Washington State Health Care Authority

Washington Apple Health (Medicaid)

Mental Health Services Billing Guide

July 1, 2017

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect July 1, 2017, and supersedes earlier 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.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
All	Reformatted guide to include new sections "Part I: Clients enrolled in a BHO, FIMC, or BHSO" and "Part II: Clients not enrolled in a BHO, FIMC, or BHSO."	Policy update
Program Overview	Added overview sections "Part I: Clients enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO)" and "Part II: Clients not enrolled in a BHO, FIMC, or BHSO." Revised information relating to the FIMC region throughout the section.	Policy update and clarification
What services are covered?	Updated this section as follows: • Replaced specific services provided by specific provider types with "mental health services DSHS-licensed mental health agencies;" • Added "psychiatric inpatient hospitalization;" and • Removed "psychological testing by psychologists."	Clarification
Partnership Access Line for prescribing practitioners	Moved this section to the "Program Overview" section from the "Professional Services" section.	Housekeeping
Additional mental-health-related services	Added hyperlinks for screening children for mental health and the *Substance Use Disorder Program Billing Guide*.	Clarification
How are services administered?	Added statement to refer to the MCO billing instructions for MCO clients that do not meet the BHO ACS and who are enrolled and receiving care from an MCO.	Clarification

Subject	Change	Reason for Change
Client Eligibility	Added new section "How can I verify a patient's coverage for mental health services?" that includes screen shots from ProviderOne.	Clarification
How do providers identify the correct payer?	Added two rows to the top of the table regarding Medicaid-covered clients with no MCO, BHO, or fully integrated managed care (FIMC) enrollment. Updated information in the table for MCO clients in non-FIMC regions.	Policy update and correction
Managed care information	Effective July 1, 2017, not all Apple Health clients will be enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC) or behavioral health services only (BHSO).	Policy update
	Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in FIMC regions have a change to services available.	Policy update
Provider Eligibility	Rearranged section to remove duplicate information and clarify information about providing and billing for mental health services to children.	Clarification
Crisis Services	Corrected hyperlink for finding crisis intervention services and added a reference to the *Tribal Health Services Billing Guide*.	Correction and clarification
Professional services	Removed the ACS language from the second "blue box" note. Added language to reference Part I of the guide.	Clarification

Subject	Change	Reason for Change
Mental Health Services Coverage Table	• Revised the coverage table as follows: Added asterisks (****) and information in the legend to denote that services performed by licensed mental health professionals (LMHP) and psychology Ph.D. (Psych PhD) are allowed in an outpatient setting only; • Removed "Hours" column; • Added "outpatient only" to "Limits" column for CPT codes 90867, 90868, and 90869; • Added "COE evaluation" to "PA/EPA" column for CPT code 96101 UC.	Clarification and housekeeping
What services can psychiatrists, P-ARNPs, and PMHNP-BCs provide?	Clarified language and removed bullets about using the most specific diagnosis code for preventative mental health services and using the *Approved Diagnosis Codes by Program* webpage for reference. Removed CPT code 99288 as a covered outpatient procedure.	Outdated information
Services delivered for treatment-resistant depression	Rearranged, added, and updated information regarding services delivered for treatment-resistant depression.	Clarification
Services delivered in an inpatient setting	Added a blue note box that instructs providers to go to the Part II: Clients Not Enrolled in a BHO, FIMC, or BHSO when a client meets above access to care standards and has no MCO, BHO, or FIMC enrollment. Added additional information regarding prior authorization (PA) requirements.	Policy change
How do I bill the professional mental health services for an inpatient MCO client?	Added language for billing inpatient mental health services rendered to a non-FIMC MCO client during a BHO-authorized admission.	Clarification

Subject	Change	Reason for Change
How do I bill the professional services in an emergency room setting for the MCO client who will be transferred to another facility for a BHO admission?	Removed section.	Outdated information
Professional services for involuntarily admitted clients	Removed incorrect and outdated information, rearranged information, and added clarifying language.	Clarification and housekeeping
What services can psychologists and neuropsychologists provide?	Removed reference to the *Approved Diagnosis Codes by Program* webpage.	Outdated information
Covered Services	Removed reference to the *Approved Diagnosis Codes by Program* webpage.	Outdated information
Services requiring EPA	Added clarifying information to expedited prior authorization (EPA) #870001369 and removed outdated EPA #870001370.	Clarification
Age of consent for voluntary inpatient hospital psychiatric care	Added members of Indian tribes to explain that the age of consent of the associated tribe supersedes the other requirements listed.	Clarification
Involuntary treatment	Removed information about applying for Apple Health and updated information about getting authorization for patients without active eligibility.	Clarification
Tribal affiliation	Removed section and added the information to the "Age of consent for voluntary inpatient hospital psychiatric care" section	Housekeeping
Authorization requirements for inpatient hospital psychiatric care	Updated the title of the section to include "(except those clients not enrolled in a BHO, FIMC, or BHSO)."	Policy change

Subject	Change	Reason for Change
Time frames for request	Changed the title from "Time frames for submission" to "Time frames for request." Updated information about requesting authorization prior to admission and requesting authorization for post stabilization care.	Clarification
Authorization procedures for inpatient hospital psychiatric care	Updated the title of the section to include "(except those clients not enrolled in a BHO, FIMC, or BHSO)."	Policy change
Documentation	Updated information about requesting authorization prior to admission and requesting authorization for post stabilization care.	Clarification
Billing for inpatient hospital psychiatric care	Updated the title of the section to include "(except those clients not enrolled in a BHO, FIMC, or BHSO)."	Policy change
Splitting claims	Added section on billing medical and psychiatric services on separate claims.	Clarification
Billing instructions specific to involuntary treatment	Removed clients who are qualified for the Aged, Blind, or Disabled (ABD) program as an exception from the requirement of out-of-state hospitals to obtain authorization from the BHO representative.	
Billing for medical admissions with psychiatric principal diagnosis	Added "for non-psychiatric care" to clarify medical admissions and a reference to "Chapter 5, Mental Behavioral and Neurodevelopmental Disorders of the ICD -10 CM" for principal diagnoses.	Clarification
Part II: Clients Not Enrolled in a BHO, FIMS, or BHSO	Added a new section for billing claims for clients that meet above access to care standards and have no MCO, BHO, or FIMC enrollment	Policy change

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers web page, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).

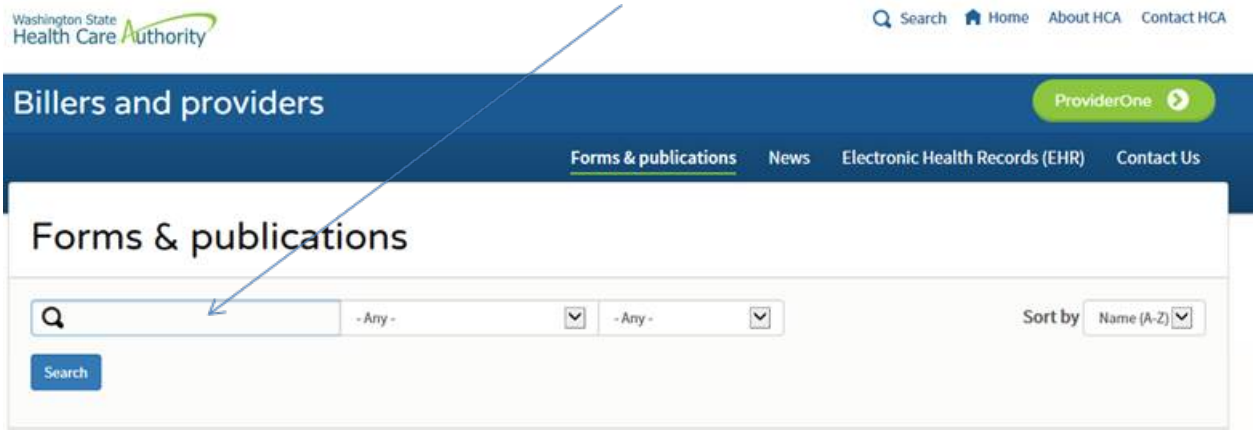


Table of Contents

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

Resources

Topic	Resources
Obtaining prior authorization or a limitation extension	For all requests for prior authorization or limitation extension, submit: • A completed, typed *General Information for Authorization form*, HCA 13-835. This request form must be the initial page when you submit your request. • A completed *Fax/Written Request Basic Information form*, HCA 13-756, and all the documentation listed on this form and any other medical justification. To download forms, see "Where can I download agency forms?" Fax your request to: 866-668-1214.
Obtaining Medicaid forms	See the agency's Medicaid Forms.
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 web page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding provider billing guides, fee schedules, and other agency documents	
Third-party liability other than agency managed care	

Program Overview

(WAC 182-531-1400)

This billing guide describes mental health benefits available to Apple Health clients that are administered through the Health Care Authority (the agency) and the Department of Social and Health Services (DSHS).

