Washington State Health Care Authority

Medicaid Provider Guide

Mental Health Services for Children, Psychiatric and Psychological Services [WAC 182-531-1400]

A Billing Instruction

About This Guide

This guide supersedes all previous Agency Mental Health Services for Children, Psychiatric and Psychological Services and published by the Washington State Health Care Authority (the Agency).

> **Note:** The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
This guide combines the: • *Psychologist Medicaid Provider Guide;* • *Mental Health Services for Children Medicaid Provider Guide*; and • Portions of Section D of the *Physicians-Related Services/Healthcare Professional Services Medicaid Provider Guide* related to psychiatry, psychology, and mental health.	07/01/2012	All		

Copyright Disclosure

How Can I Get Agency Provider Documents?

To view Agency Medicaid Provider Guides and Provider Notices, go to the Agency website at http://hrsa.dshs.wa.gov (click the ***Medicaid Provider Guide and Provider Notices*** link).

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Section D: Billing and Claim Forms

Important Contacts

Note: This section contains important contact information relevant to Mental Health Services for Children, Psychiatric and Psychological Services. For more contact information, see the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., Medicaid Provider Guides, Provider Notices, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extension, the following documentation is required: • A completed, TYPED General Information for Authorization form, 13-835. This request form MUST be the initial page when you submit your request. • A completed Fax/Written Request Basic Information form, 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Where do I get Agency forms?	To **view and download** Agency forms, visit the Agency at: http://hrsa.dshs.wa.gov/mpforms.shtml
Definitions and Abbreviations	Please refer to WACs 182-533-0315 and Medical Assistance *Glossary*.

Client Eligibility

Who Is Eligible?

Please see the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in an Agency Managed Care Plan Eligible? [Refer to WAC 182-538-060 and 095]

YES! When verifying eligibility for mental health services using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All mental health services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

Mental Health Services for Children

The Agency covers:

- Mental health services for children (clients18 years of age and younger).
- Psychiatric services by psychiatrists and psychiatric ARNPs for all clients.
- Psychological testing by psychologists for al clients.

Mental Health Services for Children

In accordance with legislation intended to improve access to mental health services for children who do not meet the Regional Support Network (RSN) access to care standards, effective July 1, 2012, the Agency expanded mental health services for eligible clients 18 years of age and younger.

Who May Provide Mental Health Services for Children?

The following list of mental health professionals, as defined in **RCW 71.34.020** and licensed by the Department of Health (DOH), may provide and bill the Agency fee-for-service for mental health services to children:

- **Psychiatrist:** Licensed Psychiatrist;
- **Psychologist:** Licensed Psychologist;
- **Psychiatric Nurse:** Advanced Registered Nurse Practitioner;
- **Social Worker:** Licensed Independent Clinical Social Worker or Advanced Social Worker;
- **Marriage and Family Therapist:** Licensed Marriage and Family Therapist; and
- **Mental Health Professionals:** Licensed Mental Health Counselor.

What is Required for Providers to Bill for Mental Health Services?

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

- Be licensed by DOH;
- Be in good standing without restriction; and
- 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.

Note: A licensed psychiatrist may provide services and bill the Agency without meeting this minimum experience requirement.

How do I Enroll to Provide Mental Health Services to Children?

To enroll you must:

- Obtain a National Provider Identifier (NPI) from the federal government;
- Complete a Core Provider Agreement;
- Write and sign a letter attesting to your experience in providing mental health services to children, youth, and their families as described above (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; and
- **Send all of these to Provider Enrollment. For more information,** contact Provider Enrollment (see the *Important Contacts* section).

What Does the Agency Cover?

The Agency covers medically necessary outpatient psychotherapy, including outpatient therapy services and family therapy visits through Healthy Options Managed Care ***or*** fee-for-service for:

- Clients 18 years of age and younger; and
- Up to a maximum of 20 hours per client, per calendar year.

Please refer to the coverage table in this section for a list of procedure codes the Agency covers.

How Many Hours Will the Agency Pay For?

