Washington State Health Care Authority

Washington Apple Health (Medicaid)

Mental Health Services Billing Guide

April 1, 2018

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 April 1, 2018, and supersedes earlier guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Program Overview	Added further explanation regarding services covered in Part II of this billing guide.	Clarification
Partnership Access Line for prescribing practitioners	Replaced outdated reference citation with a hyperlink to the Partnership Access Line (PAL) webpage.	Better information
How do providers identify the correct payer?	Added "or when no inpatient admission follows the ER visit" to the column headings for: • Professional mental health services billed separately and delivered during an ER visit; and • ER facility services	Clarification
Outpatient mental health services coverage table	Added "Outpatient" to the title of the table, and removed the designation of services by certain professionals not being allowed in an inpatient setting. All services in the table are outpatient services only.	Clarification

* This publication is a billing instruction.

Subject	Change	Reason for Change
Part II: Services for Clients Not Enrolled in a BHO, FIMC, or BHSO	Added recipient aid categories (RACs) for clients that may receive specialized mental health services.	Clarification
Professional services	Added "on a professional claim form or 837P" to clarify that these services are billed on professional claim forms.	Clarification
Services delivered in an inpatient hospital setting	Added language that clients who are eligible for specialized mental health services do not require prior authorization (PA).	Clarification
Provider requirements	Removed "Freestanding Evaluation and Treatment (E&T) facilities" from the list of providers that should not use this section.	Correction
Authorization requirements for inpatient psychiatric care	Added a "blue box" note to clarify that no digits should be entered into the *Prior Authorization Number* field when PA is not required.	Clarification

How can I get agency provider documents?

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

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

Where can I download agency forms?

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

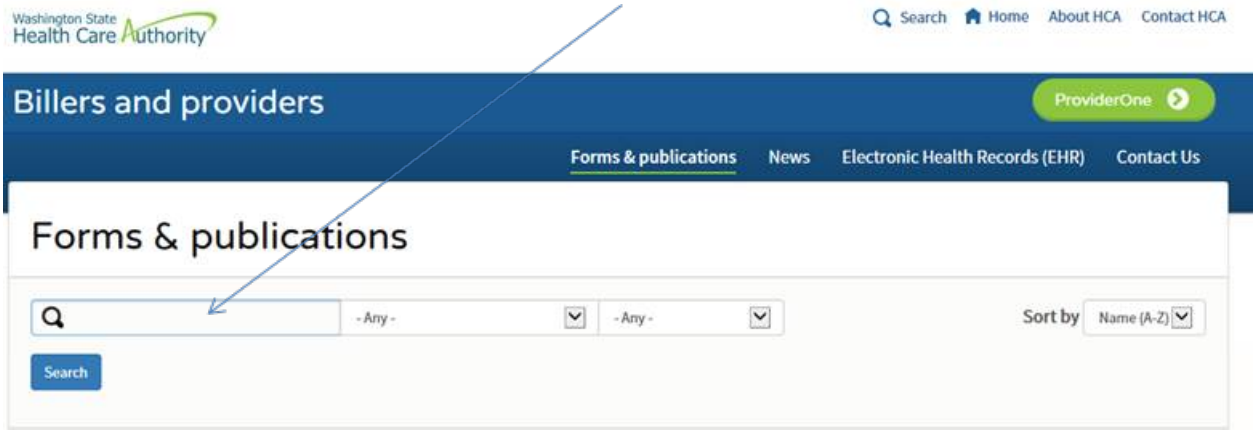

Table of Contents

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 Apple Health forms	See the agency's Forms & publications webpage.
Definitions	Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.
Contacting Provider Enrollment	See the Apple Health Billers and Providers Contact Us page.
Becoming a provider or submitting a change of address or ownership	See the Apple Health Billers and Providers webpage.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding provider billing guides, fee schedules, and other agency documents	
Third-party liability other than agency managed care	

Definitions

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

Behavioral Health Administrative Service Organization (BH-ASO) – See WAC 182-538A-050.

Behavioral Health Organization (BHO) – See WAC 182-500-0015.

Behavioral Health Services Only (BHSO) – See WAC 182-538A-050.

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

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

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

Fully Integrated Managed Care (FIMC) – See WAC 182-538A-050.

Hospital – See WAC 182-500-0045.

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

Medically necessary –See WAC 182-500-0070.

National correct coding initiative (NCCI)" –See WAC 182-500-0075.

National provider indicator (NPI) – See WAC 182-500-0075.

Outpatient – See WAC 182-500-0080.

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

Prior authorization – See WAC 182-500-0085.

Provider – See WAC 182-500-0085.