This billing guide is divided into two parts:

Part I: Clients enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO)

Part I of this guide describes the set of lower acuity mental health services provided to MCO and FFS clients and the higher acuity services provided by a BHO, FIMC, or BHSO.

Part II: Clients not enrolled in a BHO, FIMC, or BHSO

Part II of this guide describes the set of specialized mental health services available to FFS clients that are not enrolled in a BHO, FIMC, or BHSO. These services are in addition to the mental health services covered by the client's MCO and include outpatient services that are above the Access to Care Standards (ACS).

> **Note:** To find the BHO/MCO offering mental health coverage for each region, see the BHO Contacts Sheet.

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

For clients who live in the SW Region (Clark and Skamania counties)

In the fully-integrated managed care (FIMC) delivery model, currently in Clark and Skamania counties, all levels of mental health services, including inpatient and crisis services, are being provided by Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW), and Beacon Health Options and the ACS do not apply.

For residents who reside in these counties, but have fee-for-service (FFS) coverage for physical health benefits, specialized higher-acuity level of mental health services, inpatient and crisis services are provided by CHPW's, MHW's, and Beacon's "Behavioral Health Services Only" (BHSO) program with access to outpatient lower-acuity mental health services being provided through the FFS benefit. The tool being used by these plans to determine when specialized higher-level mental health services and supports must be offered to clients can be found on the Health Care Authority's website.

What services are covered?

The agency covers the following for all Apple Health clients in all regions:

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

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.

Additional mental-health-related services

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

- Applied Behavior Analysis Services 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)
- Tobacco cessation counseling
  (See the Physician-Related Services/Health Care Professional Services Billing Guide)
- Screening children for mental health,
  (See Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program Billing Guide)
- Substance Use Disorder Program Billing Guide (Fee-for-Service, Non-Behavioral Health Organization (BHO))

> **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 FFS basis for providing services to people not enrolled with a managed care organization (MCO) and whose condition does not meet the state's access to care standards (ACS) as determined by one of the following:

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

  To learn more about the ACS, see the DBHR website.

- MCOs that are under contract with the agency's Apple Health Managed Care program to provide health care services for people whose condition does not meet the BHO ACS and who are enrolled in and receiving care from an MCO. Refer to the MCO for information about billing instructions.

- BHOs that are under contract with DSHS DBHR and serve people whose condition meets the BHO ACS. A Memorandum of Understanding between DSHS and the single State Medicaid Agency (the Health Care Authority) allows DSHS to contract with BHOs.

- Molina Healthcare of Washington or Community Health Plan of Washington, who provides complex behavioral health care for managed care clients and FFS clients residing in the southwest region (Clark and Skamania counties) under their BHSO contract. See How do providers identify the correct payer?

- Beacon Health Options, which provides all crisis services for Medicaid clients and non-Medicaid clients residing in the southwest region (Clark and Skamania counties). See How do providers identify the correct payer?

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

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 Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who wish to apply for Washington Apple Health can do so 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.

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

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

This billing guide is divided into Part I: Clients Enrolled in a BHO, FIMC, or BHSO and Part II: Clients Not Enrolled in a BHO, FIMC, or BHSO. Use the ProviderOne screen shots below to identify the provider guide section that is appropriate for your client

Use PART I:Clients Enrolled in a BHO, FIMC, or BHSO of this billing guide for the following:

FFS Medical - BHO Behavioral (except FIMC Region)

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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	Salish Behavioral Health Organization	105021002	(800) 525-5637		01/01/2017	12/31/2999

MCO Medical - BHO 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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	Salish Behavioral Health Organization	105021002	(800) 525-5637		01/01/2017	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	CHPW Apple Health Adult Covera	105010108	(800) 440-1561		06/01/2017	12/31/2045

FIMC Medical and Behavioral

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	CHPW Fully Integrated Managed Care	105010109	(800) 440-1561		06/01/2017	06/30/2017

PCCM Medical – BHO 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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	Salish Behavioral Health Organization	105021002	(800) 525-5637		01/01/2017	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	NATIVE HEALTH OF SPOKANE	100781700	(509) 483-7535	NATIVE HEALTH OF SPOKANE	06/01/2017	12/31/2045

Use PART II: Clients Not Enrolled in a BHO, FIMC, or BHSO of this billing guide for the following:

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	01/01/2014	12/31/2999	N05	[redacted]		

MCO 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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	CHPW Apple Health Adult Covera	105010108	(800) 440-1561		06/01/2017	12/31/2045

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	01/01/2014	12/31/2999	N05	[redacted]		

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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	NATIVE HEALTH OF SPOKANE	06/01/2017	12/31/2045

Once the client's coverage is identified, refer to How do providers identify the correct payer?

How do providers identify the correct payer?

Provider can use the table below 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 marked with an asterisk (*). Contact the managed care organization for information and instructions regarding provider credentialing, benefits, prior authorization requirements, and billing.

Medicaid Coverage	**Outpatient mental health services** ***Lower-level outpatient mental health services provided under medical benefit manager***	**Professional mental health services billed separately AND delivered during an ER visit when the client is then transferred to a different inpatient facility for a BHO/MCO-paid admission (POS 23-ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/MCO-paid admission**	**Professional mental health services psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient voluntary psychiatric services, including ITA for inpatient psychiatric services**	**Outpatient crisis intervention for mental health services**
Medicaid-covered clients with no MCO, BHO, or FIMC enrollment – applicable statewide, including SW WA	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne (see Part II of this guide – Specialized Mental Health Services)	FFS-ProviderOne	FFS-ProviderOne
MCO coverage with no BHO – applicable to the entire state except SW WA	MCO* (Amerigroup, CCW, CHPW, MHW, UHC)	MCO* (Amerigroup, CCW, CHPW, MHW, UHC)	MCO* (Amerigroup, CCW, CHPW, MHW, UHC)	FFS-ProviderOne	FFS-ProviderOne (see Part II of guide – Specialized Mental Health Services)	FFS-ProviderOne	FFS-ProviderOne

Medicaid Coverage	**Outpatient mental health services** ***Lower-level outpatient mental health services provided under medical benefit manager***	**Professional mental health services billed separately AND delivered during an ER visit when the client is then transferred to a different inpatient facility for a BHO/MCO-paid admission (POS 23-ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/MCO-paid admission**	**Professional mental health services delivered during a BHO/MCO-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient voluntary psychiatric services, including ITA for inpatient psychiatric services**	**Outpatient crisis intervention for mental health services**
MCO coverage (applicable to entire state except SW WA)	MCO* (Amerigroup, CCW, CHPW, MHW, UHC)	MCO* (Amerigroup, CCW, CHPW, MHW, UHC) (effective 7/1/15)	MCO* (Amerigroup, CCW, CHPW, MHW, UHC)	FFS-ProviderOne	BHO	BHO	BHO
HCA-FFS coverage (applicable to entire state except SW WA)	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	BHO	BHO	BHO
Non-Medicaid covered individuals (applicable to entire state except SW WA)	No Payer*	No Payer*	No Payer*	No Payer*	No Payer*	BHO	BHO

Medicaid Coverage		**Outpatient mental health services** ***Lower-level outpatient mental health services provided under medical benefit manager***	**Professional mental health services billed separately AND delivered during an ER visit when the client is then transferred to a different inpatient facility for a BHO/MCO-paid admission (POS 23-ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/MCO-paid admission**	**Professional mental health services delivered during a BHO/MCO-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient voluntary psychiatric services, including ITA for inpatient psychiatric services**	**Outpatient crisis intervention for mental health services**
SW WA (Clark and Skamania Counties)	**FIMC** ***CHPW or MHW; or Beacon***	CHPW or MHW*	CHPW or MHW*	CHPW or MHW*	CHPW or MHW*	CHPW or MHW* **Exception:** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	CHPW or MHW* **Exception:** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	Beacon Health Options*
	BHSO for Medicaid FFS clients through ***CHPW or MHW; or Beacon***	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	CHPW or MHW* **Exception:** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	CHPW or MHW* **Exception:** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	Beacon Health Options*

