | X | X | | | Not allowed in POS 21 | | |
| *Includes Social Worker, Marriage and Family Therapists and Mental Health Professionals | | | | | | | | |
| **Use add-on codes with an appropriate CPT code (see CPT book for guidance) | | | | | | | | |
| ***A psychiatric diagnostic interview exam (CPT code 90791 or 90792) and a psychological evaluation (CPT code 96101) cannot be billed on the same day, without prior authorization. | | | | | | | | |

Note: Retroactive to dates of service on or after January 1, 2014, agency-contracted managed care plans pay for mental health drugs and therapeutic monitoring for assessing effectiveness and adverse effects, including when these services are ordered by a Regional Support Network (RSN) provider. The fee-for-service (FFS) program has been paying for these services. These services will no longer be paid for by the agency's FFS program when the client is in managed care. If the client is enrolled in a plan, bill the plan.

Where can I view the fee schedules?

See the following fee schedules for more information:

- [Psychology fee schedule](#)
- [Mental health fee schedule](#)
- [Physician-related services fee schedule](#)

Services

What services can psychiatrists, P-ARNPs and PMHNP-BCs provide?

For a comprehensive list of the services psychiatrists, psychiatric ARNPs (P-ARNPs), and psychiatric mental health nurse practitioners-board certified (PMHNP-BCs) can provide, see the mental health services [coverage table](#) and the table below.

| Inpatient Covered Procedure | CPT Codes |
|---|--------------------------|
| Initial Hospital Care | 99221-99223 |
| Subsequent Hospital Care | 99231-99233 |
| Inpatient Consultation | 99251-99255 |
| Outpatient Covered Procedure | CPT Codes |
| Emergency department visits | 99281-99288 |
| Observation | 99218-99226, 99234-99239 |
| Consultation | 99241-99245 |
| Office Covered Procedure | CPT Codes |
| Office visits | 99201-99215 |
| Consultation | 99241-99245 |
| Other Covered Procedure | CPT Codes |
| Case Management Service | |
| <ul style="list-style-type: none"> • Team Conferences • Telephone Calls | 99367, 99441-99443 |
| Domiciliary home or custodial care services | 99324-99340 |
| Home services | 99341-99359 |
| Nursing facility services | 99304-99318 |

- The agency covers the above outpatient services to treat conditions that fall within the ICD-9CM diagnosis codes 290-319, as well as for preventive care, represented by V ICD9 diagnoses codes. See the table below for the V-codes.

| Diagnosis Code | Description |
|----------------|---|
| V110 | Hx of schizophrenia |
| V111 | Hx of affective disorder |
| V112 | Hx of neurosis |
| V113 | Hx of alcoholism |
| V114 | Hx combat/stress reactn |
| V118 | Hx-mental disorder NEC |
| V119 | Hx-mental disorder NOS |
| V1541 | History of physical abuse |
| V1542 | History of emotional abuse |
| V1549 | Psychological trauma other |
| V402 | Other mental problems |
| V4031 | Wandering in diseases classified elsewhere |
| V4039 | Other specified behavioral problem |
| V6120 | Counseling for Parent-child problems unspecified |
| V6121 | Counseling for victim child abuse |
| V6122 | Counseling for perpetrator of parental child abuse |
| V6123 | Counseling for Parent-biological child problem |
| V6124 | Counseling for Parent-adopted child problem |
| V6125 | Counseling for Parent (guardian)-foster child problem |
| V6129 | Other parent-child problem |
| V6281 | Interpersonal probl NEC |
| V6282 | Bereavement, uncomplicat |
| V6283 | Cnsl perp phys/sex abuse |
| V6284 | Suicidal ideation |
| V6285 | Homicidal ideation |
| V6289 | Psychological stress NEC |
| V629 | Unspecified psychosocial circumstance |
| V790 | Screening for depression |
| V791 | Screening for alcoholism |
| V792 | Scrn intellect disability |
| V793 | Screen-development prob |
| V798 | Screen-mental dis NEC |
| V799 | Screen-mental dis NOS |

- 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).
- The agency does not cover psychiatric sleep therapy.
- The agency does not pay for HCPCS code M0064 in an inpatient setting (place of service 21).
- Claims for inpatient rounds must be charged using one of the CPT® codes in this section.

Services delivered in an inpatient setting

Note: All admissions for acute, community psychiatric inpatient care require prior authorization (PA) from the designated Division of Behavioral Health and Recovery (DBHR) designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the PA from the DBHR designee. See the list of RSNs at [DBHR's RSN](#) web site.

The agency covers professional inpatient mental health services when provided by a psychiatrist, psychiatric advanced registered nurse practitioner (P-ARNP), or psychiatric mental health nurse practitioner-board certified (PMHNP-BC) as follows:

- One hospital call per day for direct psychiatric client care. The agency pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. The agency 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 electroconvulsive therapy or nacrosthesis per client, per day only when performed by a psychiatrist.