The Agency will pay providers for one psychiatric or psychological procedure per day, up to a maximum of 20 hours, which includes the evaluation, per eligible client, per calendar year for the mental health services listed within these billing instructions. The maximum of 20 hours applies whether services are delivered by one provider or multiple providers.

Note: It is the provider's responsibility not to charge for services beyond the client's maximum benefit.

Note: For more information, including verification of the number of hours already paid by the Agency for a client, contact the Call Center (see the *Important Contacts* section).

What do I do if the Client Has Exhausted the Maximum Benefit?

You can request a limitation extension. Please see the prior authorization section within these billing instructions.

- **Healthy Options Managed Care**

  - ✓ For additional Healthy Options Managed Care outpatient mental health services needed for clients who have exhausted their 20-hour-per-calendar-year benefit limit, the provider must request and obtain a limitation extension from the client's MCO, following the MCO-identified requirements and process.

  - ✓ The managed care organizations (MCOs) ensure the provision of medically necessary healthcare services to individuals who are Medicaid and CHIP eligible, enrolled in the Healthy Options program, and assigned to the MCO.

  - ✓ Healthcare services covered through the MCOs include a mental health benefit. These mental health services are available only to individuals who do not meet the RSN Access to Care standards.

To obtain more information about Healthy Options, visit the Agency on line at:
http://hrsa.dshs.wa.gov/healthyoptions/healthyoptions.htm

What Services do the Regional Support Networks (RSN) Cover?

RSN Crisis Services

Crisis mental health services are provided upon request, 24-hours a day, 7 days a week and are available to anyone who needs them regardless of ability to pay. All RSN's publish a toll free crisis number in local phone books.

To find numbers for crisis intervention services, visit the Agency on-line at:
http://www.dshs.wa.gov/pdf/dbhr/mh/CrisisResponse.pdf

RSN Community Psychiatric Inpatient Services

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

To find the appropriate RSN and contact information, visit the Agency on-line at:
http://www.dshs.wa.gov/dbhr/rsn.shtml

RSN Access to Care Standards

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 Medicaid or CHIP-eligible and who meet the Access to Care Standards (ACS) by:

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

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

To meet the ACS for children and youth, the following five conditions **must** be true:

1. The child or youth is determined to have a mental illness that is listed as a covered diagnosis found in the ACS under "Covered Childhood Disorders."

2. The impaired level of functioning and corresponding need(s) identified must be as a result of mental illness.

3. The intervention is considered reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.

4. The child or youth is expected to benefit from the intervention.

5. The unmet need(s) of the child or youth cannot be appropriately met by any other formal or informal system or support.

To learn more about the ACS, visit the Agency on-line at:

http://www.dshs.wa.gov/dbhr/mhpublications.shtml

Coverage Table

Licensed Mental Health Providers, Psychiatrists, Psychiatric ARNPs, and Psychologists who are approved to provide mental health services for children may bill one psychiatric or psychological service, per day, per client, for up to a maximum of 20 hours per calendar year, which includes the evaluation, for clients 18 years and younger using the following procedure codes:

CPT® Procedure Code	ICD-9 CM Diagnosis Code	Limitations
90801*	Must be billed with these diagnosis codes: 290.0-319	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90806		
90808		
90810		
90812		
90814		
90847		
90853		
90857		

*The Agency pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20–hour per calendar year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization. A psychological evaluation (CPT 96101) cannot be billed on the same day. When a client is seen for a psychiatric service as listed above and medication management is necessary, a psychiatric ARNP or physician can bill medication management CPT procedure code 90862 on the same day.

Note: Please note that this benefit is for children who do not meet the RSN's access to care standards. If it is medically necessary, therapists need to transition care of the child to the RSN, as appropriate to the child's condition.