Medicaid Coverage		**Outpatient mental health services** ***Lower-level outpatient mental health services provided under medical benefit manager***	**Professional mental health services billed separately AND delivered during an ER visit when the client is then transferred to a different inpatient facility for a BHO/MCO-paid admission (POS 23-ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/MCO-paid admission**	**Professional mental health services delivered during a BHO/MCO-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient voluntary psychiatric services, including ITA for inpatient psychiatric services**	**Outpatient crisis intervention for mental health services**
SW WA (Clark and Skamania Counties)	**Behavioral health for non-Medicaid clients through** ***Beacon***	Beacon Health Options* (Lower-level outpatient services for individuals who are not eligible for Medicaid are optional for Beacon to provide within their available funding)	No Payer*	No Payer*	No Payer*	Beacon Health Options* (Voluntary inpatient or higher-level mental health outpatient services for individuals who are not eligible for Medicaid are optional for Beacon to provide, within their available funding)	Beacon Health Options*	Beacon Health Options*

Medicaid Coverage		**Outpatient mental health services** ***Lower-level outpatient mental health services provided under medical benefit manager***	**Professional mental health services billed separately AND delivered during an ER visit when the client is then transferred to a different inpatient facility for a BHO/MCO-paid admission (POS 23-ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/MCO-paid admission**	**Professional mental health services delivered during a BHO/MCO-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient voluntary psychiatric services, including ITA for inpatient psychiatric services**	**Outpatient crisis intervention for mental health services**
AHCC for clients enrolled in foster care	**CCW**	CCW*	CCW*	CCW*	FFS-ProviderOne	CHPW or MHW* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA) **<u>Exception:</u>** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	CHPW or MHW* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA) **<u>Exception:</u>** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	Beacon Health Options* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA)
	FFS	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	CHPW or MHW* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA) **<u>Exception:</u>** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	CHPW or MHW* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA) **<u>Exception:</u>** If patient is a Healthy Options-Blind/Disabled (HOBD) client and admitted to a certified public expenditure (CPE) hospital, bill FFS-ProviderOne	Beacon Health Options* (Client lives in SW WA) BHO (Client <u>does not</u> live in SW WA)

Part I: Clients Enrolled in a BHO, FIMC, or BHSO

Managed care information

Are clients enrolled in an agency-contracted managed care organization eligible for services?

Yes. Clients enrolled in one of the agency's contracted managed care organizations (MCO) are eligible for mental health services. Providers can verify eligibility for mental health services using ProviderOne. If the client is enrolled in an agency-contracted 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.

Note: For clients residing in the southwest region (Clark and Skamania counties), see How do providers identify the correct payer? Contact the client's MCO for referral requirements for mental health services.

Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO, FIMC, or BHSO

On July 1, 2017, some Apple Health clients will not be enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services (BHSO) program. For these clients, mental health and substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients must choose to enroll in one of the managed care plans, either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW) under the FIMC model receiving all physical health services, all levels of mental health services and drug and alcohol treatment coordinated by one managed care plan; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose, they will be auto-enrolled into Apple Health FFS for all their health care services.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care web site, under Providers and Billers.

Effective April 1, 2016, Important Changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service (FFS), and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Regional Resources web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a

person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **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.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in FFS or currently enrolled in an MCO are not affected by this change. Clients in FFS who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of this Mental Health Services billing guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and

all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act (ITA) for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region, some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health FFS managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in FFS
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid FFS clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid. If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Provider eligibility

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

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

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

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

(WAC 182-531-1400)

To be eligible to provide and bill the agency FFS for mental health services to children, providers must:

- Meet all of the requirements listed above.
- Be a psychologist or psychiatrist; or
- Submit a Mental Health Professionals Attestation form, HCA 13-951, attesting to a minimum of two years' experience in providing mental health services to children, youth, and their families as described in this guide. To access this form, see Where can I download agency forms? 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.

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: Beacon Health Options provides all crisis services for Medicaid clients and non-Medicaid clients residing in the southwest region (Clark and Skamania counties). See How do providers identify the correct payer?

Professional services

Note: For managed care clients receiving outpatient mental health services, providers must follow the policies and procedures of the managed care organization. For clients who reside in Clark and Skamania counties, contact the client's managed care organization for referral requirements for mental health services.

Note: If you are treating or evaluating a client who appears to need more intense services than you can provide, contact the local BHO to make a referral for an intake evaluation.

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 Part I 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.

Mental health services coverage table

CPT® Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
+90785**	Psytx complex interactive	X	X	X****	X****		
90791***	Psych diagnostic evaluation	X	X	X****	X****	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year	
90792***	Psych diag eval w/med srvcs	X	X			One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year	
90832	Psytx pt 30 minutes	X	X	X****	X****		
+90833**	Psytx pt w/e&m 30 min	X	X				
90834	Psytx pt 45 minutes	X	X	X****	X****		
+90836**	Psytx pt w/e&m 45 min	X	X				
90837	Psytx pt 60 minutes	X	X	X****	X****		
+90838**	Psytx pt w/e&m 60 min	X	X				
90845	Psychoanalysis	X					
90846	Family psytx w/o patient	X	X	X****	X****		
90847	Family psytx w/patient	X	X	X****	X****		
90849	Multiple family group psytx	X	X	X****	X****		
90853	Group psychotherapy	X	X	X****	X****		
90865	Narcosynthesis	X					
90867	Tcrania 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					

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, 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
96101	Psycho testing by psych/phys				X	See Psychological assessment and testing	Limit of two for lifetime. PA if over limit of two
96101 UC							EPA# 870001315; COE evaluation
96110	Developmental screen				X		
96116	Neurobehavioral status exam				X		
96118	Neuropsych tst 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
+ This code is billed only in conjunction with another code such as 90791							
*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 testing (CPT code 96101) cannot be billed on the same day, without prior authorization.							
****This service provided by the identified professional is allowed in an outpatient setting only.							

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, refer to a current CPT book.

Where can I view the fee schedules?

See the following fee schedules for more information:

- Mental Health Services Fee Schedule
- Physician-Related/Professional Services Fee Schedule

Note: The reimbursement rate may differ depending on the provider's education level. See the Mental Health Services and the Physician-Related/Professional Services fee schedules for details.

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

For a list of mental-health specific services psychiatrists, psychiatric advanced registered nurse practitioners (P-ARNPs), and psychiatric mental health nurse practitioners-board certified (PMHNP-BCs) can provide, see the Mental Health Services Coverage Table. For other services, see the table below.

Inpatient Covered Procedure	CPT® Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Hospital Discharge	99238, 99239
Outpatient Covered Procedure	**CPT® Codes**
Emergency department visit	99281-99285
Observation	99218-99220, 99224, 99226
Consultation	99241-99245
Office Covered Procedure	**CPT® Codes**
Office visit	99201- 99205, 99211-99215
Consultation	99241-99245
Other Covered Procedure	**CPT® Codes**
Case Management Service • Team conference • Telephone call	99367, 99441-99443
Domiciliary home or custodial care service	99324- 99328, 99334 – 99337, 99339, 99340
Home service	99341- 99350, 99354-99359
Nursing facility service	99304-99310, 99315-99316

- The agency covers the above services to treat conditions that fall within the current ICD diagnosis code range for mental health. For billing purposes, providers are required to use the most specific code available.

- 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.

- Claims for inpatient rounds must be charged using one of the inpatient CPT® codes in this section.

Services delivered 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.

The agency 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)

The agency 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

The agency 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. (Examples includes: 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

- The client is an active substance user

The agency pays for ECT when all of the following are met:

- Documentation exists supporting other treatments have been unsuccessful

- Provided by a psychiatrist

- For inpatient ECT services:

  - ✓ For fully integrated managed care (FIMC) clients, bill the managed care organization.

  - ✓ For non-FIMC MCO clients, bill FFS using expedited prior authorization (EPA) number 870001369.

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

Services delivered in an inpatient setting

Note: For Apple Health clients who are not enrolled in an MCO, BHO, or FIMC, and who are above access to care standards (ACS), go directly to Part II: Clients not enrolled in a BHO, FIMC or BHSO.

Clients enrolled in an MCO, BHO, or FIMC require prior authorization (PA) for all admissions for acute, community psychiatric inpatient care from the BHO responsible for the client. FIMC clients require PA from the MCO.

The agency covers professional inpatient mental health services when provided by a psychiatrist, P-ARNP, or PMHNP-BC.

- 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 ECT or narcosynthesis per client, per day only when performed by a psychiatrist.

Services provided to any MCO client during a psychiatric admission paid for by a BHO MCO

How do I bill the professional mental health services for an inpatient MCO client?