Involuntarily admitted clients

For Involuntary Treatment Act (ITA) admissions under Chapters 71.34 and 71.05 RCW, the agency covers the inpatient mental health services delivered by physicians and ARNPs. For all clients involuntarily detained under Chapters 71.34 and 71.05 RCW, physicians and psychiatric Advanced Registered Nursing Practitioners (P-ARNPs) may bill the agency for psychiatric services under the ITA according to the following 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.
- 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
 - ✓ Electroconvulsive therapy
- A court may request another physician or P-ARNP evaluation.
- The agency 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.
- The agency covers psychologist services only for provision of a psychological evaluation of detained clients.
- Out-of-state hospitals must obtain authorization from the appropriate DBHR designee for all Medicaid clients. Neither the agency nor DBHR pays for inpatient services for non-Medicaid clients if provided outside of the State of Washington. An exception is for clients who are qualified for the fee-for-service Medical Care Services (MCS) program. For these clients, the agency and DBHR pay for inpatient psychiatric services provided in bordering cities and critical access border hospitals. All claims for admissions to out-of-state hospitals are paid as voluntary legal status as the ITA applies only within the borders of Washington State.

Additional costs for court testimony are paid from the county ITA administrative fund.

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

Outpatient psychiatric services and limitations

See the mental health services [coverage table](#) for covered mental health services. The agency pays for only one psychiatric diagnostic interview exam (90791 or 90792) per client, per provider, per calendar year.

Drug monitoring

Drug monitoring refers to a brief office visit for the sole purpose of monitoring or changing drug prescriptions. Drug monitoring (HCPCS code M0064) 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 who are being managed primarily by psychotropic medications.
- Must be provided during a face-to-face visit with the client, unless it is part of a qualified telemedicine visit.
- Is not allowed in POS 21.

Documentation requirements for drug monitoring

The medical record must be clear, concise, and complete. A check list 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 [388-865-0610](#).

Documentation of medical necessity for drug monitoring must address all of 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 psychiatrist, P-ARNP, or a PMHNP-BC sees a client 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](#).

Partnership Access Line for prescribing practitioners

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 throughout 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. See also [Primary Care Principles for Child Mental Health](#), by Robert Hilt, MD, Program Director, Partnership Access Line, Seattle Children's Hospital.

What services can psychologists, including neuropsychologists, provide?

Covered Services

See the mental health services [coverage table](#) for covered mental health services. For outpatient psychological services, the agency pays for only one psychiatric diagnostic interview exam (90791) per client, per provider, per calendar year.

The agency covers these services to treat conditions that fall within the ICD-9CM diagnosis codes 290.0-319, as well as for preventive care, V ICD9 [diagnoses codes](#).

The agency pays licensed psychologists for all of the following:

- Psychological assessment
- Developmental testing
- Neuropsychological testing
- Mental health services

Note: Psychologists that provide mental health services for children must be [approved](#) to provide mental health services for children.

Psychological assessment and testing

(WAC [388-865-0610](#))

- Psychological assessments may be done on either an outpatient basis or an inpatient admission. Psychological assessments are not limited to Involuntary ITA admissions.
- 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.
- To receive reimbursement for the testing, the psychologist must keep a report in the client's file that contains all of the components of a psychological assessment including test results and interpretation of results.
- Use CPT code 96101 when billing for psychological testing.
- Outpatient psychological testing is limited to two units of code 96101 without prior authorization (PA) per client, per lifetime.
- If additional outpatient psychological testing is necessary, psychologists must request additional units of CPT code 96101 through the PA process.

Note: Services related to the evaluation using CPT code 96101 done by a center of excellence (COE) for a child suspected of having autism spectrum disorder have the limitation of up to 7 units per lifetime for clients 20 years of age or younger. These evaluations must be billed using UC modifier and EPA #870001315.

Psychological evaluations for clients admitted under ITA

The agency covers, without PA, psychological evaluations (CPT code 96101) for clients admitted to a psychiatric hospital as an involuntary admission in accordance with the ITA, Chapters 71.05 and 71.34 RCW.

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

- Type SCI=I in field 19 on the CMS-1500 claim form or enter SCI=I in the claim note field of the 837P professional E-claim.
- Provide documentation that the client was admitted to an inpatient facility.

Outpatient developmental testing

The agency reimburses for developmental testing (CPT codes 96110 and 96111) when conducted by a psychologist or neuropsychologist.

Outpatient neuropsychological testing

The agency reimburses for neuropsychological testing (CPT codes 96118 and 96119) only when the provider meets the first two requirements or the client meets the third requirement:

- The provider is currently licensed in Washington State to practice psychology or clinical neuropsychology.
- The provider has obtained written/faxed prior authorization from the agency.
- The client meets the expedited prior authorization (EPA) criteria. (See [Expedited prior authorization](#)).