Fee Schedule

You may view the Agency's *Mental Health Services for Children or the Psychology Fee Schedule* on-line at http://hrsa.dshs.wa.gov/RBRVS/Index.html. Scroll to *Mental Health Services for Children*, or scroll to *Psychology*

Psychiatric Services by Psychiatrists and Psychiatric ARNPs

[Refer to WAC 182-531-1400]

Agency-enrolled providers contracted with, or employed by, Community Mental Health Agencies must not bill fee-for-service (FFS) **and** report a Regional Support Network (RSN) encounter on the same service date when providing services to clients eligible for RSN services that meet access to care standards. Reportable services for Community Mental Health Agency clients meeting RSN access-to-care standards are authorized and purchased separately under the RSN Pre-paid Inpatient Health Plan.

General Guidelines

- The Agency pays a maximum of one psychiatric service procedure code per client, per day.

- Psychiatrists must bill using one procedure code for the total time spent on direct patient care during each visit. Billable procedures are listed below:

  - ✓ Individual psychotherapy (CPT codes 90804-90809, 90810-90815*, 90816-90822, and 90823-90829*);
  - ✓ Family psychotherapy (CPT code 90847);
  - ✓ Group psychotherapy (CPT codes 90853 and 90857);
  - ✓ Electroconvulsive therapy (CPT codes 90870); or
  - ✓ Pharmacological management (CPT code 90862 – Not Covered in POS 21).

  *** Interactive psychotherapy is limited to clients 20 years of age and younger.**

Claims for inpatient rounds must be charged using one of the above procedure codes.

- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].

- A psychiatrist may not bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- The Agency pays psychiatrists for the CPT codes listed in the following tables only when billed in combination with ICD-9CM Diagnosis Codes 290.0-319. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**

- Psychiatric sleep therapy is not covered.

Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

Inpatient Hospital

Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Inpatient Psychotherapy	90816-90822, 90823-90829*

*Codes 90823-90829 are limited to clients 20 years of age and younger.

Outpatient Hospital

Covered Procedure	CPT Codes
Observation	99234-99239
Psychotherapy	90804-90815*
Consultation	99241-99245

*Codes 90804-90815 are limited to clients 20 years of age and younger.

Office

Covered Procedure	CPT Codes
Consultation	99241-99245
Psychotherapy	90804-90815

Other Psychiatric Services

Covered Procedure	CPT Codes
Psychiatric Diagnostic Interview	90801, 90802*
Other Psychotherapy	90845, 90847, 90853
Other Psychiatric Services	90862-90870, 90899
Case Management Service • Team Conferences • Telephone Calls	 99367 99441-99443

*Code 90802 is limited to clients 20 years of age and younger.

Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

The Agency does not cover the following services for psychiatrists using ICD-9-CM diagnosis codes 290.0-319:

- Office visits (99201-99215);
- Emergency department visits (99281-99288);
- Nursing facility services (99304-99318);
- Domiciliary home or custodial care services (99324-99340);
- Home services (99341-99359); and
- Stand-by services (99360).

Limitations for Inpatient Psychiatric Services

- Admissions for acute, community psychiatric inpatient care require 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. Please see the list of RSNs at the Division of Mental Health's web site: http://www.dshs.wa.gov/dbhr/rsn.shtml.

- The Agency does not cover physician services for clients admitted for voluntary psychiatric admissions on the psychiatric indigent inpatient PII program who are covered under the "MIP-EMER No out-of-state care" Benefit Service Package.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year per provider. PA is required if a second examination is needed because of a change in a client's condition or if the client has a change in legal status (i.e., voluntary to involuntary or involuntary to voluntary). CPT code 90802 is limited to those clients who are 20 years of age and younger.

- 90862 is not covered in POS 21

Limitations for Outpatient Psychiatric Services

Outpatient psychiatric services are not allowed for clients on the Aged, Blind, and Disabled (ABD) program, except for medication adjustment (CPT code 90862).

Services Provided by Psychiatrists

For Clients 18 years of age and Younger

Psychiatrists may bill one psychiatric service per day, up to a maximum of 20 hours, which include the evaluation, per client, per calendar year for clients 18 years and younger using the following procedure codes:

CPT Procedure Code	ICD-9 CM Diagnosis Code	Limitations
90801*	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90805		
90806		
90807		
90808		
90809		
90810		
90811		
90812		
90813		
90814		
90815		
90845		
90847		
90853		
90857		
90865		
90870		
90899		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code 90862) on the same day. Psychiatrists can also bill other procedures listed on page D.3 which are not subject to the 20-hour visit limitation.