The agency pays for psychiatric services provided by a psychiatrist, P-ARNP, or PMHNP-BC to any MCO client during a psychiatric admission paid for by a BHO, except in an FIMC region. For clients in fully integrated managed care (FIMC) areas, such as Clark and Skamania counties, see How do providers identify the correct payer?

All professional claims submitted to the agency for inpatient mental health services rendered to a non-FIMC MCO client during a BHO-authorized admission must include EPA #870001369. See EPA#870001369 for coverage criteria. Non-psychiatric services rendered during a BHO-authorized admission must be billed to the MCO.

Professional services for involuntarily admitted clients

For Involuntary Treatment Act (ITA) admissions under Chapters 71.34 and 71.05 RCW, the agency covers the inpatient professional mental health services delivered by psychiatrists, P-ARNPs, or PMHNP-BCs to clients covered by an MCO, but not those in the FIMC regions. For clients in the FIMC region, see How do providers identify the correct payer? For all other MCO covered clients involuntarily detained under Chapters 71.34 and 71.05 RCW, physicians and 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.

  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.

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

- Out-of-state hospitals must obtain authorization from the appropriate BHO designee for all Medicaid clients. An exception is for clients who are qualified for the fee-for-service Medical Care Services (MCS) program. For these clients, the agency and BHO pay for inpatient psychiatric services provided in bordering cities and critical access border hospitals.

- ITA applies only within the borders of Washington State. Neither the agency nor the BHO pays for involuntary inpatient services for non-Medicaid clients provided outside of the State of Washington.

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 (CPT® codes 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 (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 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.

What services can psychologists and 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 (CPT® code 90791) per client, per provider, per calendar year.

The agency covers these services to treat conditions that fall within the ICD-10-CM diagnosis code range for mental health and for preventive mental health care. Providers are required to use the most specific code available.

The agency pays licensed psychologists for all of the following:

- Psychological testing
- Developmental testing

- Neuropsychological testing
- Mental health services

What psychological testing does the agency cover?

The agency 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 interview.
    - ✓ 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 of 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 of 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: The agency 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 assessment and testing requirements

- 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.
- Psychological testing is limited to two units of code 96101 without prior authorization (PA) per client, per lifetime.

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 age 20 or younger. These evaluations must be billed using UC modifier and EPA #870001315.

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 Services requiring EPA).

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 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 physiatrists, 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 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: 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 age 16 and older, 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 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 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 ➢ 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	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.

Neuropsychological Testing	
	Group 1 All of the following must be met: • 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). • 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.

Neuropsychological Testing	
	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 services can licensed mental health practitioners (LMHPs) provide?

Licensed Mental Health Practitioners (LMHPs) include:

- Licensed mental health counselors
- Licensed independent clinical social workers
- Licensed advanced social workers
- Licensed 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-10-CM diagnosis code range for mental health services and for preventive mental health care.

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.

What mental health services does the agency 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 this Apple Health web page for resources that may be helpful for providing healthcare services to transgender people are available.

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

What mental health services does the agency cover for infants?

Mental health treatment can be provided to an infant, and the infant's parent or guardian, if the treatment is directly related to the infant'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.

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

Effective for claims with dates of service on and after November 1, 2015, providers must be enrolled with ProviderOne to claim and receive payment for ABD Evaluation Services. See the DSHS Medical Evaluation and Diagnostic Procedures web page.

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 web page.

For information regarding reimbursement for psychological evaluations and testing these DSHS Community Services Division (CSD) Mental Incapacity Evaluation Services web page.

How can providers make sure a client receives services in the right place?

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 behavioral health organization (BHO) access to care standards (ACS), the client should be considered for BHO outpatient mental health services. After a client has received 15 visits outside a BHO, the agency may require a written attestation from the provider that either the provider or the BHO has assessed the client to determine if the ACS were met and, if they were met, that a timely referral to a BHO 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 BHO. Not all providers will receive this notice automatically. A mental health professional may continue to provide services under this benefit until the BHO can assume the client's care.

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

When is out-of-state outpatient 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 under the MCS eligibility program.

The agency 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.

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 Apple Health client outside the state of Washington, its payment is payment in full according to 42 C.F.R. § 447.15.

General authorization

Authorization is the agency's approval for certain medical services, 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 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.

What is the expedited prior authorization (EPA) process?

The agency 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 the agency'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, 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 the agency or the agency's designee upon request.

Services requiring EPA

The following services require EPA:

EPA Code	Service Name	CPT/HCPCS /Dx Code	Criteria
870001207	Neuropsychological Testing	CPT: 96118 and 96119	Refer to Neuropsychological 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 age 20 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, psychiatrists and qualified COEs. Providers must bill with a UC modifier.
870001369	Inpatient professional services provided to a non-FIMC-enrolled MCO client when the admission was authorized by the BHO		All of the following conditions must be met: ❖ The client is enrolled in an MCO ❖ The client's inpatient hospital (POS 21, 51) admission was paid for by the BHO ❖ The client's primary diagnosis is in the psychiatric range for ICD diagnosis codes ❖ The services are provided by a psychiatrist, psychologist, or psychiatric ARNP

❖ For fully integrated managed care (FIMC) clients, see How do providers identify the correct payor?

Note: The following CPT codes may be used for inpatient professional services provided to an MCO client during a BHO-authorized admission to place of service 21 or 51: +90785, 90791 90792, 90832, +90838, 90845, 90846, 90847, 90849,90853, 90870, 96111, 96116, 96118, 96119, 99221 – 99223, 99231 – 99233, 99251 – 99255, 99238, and 99239.

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). The agency is required by law to collect data on EBPs in Washington State. Providers who provide these services to clients under age 21 should include the appropriate EPA number from the following table when billing for EBP.

Programs/Coding for Mental Health Professionals	EPA number
Positive Parenting Program (Triple P) (Level 2)	870001318
Positive Parenting Program (Triple P) (Level 3)	870001319
Positive Parenting Program (Triple P) (Level 4)	870001401
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

What is a limitation extension (LE)?

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

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

The agency evaluates requests for LE under the provisions of WAC 182-501-0169.

How do I obtain written authorization?

Send your request to the agency's Authorization Services Office. For more information on requesting authorization, see the agency's ProviderOne Billing and Resource Guide.

Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency'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 the agency's Billers and Providers web page, 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) web page.

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.
- 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.

Inpatient hospital psychiatric admissions

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 of 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
- Certified/authorized by a behavioral health organization (BHO) on behalf of the agency for clients who do not live in Clark or Skamania County, see How do providers identify the correct payer?

Note: Providers must confirm eligibility and plan enrollment for clients who live in southwestern Washington counties of Clark and Skamania. If a person is a Medicaid client contact, either Community Health Plan of Washington (CHPW), or Molina Healthcare of Washington (MHW). If the patient is not a Medicaid client contact Beacon Health Options.

The remaining pages of this provider guide do not apply to admissions for clients who reside in Clark or Skamania County. Providers must follow the policies and procedures of CHPW, MHW, or Beacon Health Options as indicated.

Effective for claims with admissions beginning with dates of service on and after April 1, 2016, all three plans, CHPW, MHW, and Beacon Health Options, which are covering inpatient psychiatric services for people who reside in Clark or Skamania County, will follow these rules:

- For emergency admissions, including ITA admissions, each of these plans require admission notification within 24 hours, or the next business day, of the decision to admit.
- Emergency and non-emergency voluntary admissions for non-Medicaid clients require prior authorization from Beacon Health Options.
- The plans will conduct concurrent review activities on all psychiatric admissions. These activities must be completed according to the managed care plan's policies and instructions.
- Please contact the plans for additional information.
- Providers must submit inpatient psychiatric claims to the client's managed care organization 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 client, the provider must bill ProviderOne.
- Providers must submit inpatient professional mental health service claims to a client's managed care organization for processing and payment.

Provider requirements

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

- Freestanding Evaluation and Treatment (E&T) facilities
- Children's Long Term Inpatient Program (CLIP) facilities
- Eastern State Hospital
- Western State Hospital
- Residential treatment facilities

The agency 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 Division of Behavioral Health and Recovery (DBHR) 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

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by DSHS DBHR in accordance with WAC 388-865-0511 and must meet the general conditions of payment criteria in WAC 182-502-0100.

If a client is detained for involuntary care and a bed is not available in a facility certified by DBHR, the state psychiatric hospitals (under the authority of DBHR) may, at their discretion, issue a **single bed certification** which serves as temporary certification (see WAC 388-865-0526) allowing for inpatient admission to occur in that setting.