A prior authorization (PA) request for neuropsychological testing of children requires a detailed review of the individualized education plan (IEP) outlining all of the following:

- The specific clinical issues in the IEP that have not been sufficiently addressed
- The aspects of the child's rehabilitation that are not improving
- Specific additional benefits that psychological 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.

A PA request for neuropsychological testing of adults and children, who are not in school, requires all of the following information:

- The client's current diagnoses
- If available, a copy of the reports produced by the testing for the agency to review
- For psychological testing that has been done in the past:
 - ✓ Documentation of the provider's review of reports produced by the testing

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- ✓ 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 psychological testing
- Specific details documenting how the results of psychological testing will improve the day-to-day care of this client

Note: The agency 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.

| Neuropsychological Testing | |
|--|---|
| Note: If the client does not meet the expedited prior authorization (EPA) criteria listed in this guide and this table, the agency requires prior authorization (PA) for the testing. | |
| Services | Neuropsychological testing of clients 16 years of age and older, in an outpatient or inpatient setting |
| Providers | <p>The agency pays only “qualified” providers for administering neuropsychological testing to eligible agency clients. To be “qualified,” providers must be both of the following:</p> <ul style="list-style-type: none"> • Currently licensed in Washington State to practice psychology or clinical neuropsychology • One of the following: <ul style="list-style-type: none"> ✓ Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology ✓ Have adequate education, training, and experience as defined by having completed all of the following: <ul style="list-style-type: none"> ➤ 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) |

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| Neuropsychological Testing | |
|-----------------------------------|---|
| Billing Codes | 96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met. |
| Billing and Payment Limits | <p>This section describes 4 groups of criteria that apply to billing in certain circumstances.</p> <p>To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met.</p> <p>For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.</p> <p>Group 1</p> <p>All of the following must be met:</p> <ul style="list-style-type: none"> • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy. • The patient is 16 years of age 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. <p>Group 2</p> <p>The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following:</p> <ul style="list-style-type: none"> • Client or family complaints • A head CT (computed tomography scan) • A mental status examination or other medical examination <p>This suspected diagnosis is not confirmed or able to be differentiated from the following:</p> |

| Neuropsychological Testing | |
|-----------------------------------|---|
| | <ul style="list-style-type: none"> • Normal aging • Mild concussion • Depression • Focal neurological impairments <p>A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.</p> <p>Group 3</p> <p>The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson’s disease, and neuropsychological testing may help with either of the following:</p> <ul style="list-style-type: none"> • 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) <p>Group 4</p> <p>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).</p> |

What services can LMHPs provide?

Licensed mental health practitioner (LMHP) includes:

- Counselors
- Independent clinical social workers
- Advanced social workers
- Marriage and family therapists

Covered Services

See the mental health services [coverage table](#) for covered services provided by the above practitioners. The agency covers these services to treat conditions that fall within the ICD-9CM diagnosis codes 290-319, as well as for preventive care V ICD9 [diagnoses codes](#).

Limitations

Outpatient LMHP services are subject to the following limitations:

- The agency pays for only one psychiatric diagnostic interview exam (CPT code 90791) per client, per provider, per calendar year.
- LMHPs must document client encounters according to WAC [182-502-0020](#).

How can all providers make sure they have the right place of service?

Since the agency does not limit the total number of outpatient mental health visits, the agency requires the appropriate place of service for mental health services. When the client meets the regional support network's (RSN) access to care standards (ACS), the client must be referred to the RSN for outpatient mental health services. After a client has received 15 visits outside an RSN, the agency requires written attestation from the provider that either the provider or the RSN has assessed the client to determine if the ACS were met and, if they were met, that a timely referral to an RSN for further care has been made. The agency will send this attestation form to providers when the agency identifies that the client has reached or exceeded 15 visits outside the RSN. Not all providers will receive this notice automatically. A mental health professional may continue to provide services under this benefit until the RSN can assume the client's care.

Agency-enrolled providers contracted with, or employed by, Community Mental Health Agencies (CMHAs) must not bill fee-for-service (FFS) and report an RSN encounter on the same service date when providing services to clients eligible for RSN services that meet the ACS. Reportable services for CMHA clients meeting ACS are authorized and purchased separately under the RSN -Prepaid Inpatient Health Plan (PIHP).

When is out-of-state care covered?

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

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

Note: Out-of-state mental health care is not covered for clients covered under the MCS eligibility program.

The agency covers emergency and nonemergency out-of-state health care services provided to eligible Washington State 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.

The agency does not cover services provided outside the State of Washington under the ITA (chapter 71.05 RCW and chapter 388-865 WAC), including designated bordering cities.

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

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Prior Authorization

What is prior authorization?

Prior authorization (PA) is the agency or its 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.