*The Agency pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20–hour-per-calendar-year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization for the additional exam.

Note: Pharmacological management is not subject to the 12-visit limitation.

For Clients 19 years of age and Older

The Agency limits outpatient psychotherapy and electroconvulsive therapy in any combination for clients 19 years of age and older to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. The following codes are included in the allowed 12 hours:

90804	90805	90806	90807	90808	90809	90810
90811	90812	90813	90814	90815	90845	90847
90853	90857	90865	90870	90899		

Note: Pharmacological management is not subject to the 12-visit limitation.

Services Provided by Psychiatric Advanced Registered Nurse Practitioners (ARNPs)

For Clients 18 Years of Age and Younger

Psychiatric ARNPs may bill one psychiatric service per day, up to 20 hours (including the diagnostic interview exam), per client, per calendar year, using the following procedure codes:

PSYCHIATRIC ARNP CODE TABLE 2		
CPT Procedure Code	**ICD-9 CM Diagnosis Code**	**Limitations**
90801*	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90805		
90806		
90807		
90808		
90809		
90810		
90811		
90812		
90813		
90814		
90815		
90847		
90853		
90857		
90899		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code 90862) on the same day. This code is not covered in POS 21.

*The Agency pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20–hour limitation unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization.

When a psychiatric ARNP is performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate psychiatric CPT procedure code that includes the E&M service (e.g., CPT code 90805)

Note: Pharmacological management is not subject to the 12-visit limitation.

For Clients of Any Age

Psychiatric ARNPs **who have not applied to provide expanded mental health services or who do not meet the requirements in Section B** may bill for one psychiatric diagnostic interview examination once per calendar year, per client, in addition to only those services in the following table:

PSYCHIATRIC ARNP CODE TABLE 2			
Covered Procedure	**CPT Procedure Code**	**ICD-9 CM Diagnosis Code**	**Limitations**
Initial Hospital Care	99221-99223	Must be billed with these diagnosis codes: 290.0-319.	
Subsequent Hospital Care	99231-99233		
Observation Hospital	99234-99239		
Psychiatric Diagnostic Interview	90801, 90802		
Pharmacological Management	90862 Not Covered in POS 21		
Case Management Services • Team Conferences • Telephone Calls	99367, 99441-99443		

The Agency does not pay the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the provider bills using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.

The Agency does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. The Agency pays one psychiatric diagnostic interview examination 90801 or 90802 once a calendar year. Office visits 99201 – 99215 cannot be billed for psychotherapy. When 90862 is the only covered service, additional psychotherapy cannot be billed.

Pharmacological Management (CPT 90862)

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with the potential for serious side effects. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a pharmacological management 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 pharmacological management.

Pharmacological management (CPT 90862):

- May be billed when prescribing the medication(s) and when reviewing the effects of the prescribed medication(s), with no more than minimal medical psychotherapy.
- 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 telehealth visit.
- CPT 90862 is not covered in POS 21

Documentation Requirements

The medical record must be clear, concise, and complete. A check-off list by itself is not accepted as complete documentation. The treating provider must document in the medical record that pharmacologic management was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated pharmacological management.

Documentation of medical necessity for pharmacological management 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 and/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 outcome(s).

Involuntary Treatment Act (ITA)

For persons over the age of 12 (see "Age of Consent" below) detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW, DBHR designees authorize and pay for services provided to clients receiving medical assistance. When the client is in the process of applying for medical assistance, payment by the DBHR designee is subject to eligibility determination.

The Agency pays for services provided to clients detained under ITA law when the client either refuses to apply for, or does not qualify for, any medical assistance program. These stays are paid for through the use of state funds allocated to DBHR.