Voluntary treatment

The BHO/MCO 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). In Clark and Skamania Counties, Beacon Health Options may authorize and pay for voluntary hospital inpatient psychiatric admissions for clients who are not eligible for Apple Health. For more information on Apple Health programs, see the agency's ProviderOne Billing and Resource Guide.

Age of consent for voluntary inpatient hospital psychiatric care

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: • The minor and the minor's parent/guardian • The minor without parental consent • The minor's parent/legal guardian without the minor's consent
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

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. The agency's representative (BHO, MCO, or Beacon Health Options) pays for services provided to clients who are receiving medical assistance. See How do providers identify the correct payer? to determine the payer for any Apple Health client or any Washington state residence 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 BHO representative for authorization;
- Requests the creation of an ITA-based eligibility segment; and

- Provides the BHO representative with the following information:

  - ✓ **Name:** First, Last, Middle Initial
  - ✓ **Date of birth**
  - ✓ **Social Security Number** (if available)
  - ✓ **WA county of residence**
  - ✓ **A brief summary of services and care to date** (if possible)

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 (except those clients not enrolled in an MCO, BHO, or FIMC)

The hospital must obtain prior authorization (PA) for payment from the appropriate BHO representative for *all* inpatient hospital psychiatric admissions when the agency is the primary payer. To view BHO information, visit the DSHS web site for Information for Mental Health Providers.

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

This PA requirement includes clients eligible for both Medicare and Apple Health who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. This also includes clients with primary commercial or private insurance and who have secondary Apple Health coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. Unless the hospital receives this authorization, the agency will not pay for the services rendered. The BHO representative may not withhold its decision pending eligibility for Apple Health and must issue a documented authorization decision within the timelines described below upon hospital request regardless of whether or not third party liability (TPL) is present.

To determine which BHO to contact when BHO responsibility is unclear, refer to the designee flow chart.

Time frames for PA requests

Time frames for submission of PA requests are as follows:

- Hospitals must request authorization prior to admission unless the stay results from a prudent layperson emergency. This PA requirement includes clients eligible for both Medicare and Apple Health who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization and for clients with primary commercial or private insurance and secondary Apple Health coverage when their primary insurance has been exhausted at admission or during the course of hospitalization.

- If Medicare or primary benefits are exhausted during the course of hospitalization, PA must be requested within the calendar day of benefit exhaustion.

- If a client presents at a hospital for emergency services, the hospital must contact the BHO for authorization of post stabilization care as soon as the client is protected and prevented from injuring or harming themselves or others and the client is stable enough to be transferred or discharged. The BHO must respond within an hour of the hospital's request.

- If the BHO does not respond to the hospital's request for authorization of post stabilization services, the treating staff may assume authorization and execute their plan of care until contact is made.

Length of Stay Extension: Unless the BHO representative specifies otherwise within the PA record, hospitals must submit requests for continued stay at least 24 hours prior to the expiration of the authorization period. A hospital may choose to submit a request more than 24 hours prior to an expiration of an authorization period. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours. BHO representatives are required to provide a determination within 24 hours of the receipt of the extension request.

- **Transfer:** If the admitted client is to be transferred from one hospital to another hospital during the course of hospital inpatient psychiatric care, the hospital from which the client is being transferred must contact the BHO representative to request a new authorization for services to be provided in the new hospital at least 24 hours prior to the change in hospital of service (transfer). BHO representatives are required to provide a determination on the request within 24 hours of the receipt of the transfer request.

- **Retrospective:** 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. BHO representatives acting as the prepaid inpatient health plan (PIHP) have the authority to consider requests 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 BHO 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 BHO representative was contacted), the hospital must submit a separate request for authorization. The BHO 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 BHO representative within 30 days of discharge. The BHO representative must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

  All retrospective certifications must be in accordance with the requirements of this section and an authorization or denial must be based upon the client's condition and services rendered at the time of admission and over the course of the hospital stay until the date of notification or discharge, as applicable.

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:

- Although hospitals are not required to seek the BHO representative's authorization for Medicare inpatient services, they *are* required to notify the BHO representative of a client's dual eligibility at the time of admission via phone or fax within the same calendar day as the admission. The BHO representative is responsible for the client's deductible, co-insurance, or co-payment, up to the agency determined allowed amount.

- If the client with Medicare dual eligibility has exhausted the Medicare lifetime benefit at admission, the hospital is required to seek authorization from the BHO representative at admission. BHO representatives are required to respond within 2 hours and provide determination within 12 hours.

- If the client with Medicare dual eligibility has exhausted the Medicare lifetime benefit during the course of hospital inpatient psychiatric care, the hospital is required to request authorization from the BHO representative prior to the anticipated benefit exhaustion for the remaining expected days. BHO representatives are required to respond within 2 hours and provide a determination within 12 hours.

Commercial (private) insurance

As with Medicare and Medicaid dual eligibility, hospitals are required to notify the BHO representative at admission if a client has commercial or private insurance that pays for hospital inpatient psychiatric care and has Apple Health as a secondary payer. Hospitals are required to request the BHO representative's authorization 24 hours prior to the benefit exhaustion of the commercial or private insurance for any anticipated days past the benefit exhaustion date. The BHO representative may provide authorization retrospectively in cases where a delay has occurred in the commercial or private insurer's notification to the hospital that the benefit is exhausted. BHO representatives are required to respond to requests within 2 hours and make a determination within 12 hours.

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 hospital of service as indicated below. BHO representatives must respond to hospital requests for authorization within the timelines below when there has been a change in client's legal status, principal diagnosis, or hospital of service as follows:

- **Change in legal status**: If a client's legal status changes from involuntary to voluntary, the hospital must contact the BHO representative within 24 hours to request a new authorization reflecting the changed legal status. A subsequent authorization may be issued if the stay is authorized. If a client's legal status changes from voluntary to involuntary, the hospital is not required to notify the BHO representative because a designated mental health professional (DMHP) is required for detention; therefore the BHO representative would already be notified. The BHO representative will issue a separate authorization for the involuntary days. Any previously authorized days under the previous legal status that are past the date of the change in legal status are not covered. BHO representatives are required to respond to requests within 2 hours and make a determination within 12 hours.

- **Change in Principal Diagnosis**: The situations below outline different scenarios and corresponding expectations when a change in principal diagnosis occurs. BHO

representatives must respond within 2 hours and provide determinations within 12 hours for requests related to changes in principal diagnosis:

- ✓ If a client's principal diagnosis changes from a physical health condition to a covered mental health condition, the hospital must contact the BHO representative within the calendar day to request an authorization related to the new principal covered diagnosis.
- ✓ If a client's principal diagnosis changes from a covered mental health diagnosis to a physical health diagnosis, the hospital must notify the authorizing BHO representative within 24 hours of this change. Any previously authorized days under the previous principal covered diagnosis that are past the date of the change in principal covered diagnosis are not covered.
- ✓ If a client's principal diagnosis changes from a covered mental health diagnosis to another covered mental health diagnosis, a new authorization is *not* required, though this change should be communicated to the BHO representative within 24 hours of the change as a matter of best practice.
- ✓ 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 the course of their hospitalization, the BHO representative must be notified of the initial discharge from psychiatric care and a new authorization is 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 the course of inpatient psychiatric care, the hospital from which the client is being transferred must contact the BHO representative to request a new 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 is transferred from one facility to another, the client's current medical, psychiatric, and copies of any ITA or court papers accompany the client. BHO representatives are 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 BHO representative, hospitals must notify the BHO representative within 24 hours when a client has been discharged or has left against medical advice prior to the expiration of the authorized period. Authorized days which extend past the date the client was discharged or left the facility are not covered. The BHO representative will add the discharge date information to the ProviderOne PA record.

Denials

A denial must be issued by the BHO representative if the hospital believes medical necessity is met for a hospital level of inpatient care and the BHO representative disagrees and therefore does not authorize the care. Free standing evaluation and treatment (E&T) facilities also provide acute psychiatric care. E&Ts are considered a lower level of inpatient care than a hospital. If the BHO representative believes a freestanding E&T is the more appropriate level of inpatient care and the hospital *agrees*, it is NOT a denial, it is a diversion from hospital level of care. If the BHO representative believes an E&T is the more appropriate level of acute care and the hospital does *not* agree, it ***is*** a denial. A transfer from one community hospital to another community hospital is not a denial.

Diversions

A diversion is considered to be any time a community hospital *agrees* to alternative level of inpatient care (freestanding E&T) or any other alternative level of care (e.g. community-based crisis stabilization placement) A diversion can occur prior to admission or during continued stay review if it is determined that another level of care is medically indicated.