Psychiatric hospital – See WAC 182-550-1050.

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

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

Program Overview

(WAC 182-531-1400)

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

This billing guide is divided into two parts:

Part I of this guide describes the set of lower acuity mental health services covered by managed care organizations (MCOs) or fee-for-service (FFS) and the higher acuity services covered by a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) for clients enrolled in these programs. (A BHSO provides behavioral health services to clients who enroll in an FIMC managed care plan for behavioral health services only.)

Part II of this guide describes the set of specialized mental health services available to FFS or MCO-enrolled clients that are not enrolled in a BHO, FIMC, or BHSO for mental health services and have one of the recipient aid categories (RACs) listed in that section. These specialized services are in addition to the lower acuity mental health services covered by the client's MCO or FFS program and includes inpatient services as well as outpatient services that are classified as higher acuity and above the Access to Care Standards (ACS).

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

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

What services are covered?

Apple Health clients in all regions have coverage for:

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

National correct coding initiative

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

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

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

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

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

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

Partnership Access Line 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. For more information, see the Partnership Access Line webpage.

Additional mental-health-related services

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

- Applied Behavior Analysis (ABA) Program Billing Guide
- Alcohol or substance misuse counseling (screening, brief interventions, and referral to treatment) (SBIRT)
  (See the Physician-Related Services/Health Care Professional Services Billing Guide)
- Collaborative Care Model Guidelines
  (See the Physician-Related Services/Health Care Professional Services Billing Guide)
- Screening children for mental health and caregiver depression screening
  (See Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program Billing Guide)
- Substance Use Disorder Program Billing Guide (Fee-for-Service, Non-Behavioral Health Organization (BHO))
- Tobacco cessation counseling
  (See the Physician-Related Services/Health Care Professional Services Billing Guide)

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:

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

    To learn more about the ACS, see the Access to Care Standards (ACS) and ICD Information webpage.

- MCOs under contract with the agency's Apple Health Managed Care program to provide health care services for enrollees whose condition does not meet the BHO ACS. Refer to the enrolled client's MCO for information about billing instructions.

- BHOs under contract with DSHS DBHR and serving 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.

- BHSOs and FIMCs under contract to provide complex behavioral health care for managed care clients and FFS clients residing in designated FIMC regions. See How do providers identify the correct payer?

- The regional behavioral health administrative service organization (BH-ASO), which provides all crisis services for Apple Health clients and non-Apple Health clients residing in designated FIMC regions. 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

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care webpage for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services web page.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are 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 when referred by a provider participating with the MCO to a non-participating provider.

Note: For clients residing in designated FIMC regions, see How do providers identify the correct payer? Contact the client's MCO for referral requirements for mental health services.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on FIMC, see the agency's Changes to Apple Health managed care webpage.

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's Apple Health managed care webpage.

North Central Region – Douglas, Chelan and Grant Counties
Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties
Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support

- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

See the agency's Apple Health managed care webpage, Apple Health Foster Care for further details.

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: Services for Clients Enrolled in a BHO, FIMC, or BHSO and Part II: Services for Clients Not Enrolled in a BHO, FIMC, or BHSO. Use the following lists and ProviderOne screen shots below to identify the provider guide section appropriate for your client. The lists provide the names of MCOs, BHOs, FIMCs, and BHSOs, as they appear in ProviderOne when viewing *Managed Care Information*. The screen shots demonstrate which organization is responsible for a client's medical benefits and behavioral health benefits.

The following list includes MCOs and FIMCs (as they appear in ProviderOne) because both MCOs and FIMCs cover physical health and lower-level mental health:

- AMG Fully Integrated Managed Care
- AMG Apple Health Adult Coverag
- AMG Healthy Options Blind/Disabled
- AMG State Children's Health Insurance Program
- MHC Fully Integrated Managed Care
- MHC Apple Health Adult Coverag
- MHC Healthy Options Blind/Disabled
- MHC State Childrens Health Insurance Program
- MHC Healthy Options
- CHPW Fully Integrated Managed Care
- CHPW Apple Health Adult Coverag
- CHPW Healthy Options Blind/Disabled
- CHPW State Childrens Health Insurance Program
- CHPW Healthy Options
- CCW Fully Integrated Managed Care
- Coordinated Care Apple Health Adult Coverag
- Coordinated Care Healthy Options Foster Care
- Coordinated Care Healthy Options Blind/Disabled
- Coordinated Care State Childrens Health Insurance Program
- Coordinated Care Healthy Options
- UHC Apple Health Adult Coverag
- UHC Healthy Options Blind/Disabled
- UHC State Childrens Health Insurance Program
- UHC Healthy Options