Unlike the PII program, under ITA, the Agency ***does*** cover the ancillary charges for physicians, transportation (including ambulance), or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

For all clients involuntarily detained under Chapter 71.34 and 71.05 RCW, physicians and/or psychiatric Advanced Registered Nursing Practitioners (ARNPs) may bill the Agency for psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician and/or psychiatric 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 90801 or 90802.

- 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, or electroconvulsive therapy.

- A court may request another physician or psychiatric ARNP evaluation.

- The Agency pays for physician and/or psychiatric advanced registered nursing practitioner 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.

- **Psychologist services** are covered *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 the DBHR designee pays for inpatient services for non Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the *Aged, Blind, & Disabled (ABD)* program. For these clients, the Agency and the DBHR designee 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 Involuntary Treatment Act applies only within the borders of Washington State.

- Additional costs for court testimony are paid from county ITA administrative funds.

Psychological Testing by Psychologists and Neuropsychologists

What Is Covered?

The Agency pays licensed psychologists for:

- Psychological evaluations;
- Developmental testing;
- Neuropsychological testing ; and
- Mental Health Services for Children (see the Mental Health Services for Children section within this guide).

The Agency will ***not*** reimburse for:

- Psychotherapy provided by a psychologist unless the psychologist is approved to provide mental health services for children; or

- Continuing care provided by psychologist or by staff employed by the psychologist for clients age 19 years of age and older or for psychologists who are not approved to provide mental health services for children.

Psychological Evaluation **[Refer to WAC 388-865-0610]**

- A psychological evaluation must include a complete diagnostic history, examination, and assessment. The testing of cognitive processes, visual motor responses, and abstract abilities is accomplished by the combination of several types of testing procedures.

- To receive reimbursement for the evaluation, the psychologist must keep a report in the client's file that contains all of the components of a psychological evaluation including test results and interpretation of results.

- Use CPT® code 96101 when billing for psychological evaluations.
- Up to two (2) units of CPT® code 96101 are allowed **without prior authorization** (PA) per client, per lifetime.

- If additional testing is necessary, psychologists **must** request additional units of CPT® code 96101 through the PA process.

Psychological Evaluations for Clients Admitted on an Involuntary Admission

The Agency covers without prior authorization, psychological evaluations (96101) for clients admitted to a psychiatric hospital as an involuntary admission in accordance with the Involuntary Treatment Act (ITA), Chapters 71.05 and 71.34.

When billing for ITA:

- Write ITA in field 19 on the CMS-1500 claim form; and
- Include a copy of an Initial Certification Authorization for Admission to Inpatient Psychiatric Care form, 13-821.

The Agency pays for up to 2 units of 96101 in a 90-day period.

Developmental Testing

The Agency reimburses for developmental testing (CPT® codes 96110 and 96111) only when:

- The provider is a psychologist or neuropsychologist; **and**
- The provider has obtained written/fax prior authorization from the Agency.

Coverage Table Psychological Testing

CPT® Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Note: Due to its licensing agreement with the American Medical Association (AMA), the Agency publishes only the official, brief CPT® procedure code descriptions. To view the entire descriptions, please refer to your current CPT book				
96101		Psycho testing by psych/phys		Limit 2 units per lifetime.
96102		Psycho testing by technician		Not covered
96103		Psycho testing admin by comp		Not covered
96105		Assessment of aphasia		Not covered
96110		Developmental test, lim	PA	
96111		Developmental test, extend	PA	
96116		Neurobehavioral status exam	PA	
96118		Neuropsych tst by psych/phys	EPA # 870001207	
96119		Neuropsych testing by tech	EPA # 870001207	
96120		Neuropsych tst admin w/comp		Not covered

Neuropsychological Testing

The Agency reimburses for neuropsychological testing (CPT® codes 96118 and 96119) only when:

- The provider is a neuropsychologist; **and**
- The provider has obtained written/faxed prior authorization from the Agency; or
- The client meets the EPA criteria below.

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

- The specific clinical issues and the IEP has not been or not 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; and
- Relevant consultations from physiatrists, neurologists, developmental pediatricians, etc.