Clinical appeals

Medical necessity determinations resulting in denials of authorization by the BHO representative may be appealed. Hospitals that disagree with a particular BHO representative's medical necessity determination for admission or number of days authorized must use the appeal process established by the BHO representative who issued the decision. Clinical appeals will be conducted by a different psychiatrist than the psychiatrist that issued the original decision, per WAC 284-43-322 and 42 CFR 431. The psychiatrist conducting the second review may not be part of the BHO representative's provider network. The review conducted by the second psychiatrist is final.

Administrative disputes

Hospitals that have administrative issues (i.e. NOT medical necessity) with a particular BHO representative must use the administrative dispute resolution process established by the BHO representative involved. If not resolved at the BHO representative level, hospitals may contact DBHR for instructions regarding a second level review. The DBHR review is final.

Authorization procedures for inpatient hospital psychiatric care (except those clients not enrolled in an MCO, BHO, or FIMC)

Documentation

To receive authorization for hospital inpatient psychiatric care, the hospital intending to provide the service must contact the appropriate BHO representative so the designee may construct an accurate prior authorization (PA) record within the following required timelines:

- **PA:** Hospitals must request authorization prior to admission unless the services result from an emergency medical condition such as danger to self or others. This PA requirement includes clients with Medicare dual eligibility and clients with commercial or private insurance with Medicaid as secondary when the client has exhausted lifetime Medicare benefits at admission, or the commercial or private insurance has been exhausted at admission.

- For clients with Medicare dual eligibility and clients with commercial or private insurance who exhaust their lifetime benefits during the course of hospitalization, authorization must be requested within the calendar day of benefit exhaustion. If the hospital chooses to admit a client without PA due to due to an emergency medical condition, the hospital must submit a request for post stabilization care. BHO representatives are required to respond to requests for post stabilization care one hour.

  The PA record generated by the BHO provides the BHO representative's authorization of the:

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

  These days are important for billing purposes (see Billing for inpatient hospital psychiatric care for instructions on how to use the Initial Certification form in the billing process.)

Hospitals must request **subsequent/new authorizations** from the BHO representative for changes in all of the following:

- ✓ Legal status
- ✓ Principal covered diagnosis
- ✓ Hospital of service (see Changes in status)

- **Application for Medical Assistance**: If a client applies for Apple Health eligibility, the BHO representative must be contacted within the calendar day. The BHO representative may not withhold its decision pending the outcome of the applicant's Apple Health eligibility. BHO representatives are required to respond to requests within 2 hours and communicate a determination within 12 hours.

> **Note:** A PA record may be created for voluntary services before eligibility is established; however, a valid ProviderOne Client ID is required for payment. If the patient establishes eligibility, give the ProviderOne Client ID to the BHO. The BHO will then add the ProviderOne Client ID to the PA record and payment may proceed.

- **Extension certification for admission to inpatient psychiatric care (extension certification):** The BHO representative must be contacted for requests for extension at least 24 hours prior to expiration of the currently authorized period, unless otherwise indicated by the BHO representative. A hospital may request an extension more than 24 hours prior to the expiration of the currently authorized period. The extension certification provides the BHO representative's authorization of the:

  - ✓ Authorized days (covered).
  - ✓ Administrative days, if applicable (paid at the administrative day rate).
  - ✓ Nonauthorized days (non-covered) for the extended stay.

  These days are important for billing purposes (see Billing for inpatient hospital psychiatric care for instructions on how to use the Initial Certification form in the billing process.)

  The BHO 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 BHO 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 would need to 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 BHO 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. A BHO representative on behalf of the agency 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 BHO 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 BHO representative was contacted), the hospital must submit a separate request for authorization. The BHO 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 BHO representative within 30 days of discharge. The BHO 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 BHO representative may issue approval for administrative days only when all of 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 BHO representative mutually agree to the appropriateness of the administrative day.

- **Extensions for youth waiting for children's long-term inpatient program (CLIP):** The BHO representative cannot deny an extension request for a child or youth who has been detained under ITA and is waiting for a CLIP placement 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 CLIP placement who is in a community psychiatric hospital on a voluntary basis, the BHO representative may authorize or deny extensions or authorize administrative days. Hospitals and BHO representatives are encouraged to work together to find less restrictive alternatives for these children.

  - ✓ **Involuntary:** For a youth waiting for CLIP placement, who is in a community psychiatric hospital on an involuntary basis, extensions may *not* be denied and the BHO representative may *not* authorize administrative days. The hospitals and BHO representatives are encouraged to work together to find less restrictive alternatives 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 the purpose of 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**

  - ✓ 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.

- **Provision of required clinical data:** In order for the BHO representative to make medical necessity determination, the hospital must provide the requisite DBHR - **required clinical data** for initial and extended authorizations. While BHO representatives may use different formats for collection of this clinical data, the data set that is required is the same regardless of which BHO representative is certifying the need for inpatient psychiatric care.

> **Note:** See the Clinical data required for initial certification and Clinical data required for extension certification requests.

- **Determination of the appropriate BHO representative to contact:** For assistance in determining which Division of Behavioral Health and Recovery (DBHR) designee is appropriate for authorization, see the following **resources:**

  - ✓ The BHO representative flow chart
  - ✓ BHO contact information on the BHO Contacts Sheet
  - ✓ CSO and HCS Office Information List on the Community Services Offices web site

> **Note:** If the client is eligible for mental health services, the BHO will appear under "Managed Care Information." See Key Step 2 "Identify the Primary Payer" of the ProviderOne Billing and Resource Guide.

- **Referral to the children's long-term inpatient program (CLIP)**: Children and youth ages 6-17 can be referred to CLIP voluntarily or involuntarily using the process outlined on the CLIP Administration webpage. 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 BHO representative (see the agency's BHO representative DBHR designee flow chart.)

Note:	The agency ***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

  Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the BHO 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 BHO representative. The BHO 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 the180-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 of 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
  - ✓ The agency 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 (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) website.

Billing for inpatient hospital psychiatric care (except those clients not enrolled in an MCO, BHO, or FIMC)

General billing of institutional claims for inpatient hospital psychiatric care

Note: For clients residing in Clark and Skamania counties, providers must submit inpatient psychiatric claims to the client's managed care organization (MCO) 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 of the following must occur in order for hospitals to be paid for providing inpatient hospital psychiatric care:

- Hospitals must contact the appropriate BHO so that the BHO may construct a valid prior authorization (PA) record for voluntary or involuntary hospital inpatient psychiatric admission in accordance with the agency'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 Medicaid as secondary payer (when the primary insurance is exhausted), hospitals must obtain authorization from the appropriate BHO representative.

- Each claim for inpatient psychiatric care must include an **authorization number**. The BHO representative that authorized the hospital admission must provide an authorization number. In order 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 obtain a **subsequent/new authorization** from the agency's BHO representative on an Initial Certification Authorization for Admission to Inpatient Psychiatric Care form, when there is a change in any of the following:

  ✓ Legal status
  ✓ Principal covered diagnosis
  ✓ Hospital of service

- The PA record provides the hospital with authorization for all of the following:

  ✓ Authorized days (covered REV code days)
  ✓ Administrative days, if applicable (paid at the administrative payment methodology)
  ✓ Nonauthorized days (non-covered) for the **initial** or **extended** stay respectively
  ✓ Date when the hospital must contact the BHO representative for an extension request

- 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:** The agency'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 BHO 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 or 0204.

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

Note: The claim must indicate in the *Billing Note* section of the claim whether the days billed were **voluntary** or **involuntary. Use one of the following special claims indicator to show how the client was admitted:**

- **"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 of the BHO 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 a BHO representative on behalf of the agency.

- 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.

Billing instructions specific to involuntary treatment

- The agency will process claims for services provided to detained clients who have applied for Apple Health and were denied if the BHO representative requests the creation of an ITA-related eligibility segment (previously called ITA-Q).

- **Out-of-state hospitals** must obtain authorization from the appropriate BHO representative for all **Medicaid** clients. Neither the agency nor the BHO representative pays for inpatient services for non-Medicaid 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, the agency 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 BHO representative.

Note:	In order 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 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 the agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the agency 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect the agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the agency 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

* The agency pays line item by line item on some claims (RCC, CPE, and CAH). The agency does not pay for line items that Medicare has already paid. The agency pays by the stay (DRG claims) or the day (Per Diem) on other claims. The agency calculates the payment and then subtracts what Medicare has already paid. The agency 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 the agency 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 the agency (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. The agency 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 the agency:
   - 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. The agency may pay an amount using the following formula:
   - The agency's allowed amount for the entire stay minus Medicare's payment minus the agency'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 the agency 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-10 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 the agency.