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

What is the EPA process?

The agency or its designee's 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 the agency's designated "EPA" number when appropriate.

Billing with an EPA number

Enter the EPA number on the billing form in the authorization number field when billing. With HIPAA 5010 implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. When billing multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the paper claim form exactly as follows (not all required fields are represented in the example):

19. Line 1: 870000725/ Line 2: 870000726

When billing only one EPA number on a paper CMS-1500 claim form, list the 9-digit EPA number in field 23 of the claim form. If billing an electronic claim or DDE, add the EPA number at claim level.

When billing multiple authorizations (prior/expedited) numbers on an electronic batch claim (837P) or DDE professional claim, HIPAA 5010 only allows one authorization (prior/expedited) at the claim level. For correct process of the claim, enter the authorization (prior/expedited) for the service to the appropriate service line of the claim.

Note: When the client's situation does not meet published criteria, written prior authorization 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 the agency or the agency’s designee upon request.

Services requiring EPA

The following services require EPA:

| EPA Code | Service Name | CPT/HCPC S/Dx Code | Criteria |
|-----------|----------------------------|----------------------|--|
| 870001207 | Neuropsychological Testing | CPT: 96118 and 96119 | Refer to Neurological Testing . Up to 15 units for any of these codes combined in a calendar year. |
| 870001315 | Psychological Testing | CPT: 96101 UC | Up to 7 hours for clients 20 years of age and younger for whom psychological testing is required to determine a definitive diagnosis for autism spectrum disorder and service is provided at a Center of Excellence. This EPA code is only available to psychologists and psychiatrists. Providers must bill with a UC modifier. |

What are the specific requirements for evidence-based medicine?

Evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively “EBM”) include programs such as Triple P. The agency is required by law to collect data on EBM in Washington State. Providers who provide these services to clients under 21 should include the appropriate EPA number from the following table when billing for EBM.

| Programs / Coding for Mental Health Professionals | EPA number |
|---|------------|
| Positive Parenting Program (Triple P) (Level 2) | 870001318 |
| Positive Parenting Program (Triple P) (Level 3) | 870001319 |
| Parent-Child Interaction Therapy (PCIT) | 870001330 |
| Cognitive Behavioral Therapy (CBT)+ for Behaviors, Anxiety and Depression | 870001331 |
| Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) | 870001332 |
| Bonding and Attachment via the Theraplay model (Promising Practice) | 870001333 |
| Cognitive Behavioral Therapy (CBT) | 870001334 |
| Strengthening Families Program | 870001335 |

How do I obtain written authorization?

Send your request to the agency’s Authorization Services Office (see [Resources Available](#)). For more information on requesting authorization, see the agency’s [ProviderOne Billing and Resource Guide](#).

Understanding RSNs

What services do RSNs cover?

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 [Regional Support Network RSN Services Information](#) web page.

Community psychiatric inpatient services

RSNs authorize and pay for all medically necessary community psychiatric inpatient services (see WAC [182-550-2600](#)). To refer a client for community psychiatric inpatient services, contact your local RSN.

Note: All inpatient psychiatric admissions, including out-of-state psychiatric hospital admissions, must be approved by the Regional Support Network (RSN).

To find the appropriate RSN and contact information, see the [Regional Support Network RSN Services Information](#) web page.

Involuntary Treatment Act (ITA)

For persons 13 years of age and older that are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters [71.05](#) and [71.34](#) RCW, Division of Behavioral Health and Recovery (DBHR) designees authorize payment for services provided to clients receiving medical assistance. When the client is in the process of applying for medical assistance, authorization for payment by the DBHR designee is subject to eligibility determination.

The agency pays for services provided to clients detained under the ITA when the client either refuses to apply for, or does not qualify for any medical assistance program. The agency covers the ancillary charges for physicians, transportation (including ambulance), or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

RSN access to care standards (ACS)

In addition to providing crisis intervention services and community inpatient services, RSNs also manage the public mental health services that are delivered to individuals who are eligible for Medicaid or CHIP and who meet the ACS as determined by:

- Division of Behavioral Health and Recovery (DBHR).
- Licensed and RSN contracted community mental health agencies.

Note: If you are treating or evaluating a client who appears to meet the ACS, contact the local RSN to make a referral for an intake evaluation.

To learn more about the ACS, see the [DBHR](#) website.

Billing and Claim Forms

How do I complete the CMS-1500 claim form?

The agency's online Webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- [DDE Professional claim](#)
- [DDE Professional with Primary Insurance](#)
- [DDE Medicare Crossover Claim](#)

Also, see Appendix I of the agency's [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 claim form.

What are the billing instructions specific to this program?

- Providers must bill using the most appropriate procedure code for the total time spent on direct patient care during each visit.
- The agency pays a maximum of one psychiatric service procedure code per client, per day.
- For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.