The following list includes BHOs, FIMCs, and BHSOs (as they appear in ProviderOne) because they all cover substance use disorder and high acuity mental health:

BHOs

- North Sound Behavioral Health Org
- Thurston-Mason Behavioral Health Organizations
- Great Rivers Behavioral Health Organization
- King County Behavioral Health Organization
- Optum Pierce BHO
- North Central Washington Behavioral Health
- Salish Behavior Health Organization
- Spokane Behavioral Health Organization
- Greater Columbia Behavioral Health

FIMC MCO

- AMG Fully Integrated Managed Care
- CCW Fully Integrated Managed Care
- CHPW Fully Integrated Managed Care
- MHC Fully Integrated Managed Care

BHSO MCO

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

Use PART I: Services for 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

FFS Medical - BHSO Behavioral (FIMC Region only)

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	1149	CNP/QMB	02/01/2011	12/31/2999	L22	[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	MHC Behavioral Health Services Only	105010209	(800) 869-7165		04/01/2016	06/30/2017

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

Message(s):

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

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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

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

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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

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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: Services for 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.

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/ FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during an inpatient psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA in the community hospital setting**	**Outpatient crisis intervention for mental health services**
FFS Apple Health client with no MCO, BHO, or FIMC enrollment for behavioral health services – applicable statewide, including designated FIMC regions	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-enrolled client with no BHO – applicable to the entire state except designated FIMC regions	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

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during a BHO/FIMC-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA, in the community hospital setting**	**Outpatient crisis intervention for mental health services**
MCO-enrolled client with a BHO (applicable to entire state except designated FIMC regions)	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
FFS Apple Health client with a BHO (applicable to entire state except designated FIMC regions)	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	BHO	BHO	BHO
Non-Apple Health eligible person (applicable to entire state except designated FIMC regions)	No Payer*	FFS-ProviderOne: ITA Admissions ONLY	FFS-ProviderOne	FFS-ProviderOne: ITA Admissions ONLY	No Payer*	BHO	BHO

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/ FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during a BHO/FIMC-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA in the community hospital setting**	**Outpatient crisis intervention for mental health services**
Designated FIMC regions	**FIMC-enrolled client**	Applicable MCO*	Applicable MCO*	Applicable MCO*	Applicable MCO*	Applicable MCO*	Applicable MCO* **<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	Regional BH-ASO*
	FFS Apple Health client with BHSO	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	Applicable BHSO*	Applicable BHSO* **<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	Regional BH-ASO*

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/ FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during a BHO/FIMC-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA in the community hospital setting**	**Outpatient crisis intervention for mental health services**
Designated FIMC regions	**Behavioral health for non-Apple Health eligible people through** ***Beacon***	Regional BH-ASO* (Lower-level outpatient services for people who are not eligible for Apple Health are optional for Beacon to provide within their available funding)	FFS-ProviderOne: ITA Admissions ONLY	Regional BH-ASO*	FFS-ProviderOne: ITA Admissions ONLY	Regional BH-ASO* (Voluntary higher-level mental health outpatient services for people who are not eligible for Apple Health are optional for Beacon to provide, within their available funding)	Regional BH-ASO* (Voluntary inpatient psychiatric services for people who are not eligible for Apple Health are optional for Beacon to provide, within their available funding)	Regional BH-ASO*

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/ FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during a BHO/FIMC-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA in the community hospital setting**	**Outpatient crisis intervention for mental health services**
AHCC for clients enrolled in foster care	**CCW-enrolled client**	CCW*	CCW*	CCW*	FFS-ProviderOne	Applicable BHSO* (Client lives in a designated FIMC region) BHO* (Client <u>does not</u> live in a designated FIMC region)	Applicable BHSO* (Client lives in a designated FIMC region) BHO* (Client <u>does not</u> live in a designated FIMC region) **<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	Regional BH-ASO* (Client lives in a designated FIMC region) BHO* (Client <u>does not</u> live in a designated FIMC region)

Apple Health (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/FIMC-paid admission or when no inpatient admission follows the ER visit (POS 23- ER)**	**ER facility services for a client transferred to a different inpatient facility for a BHO/ FIMC-paid admission or when no inpatient admission follows the ER visit**	**Professional mental health services delivered during a BHO/FIMC-paid psychiatric admission (POS 21- inpatient)**	**Outpatient mental health services** ***Higher-level outpatient mental health services***	**Inpatient psychiatric services, including ITA in the community hospital setting**	**Outpatient crisis intervention for mental health services**
AHCC for clients enrolled in foster care	**FFS Apple Health client**	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	FFS-ProviderOne	CHPW or MHW* (Client lives in SW WA) CCW, AMG, or MHW* (Client lives in North Central) BHO (Client <u>does not</u> live in a designated FIMC region)	CHPW or MHW* (Client lives in SW WA) CCW, AMG, or MHW* (Client lives in North Central) BHO (Client <u>does not</u> live in a designated FIMC region) **<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	Regional BH-ASO* (Client lives in a designated FIMC region) BHO* (Client <u>does not</u> live in a designated FIMC region)

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

Part I describes the set of lower acuity mental health services covered by managed care organizations (MCOs) or fee-for-service (FFS) and the higher acuity services covered by a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) for clients enrolled in these programs.