Recoupment of payments

The agency 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 the Division of Behavioral Health and Recovery (DBHR). 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. While BHO representatives may use different formats for collection of this clinical data, the elements that are required are the same regardless of which BHO representative is certifying and authorizing the need for inpatient psychiatric care. BHO representatives use this information to determine medical necessity and (if authorized) the number of days authorized.

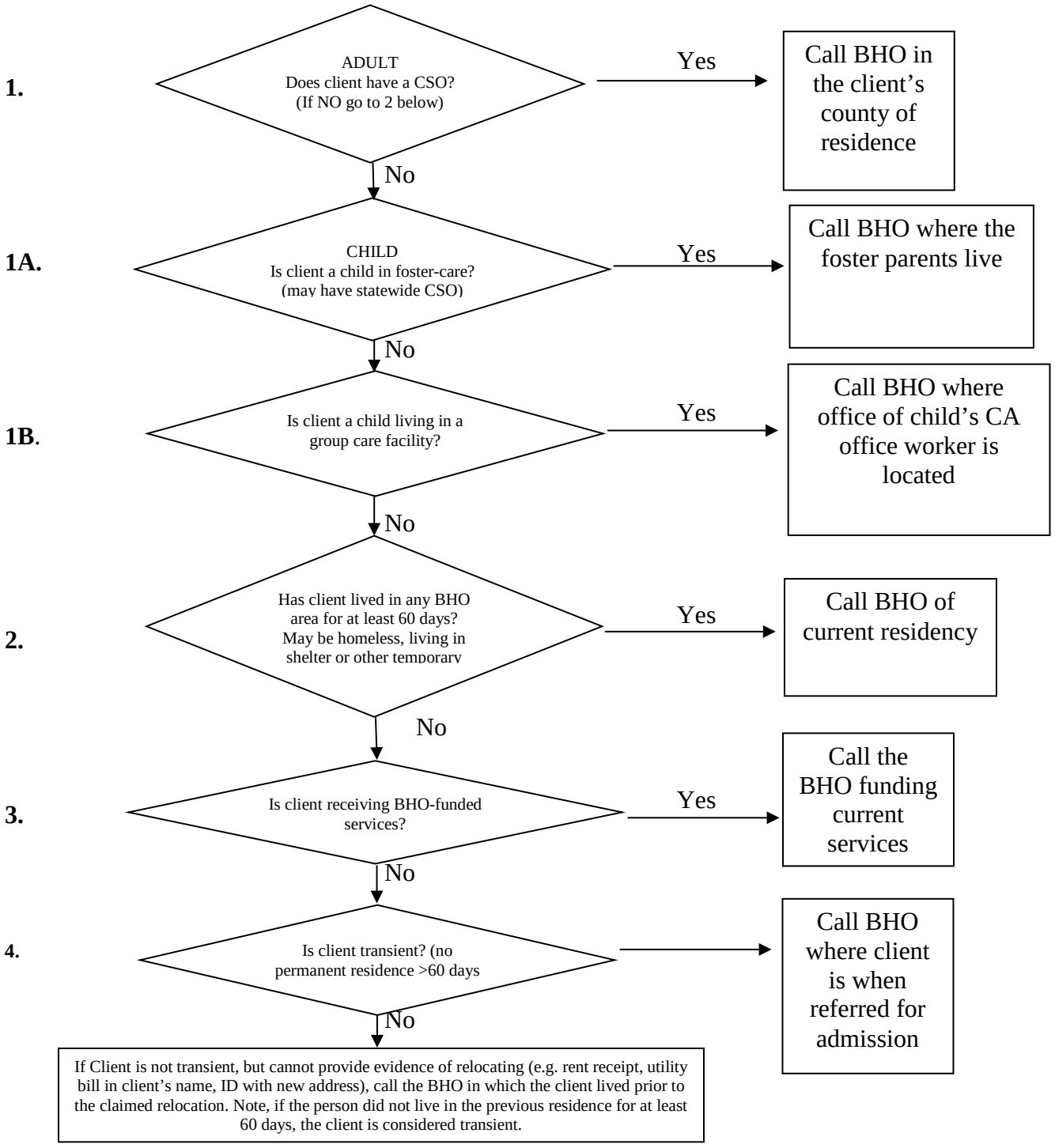
History	
Risk Factors by HX	Prior hospitalizations, CLIP, foster care, suicide attempts, ER use, legal system involvement, homelessness, substance abuse TX, and enrollment in MH system.
Presenting Problems	
Mental Status	Diagnosis, thought content, risk of harm to self or others, behavioral presentation.
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. While BHO representatives may use different formats for collection of this clinical data, the elements that are required are the same regardless of which BHO representative is certifying and authorizing the need for inpatient psychiatric care. BHO representatives use this information to determine medical necessity and (if authorized) the number of days authorized.

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.

Division of Behavioral Health and Recovery (DBHR) designee flow chart – "Which BHO to Contact"



See the BHO Contacts Sheet.

Part II: Clients Not Enrolled in a BHO, FIMC, or BHSO

Specialized mental health services are for clients not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO). This includes assessment, outpatient treatment, evaluation and treatment, hospitalization, and crisis services. These services are in addition to the mental health services covered by the client's MCO and include outpatient services that meet the state medical necessity criteria based on the access to care standards (ACS). See the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) website for this criteria.

Specialized mental health services are available through providers who:

- Have a Health Care Authority (HCA) core provider agreement;
- Are licensed by DSHS as a behavioral health agency; and
- Have registered through the DSHS Provider Entry Portal (PEP) on the DBHR Contractors and Providers webpage.

Provider eligibility

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

To be eligible to provide and bill the agency fee-for-service for mental health services described above, the provider must:

- Be licensed and certified by DSHS 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 web page for new providers; and
- Be registered with the DSHS Provider Network through the provider entry portal (PEP). See the DBHR Contractors and Providers 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 a BHO, FIMC or BHSO 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

The agency covers professional outpatient services for medically necessary specialized mental health services, including services rendered at a free standing evaluation and treatment center, using CPT and HCPCS codes. For more information about coverage, services, and codes, see the DBHR Contractors and Providers webpage. All providers must comply with the documentation requirements in WAC 388-877A-0120. For inpatient hospital professional services, see Services delivered in an inpatient hospital setting.

State Plan Modality	CPT/HCPCS Codes	Brief 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 psychotherapy (w/o patient)	TG
Family Treatment	90847	Family psychotherapy (w/ patient)	TG
Group Treatment Services	90849	Multiple family group psychotherapy	TG
Group Treatment Services	90853	Group pscyhotherapy	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	Psychotherapy 30 minutes with patient and/or family member	TG
Individual Treatment	90833	Psychotherapy 30 minutes with patient and/or family member when performed with an evaluation and management service	TG
Individual Treatment	90834	Psychotherapy 45 minutes with patient and/or family member	TG
Individual Treatment	90836	Psychotherapy 45 minutes with patient and/or family member when performed with an evaluation and management service	TG
Individual Treatment	90837	Psychotherapy 60 minutes with patient and/or family member	TG
Individual Treatment	90838	Psychotherapy 60 minutes with patient and/or family member when performed with an evaluation and management service	TG
Individual Treatment	90889	Preparation of reports of patient psychiatric status, hex, TX, or progress for other individuals, agencies, or ins. carriers	TG
Individual Treatment	99354	Prolonged evaluation and management or psychotherapy services in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	TG
Individual Treatment	99355	Prolonged evaluation and management or psychotherapy services in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes	TG

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, refer to a current CPT book.

State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
Individual Treatment	H0004	Beh health counseling and therapy, per 15 minutes	TG
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	Psychiatric diagnostic evaluation	TG
Intake Evaluation	90792	Psychiatric diagnostic evaluation with medical services	TG
Intake Evaluation	99201	Evaluation & Management, new patient, level 1	TG
Intake Evaluation	99202	Evaluation & Management, new patient, level 2	TG
Intake Evaluation	99203	Evaluation & Management, new patient, level 3	TG
Intake Evaluation	99204	Evaluation & Management, new patient, level 4	TG
Intake Evaluation	99205	Evaluation & Management, new patient, level 5	TG
Intake Evaluation	99304	E&M, nursing facility, new patient, level 1	TG
Intake Evaluation	99305	E&M, nursing facility, new patient, level 2	TG
Intake Evaluation	99306	E&M, nursing facility, new patient, level 3	TG
Intake Evaluation	99324	E&M, rest home, new patient, level 1	TG
Intake Evaluation	99325	E&M, rest home, new patient, level 2	TG
Intake Evaluation	99326	E&M, rest home, new patient, level 3	TG
Intake Evaluation	99327	E&M, rest home, new patient, level 4	TG
Intake Evaluation	99328	E&M, rest home, new patient, level 5	TG
Intake Evaluation	99341	Home visit	TG
Intake Evaluation	99342	Home visit	TG
Intake Evaluation	99343	Home visit	TG
Intake Evaluation	99344	Home visit	TG
Intake Evaluation	99345	Home visit	TG
Intake Evaluation	99354	Prolonged evaluation and management or psychotherapy services in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	TG
Intake Evaluation	99355	Prolonged evaluation and management or psychotherapy services in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes	TG
Intake Evaluation	99356	Prolonged service in the inpatient or observation setting, first hour	TG
Intake Evaluation	99357	Prolonged service in the inpatient or observation setting, additional 30 minutes	TG
Intake Evaluation	H0031	Mental health assessment, by non-physician	TG
Medication Management	96372	Therapeutic, prophylactic or diagnostic injection	TG

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, refer to a current CPT book.