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

- The client's current diagnoses;
- If available, a copy of the reports produced by the testing for the Agency to review;
- Psychological 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 psychological testing; and
- Specific details that the results of psychological testing will make in 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.

Note: If the client does not meet the EPA criteria listed in this section, the Agency requires PA for the testing. In addition, the Agency requires providers to request PA for testing that exceeds 15 hours per calendar year.

Services(s)	Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.
Providers	The Agency pays only "qualified" providers for administering neuropsychological testing to eligible Agency clients. To be "qualified," providers must be: • Currently licensed in Washington State to practice psychology and/or clinical neuropsychology; and • Either: ✓ Board certified in clinical neuropsychology by the American Board of Clinical Neuropsychology; or ✓ Have adequate education, training, and experience as defined by having completed **all** of 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; and ➢ 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 Codes	96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.
Billing and Payment Limits	A qualified provider may bill 96118 alone if he or she administers the test. If a technician administers the test, 96119 must be billed with 96118 to account for the professional interpretation and report of test results. Up to a maximum of 15 hours per calendar year for a combination of CPT 96118 and 96119 are allowed for patients who meet the criteria specified here. **Note:** If the client does not meet the criteria in this section or requires more than 15 hours of testing, the provider must request PA.

Neuropsychological Testing (cont.)

Criteria	The following are four groups of criteria that apply in different 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** • 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 age 16 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); **AND** • 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); or • 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; or • 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: • Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language; or • 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 general 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).

Note: If the client does not meet the criteria in this section, the provider must request PA (see the *Important Contacts* section).

Prior Authorization

What Is Prior Authorization?

Prior authorization (PA) is the Agency or the Agency's designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LEs) are forms of prior authorization.**

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state care is not covered. Out-of-state hospital admissions are not covered unless they are emergency admissions.

What is the EPA process?

The Agency or the Agency's 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 provider to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the criteria set that indicates what procedure you are billing for and what information qualifies for use of the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in *field 19* of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are billing only one EPA number on a paper CMS-1500 Claim Form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Note: When the client's situation does not meet published criteria, written/fax prior authorization is necessary.

Mental Health Services for Children

If clients need additional visits after they have used their first 20-hour-per-calendar-year benefit, please have the RSN evaluate whether they meet criteria for additional services or meet the access to care standard. Include the RSN denial or assessment from an RSN-contracted community mental health center with the request to the Agency.

The provider must request and obtain a limitation extension from the Agency following the requirements found in WAC 182-501-0169 including:

- Justification of medical necessity;
- Description of services provided and outcomes obtained in treatment to date;
- Expected outcome of extended services; and
- An RSN denial or assessment from an RSN-contracted community mental health center;
- A copy of the RSN assessment or documentation of provider review indicating the client would not likely meet the Access to Care Standards.

For the Agency to authorize payment, complete the Fax/Written Request Basic Information form, 13-756 faxed to the Agency (see the *Important Contacts* section).

Limitation Extensions

What is a Limitation Extension?

A limitation extension (LE) is the Agency or the Agency's designee's authorization for the provider to furnish more units of service than are allowed in Washington Administrative Code (WAC) and the Agency's or the Agency's designee's this Medicaid Provider Guide. The provider must provide justification that the additional units of service are medically necessary.

Limitation Extensions do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. **For Example:** Kidney dialysis is not covered under the Family Planning Only Program.

How do I obtain Limitation Extension (LE) authorization?

Obtain an LE by using the Written/Fax Authorization process below.

Expedited Prior Authorization Guidelines

- **Diagnoses**

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

- **Documentation. What documentation is required when using expedited prior authorization?**

  The billing provider must have documentation of how expedited criteria were met, and have this information in the client's file available to the Agency or the Agency's designee on request.

Which services require EPA?

Services requiring EPA are noted in this Guide as follows:

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
870001207	Neuropsychological Testing	**CPT:** 96118 and 96119	Refer to Section D

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is the paper authorization process providers must use when requesting an LE.

How do I obtain written/fax authorization?

Send or fax your request to the Agency or the Agency's designee Medical Request Coordinator (see Important Contacts).

Note: Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.