Provider eligibility for FFS-covered mental health services

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

To be eligible to provide and bill the agency fee-for-service (FFS) 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 webpage 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: The behavioral health administrative service organization (BH-ASO) provides all crisis services for Apple Health clients and non-Apple Health clients residing in designated FIMC regions. 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 designated FIMC regions, 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 client's BHO or BHSO 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.

Outpatient 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.

Outpatient mental health services coverage table

CPT® Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
96101	Psychological 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.							

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:

- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Fee Schedule
- 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
Nursing facility service	99304-99310, 99315-99316
Prolonged services	99354-99359 **Note:** CPT codes 99354-99359 are add-on codes and must be used in conjunction with the appropriate CPT codes. Refer to the CPT manual for guidelines.

- 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), refer to Part II: Services for Clients Not Enrolled in a BHO, FIMC or BHSO.

Clients enrolled in a BHO for higher acuity behavioral health services require prior authorization (PA) for all admissions for acute, community psychiatric inpatient care from the BHO responsible for the client. For clients residing in an FIMC region, follow any PA procedures required by the plan in which they are enrolled for behavioral health services.
For more information, see:

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

Professional services provided to a FFS-covered client during a psychiatric admission paid for by a BHO, including ITA admissions

The agency covers professional inpatient mental health services when provided by a psychiatrist, P-ARNP, or PMHNP-BC to FFS Apple Health-covered clients or clients determined Apple Health-eligible as a result of this admission, even when it is an Involuntary Treatment Act (ITA) admission under Chapters 71.34 and 71.05 RCW.

- 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.

Professional services provided to any MCO-enrolled client during a psychiatric admission paid for by a BHO, including ITA admissions

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-enrolled client during a psychiatric admission, including an ITA admission, paid for by a BHO.

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.

For payment of these services for clients who are enrolled in fully integrated managed care (FIMC), see How do providers identify the correct payer?

Non-psychiatric services (physical/medical services) rendered during a BHO-authorized admission must be billed to the MCO, including the FIMC MCO.

Professional services during an ITA admission for people who are not eligible for Apple Health

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

The agency covers the inpatient professional mental health services delivered by psychiatrists, P-ARNPs, or PMHNP-BCs for people residing in Washington state who are admitted under the Involuntary Treatment Act (ITA), Chapters 71.34 and 71.05 RCW, and are not Apple Health clients or Apple Health-eligible.

Billing for professional services provided under ITA

Physicians and P-ARNPs may bill the agency for all psychiatric services provided 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.

- If an Apple Health client requires psychiatric hospitalization while out of state, the hospital must obtain authorization from the appropriate behavioral health designee. See How can I verify a patient's coverage for mental health services?

  ✓ The agency does not pay for services provided to Medical Care Services (MCS) program clients out-of-state, unless the services are provided in a bordering city listed in WAC 182-501-0175.

- ITA applies only within the borders of Washington State. Neither the agency nor the BHO pays for involuntary inpatient services for non-Apple Health 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.

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

See How do providers identify the correct payer?

Outpatient psychiatric services and limitations

See the Mental Health Services Coverage Table for covered mental health services. 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 whose condition is 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 an inpatient hospital (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 client sees a psychiatrist, P-ARNP, or a PMHNP-BC for psychiatric care and only drug monitoring is necessary, the practitioner may bill for either drug monitoring or an evaluation and management (E&M) visit for that date of service.
>
> Alternatively, when a psychiatrist, P-ARNP, or a PMHNP-BC provides psychotherapy and drug monitoring, the practitioner may bill an E&M visit and a qualifying psychotherapy service on that date of service.
>
> In accordance with the National Correct Coding Initiative (NCCI), drug monitoring and an E&M or psychotherapy service cannot be billed on the same day of service, by the same provider. For additional information, see NCCI.

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 evaluation.
  - ✓ Observation during therapy.
  - ✓ An assessment for level-of-care determinations at a mental health or substance-abuse facility.