State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
Medication Management	99211	E&M, established patient, level 1	TG
Medication Management	99212	E&M, established patient, level 2	TG
Medication Management	99213	E&M, established patient, level 3	TG
Medication Management	99214	E&M, established patient, level 4	TG
Medication Management	99215	E&M, established patient, level 5	TG
Medication Management	99307	E&M, established patient, nursing facility, level 1	TG
Medication Management	99308	E&M, established patient, nursing facility, level 2	TG
Medication Management	99309	E&M, established patient, nursing facility, level 3	TG
Medication Management	99310	E&M, established patient, nursing facility, level 4	TG
Medication Management	99334	E&M, established patient, rest home, level 1	TG
Medication Management	99335	E&M, established patient, rest home, level 2	TG
Medication Management	99336	E&M, established patient, rest home, level 3	TG
Medication Management	99337	E&M, established patient, rest home, level 4	TG
Medication Management	99347	Domiciliary or rest home visit,	TG
Medication Management	99348	Home visit,	TG
Medication Management	99349	Home visit,	TG
Medication Management	99350	Home visit,	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	96101	Psychological testing, per hour of the psychologist's or physician's time	TG
Psychological Assessment	96102	Psychological testing, by technician w/interpretation by professional, per hour of the technician's time	TG
Psychological Assessment	96103	Psychological testing, by computer w/interpretation by professional	TG
Psychological Assessment	96110	Developmental testing, limited	TG

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, refer to a current CPT book.

State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
Psychological Assessment	96111	Developmental testing, extended	TG
Psychological Assessment	96116	Neurobehavioral status exam, by physician or psychologist, per hour	TG
Psychological Assessment	96118	Neuropsychological testing, by physician or psychologist, per hour	TG
Psychological Assessment	96119	Neuropsychological testing, by technician w/interpretation by professional, per hour	TG
Psychological Assessment	96120	Neuropsychological testing, by technician w/interpretation by professional	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 Psychoeducaton	H0025	Beh health prevention education service	TG
Therapeutic Psychoeducaton	H2027	Psychoeducational service, per 15 minutes	TG
Therapeutic Psychoeducaton	S9446	Patient education, nonphysician provider, group, per session	TG

Freestanding Evaluation and Treatment Services	S9976	Lodging	TG

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.

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, refer to a current CPT book.

Services delivered in an inpatient hospital setting

For people who are not enrolled in a BHO, FIMC or BHSO plan, prior authorization (PA) is not required for any acute, community psychiatric inpatient admission.

The agency covers professional inpatient mental health services when provided by a psychiatrist, P-ARNP, or PMHNP-BC.

- 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 ECT or narcosynthesis per client, per day only when performed by a psychiatrist.

How do I bill inpatient professional psychiatric services provided to any Apple Health client who is not enrolled in FIMC (Clark and Skamania only)?

See How do providers identify the correct payer?

The agency pays for psychiatric services provided by a psychiatrist, P-ARNP, or PMHNP-BC to any client during a psychiatric admission when the client is not enrolled in a FIMC care delivery system.

If a client is an MCO-covered client and is not in FIMC, all professional claims submitted to the agency for inpatient psychiatric services must include EPA #87001369.

> **Note:** Non-psychiatric services rendered during an inpatient psychiatric admission must be billed to the MCO.

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, the agency covers the inpatient professional mental health services delivered by psychiatrists, P-ARNPs, or PMHNP-BCs to clients covered by an MCO, except for those in the FIMC 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.

- 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.

- ITA applies only within the borders of Washington State. The agency does not pay for involuntary inpatient services for clients provided outside of the State of Washington.

When is out-of-state outpatient care covered?

(WAC 182-501-0182)

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

The agency 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.

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

When the agency 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.

Billing

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency'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 the agency's Billers and Providers web page, 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) web page.

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.
- 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 general billing information see the instructions in the agency's ProviderOne Billing and Resource Guide.

All specialized mental health providers must bill as follows:

- Report modifier TG as the first modifier for services that meet ACS.
- Use billing taxonomy 261QM0801X.
- Do not bill with individual servicing provider NPIs. Bill with the clinic NPI and taxonomy only.
- Do not report services that meet ACS on the same claim form as services that do not meet ACS.

Inpatient hospital psychiatric admissions

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 of 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

Provider requirements

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

- Freestanding Evaluation and Treatment (E&T) facilities
- Children's Long Term Inpatient Program (CLIP) facilities
- Eastern State Hospital
- Western State Hospital
- Residential treatment facilities

The agency 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 Division of Behavioral Health and Recovery (DBHR) 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

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by the DSHS, Division of Behavioral Health and Recovery (DBHR) in accordance with WAC 388-865-0511 and must meet the general conditions of payment criteria in WAC 182-502-0100.

If a client is detained for involuntary care under RCW 71.05 and a bed is not available in a facility certified by DBHR, the state psychiatric hospitals (under the authority of DBHR) may, at their discretion, issue a **single bed certification** which serves as temporary certification (see WAC 388-865-0526) allowing for inpatient admission to occur in that setting.

Voluntary treatment

For clients who are not enrolled in a BHO, FIMC or BHSO, 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 the agency.

Age of consent for voluntary inpatient hospital psychiatric care

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: • The minor and the minor's parent/guardian • The minor without parental consent • The minor's parent/legal guardian without the minor's consent
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. The agency 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.

Authorization requirements for inpatient hospital psychiatric care

The hospital does not have a prior authorization requirement for Apple Health clients who are not enrolled in a BHO, FIMC or BHSO.

If an Apple Health FFS client not enrolled in a BHO, FIMC or BHSO program requires inpatient psychiatric services the hospital may submit a claim for medically necessary inpatient days of care or administrative days without prior authorization.

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, the agency will coordinate benefits based on applicable adjudication rules.

- **Administrative days:** administrative days are eligible for payment when all of 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.

Additional requirements

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

- For the purpose of 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**

  - ✓ 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 involuntarily using the process outlined on the CLIP Administration webpage. 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 BHO representative (see the agency's BHO representative DBHR designee flow chart.)

The agency ***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

  Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the BHO 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 BHO representative. The BHO 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 of 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
  - ✓ The agency 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) website.

Billing for inpatient hospital psychiatric care

General billing of institutional claims for inpatient hospital psychiatric care for clients who are not enrolled in a BHO, FIMC or BHSO

All of the following must occur in order for hospitals to be paid for providing inpatient hospital psychiatric care for clients who are not enrolled in a BHO, FIMC or BHSO:

- In order 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.

- 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 10 diagnosis codes at the highest level of specificity**.

Note: The claim must indicate in the *Billing Note* section of the claim whether the days billed were **voluntary** or **involuntary. Use one of the following special claims indicator to show how the client was admitted:**

- **"SCI=V" for voluntary**
- **"SCI=I" for involuntary**

Claims for voluntary or involuntary portions of an episode of care must be 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: In order 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 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 the agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the agency 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect the agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the agency 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

* The agency pays line item by line item on some claims (RCC, CPE, and CAH). The agency does not pay for line items that Medicare has already paid. The agency pays by the stay (DRG claims) or the day (Per Diem) on other claims. The agency calculates the payment and then subtracts what Medicare has already paid. The agency 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 the agency 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 the agency (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. The agency 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 the agency:
   - 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. The agency may pay an amount using the following formula:
   - The agency's allowed amount for the entire stay minus Medicare's payment minus the agency'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. Sometimes it is necessary for the agency 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-10 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 the agency.

Recoupment of payments

The agency recoups any inappropriate payments made to hospitals.