- The client has tried various medications and psychotherapies but has not progressed, and continues to be symptomatic. All 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.

Neuropsychological Testing	
Billing and Payment Limits	This section describes four groups of criteria that apply to billing in certain circumstances. To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met. For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.
	Group 1 All 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.

Neuropsychological Testing	
	Group 2 The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following: • Client or family complaints • A head CT (computed tomography scan) • A mental status examination or other medical examination This suspected diagnosis is not confirmed or able to be differentiated from the following: • Normal aging • Mild concussion • Depression • Focal neurological impairments A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.
	Group 3 The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help with either of the following: • Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors)
	Group 4 The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post-transplant protocol to prevent organ rejection).

What 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 webpage 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.

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

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 webpage.

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

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

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. 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, unless the services are provided in a bordering city listed in WAC 182-508-0005.

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.

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, 96101, 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 webpage, under Webinars. See Direct data entry of an institutional claim or Medical provider workshop for professional claims.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

What are the guidelines for billing professional services?

- Providers must bill using the most appropriate procedure code for the total time spent on direct patient care during each visit.
- 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 designated FIMC regions, see How do providers identify the correct payer?

Note: Providers must confirm eligibility and plan enrollment for clients who live in designated FIMC regions. If a person is an Apple Health client, contact the client's managed care organization (MCO). If the patient is not an Apple Health client or Apple Health-eligible, contact the regional BH-ASO.

Except for the section on Involuntary treatment, the remaining pages of this provider guide do not apply to admissions for managed care clients who reside in designated FIMC regions. Providers must follow the policies and procedures of the client's MCO or the regional BH-ASO as indicated.

Effective for claims with admissions beginning with dates of service on and after April 1, 2016, the MCOs and the regional BH-ASOs, which are covering inpatient psychiatric services for people who reside in designated FIMC regions, will follow these rules:

- For emergency admissions, including ITA admissions for enrollees, the MCOs require admission notification within 24 hours, or the next business day, of the decision to admit.
- Emergency and non-emergency voluntary admissions for non-Apple Health clients require prior authorization from the regional BH-ASO.
- The regional BH-ASO may authorize and pay for voluntary hospital inpatient psychiatric admissions for people who are **not** eligible for Apple Health. Contact the regional BH-ASO for more information.
- The plans will conduct concurrent review activities on all psychiatric admissions. These activities must be completed according to the MCO's policies and instructions.
- Please contact the plans for additional information.
- Providers must submit inpatient psychiatric claims to the client's MCO for processing and payment; not ProviderOne. However, if the client is admitted to a certified public expenditure (CPE)-designated hospital and the client is a Healthy Options – Blind/Disabled client, the provider must bill the agency via ProviderOne.

- Claims for inpatient professional mental health services for a client must be submitted to the client's MCO.
- Claims for inpatient professional mental health services for a person who resides in these regions, but who is **not** Apple Health eligible, must be billed to the agency via ProviderOne. See Professional services for ITA individuals who are not receiving or not eligible for Apple Health.

Provider requirements

This section of the billing 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, including single-bed certifications for ITA admissions and voluntary admissions that occur in an emergency circumstance under the direction of the designated mental health professional (DMHP) or written order of the emergency 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 person 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). 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 in an inpatient community hospital setting under the provisions of the Involuntary Treatment Act (ITA) as defined by Chapters 71.05 and 71.34 RCW. The agency's representative (BHO, MCO, or BHSO) pays for services provided to clients who are Apple Health-enrolled or eligible. The BHO (or the BH-ASO for clients residing in the designated FIMC regions) pays for these services if the person is not eligible for Apple Health. See How do providers identify the correct payer? to determine the payer for any Apple Health client or any person who is not eligible for Apple Health.

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

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

- Contacts the BHO (or the BH-ASO for people residing in the designated FIMC regions) representative for authorization;
- Requests the creation of an ITA-based eligibility segment; and
- Provides the BHO/BH-ASO 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 webpage 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 Behavioral Health Organization (BHO) Contacts for Services sheet.

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 services 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 with a decision 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 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.

Adverse benefit determinations

BHOs are required to issue adverse benefit determinations to enrollees or their representatives whenever the following occur:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to reach service authorization decisions within the required time frame, or the failure to provide services in a timely manner (see WAC 388-877-0665)

BHOs must maintain a single-level appeal process.

Enrollees may request an administrative hearing after receiving notice that an adverse benefit determination by the BHO has been upheld. If a BHO fails to comply with the notice and timing requirements in 42 CFR 438.408, the enrollee is considered to have exhausted the BHO's appeals process and may request an administrative hearing.

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.

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 Apple Health 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:**

  - ✓ BHO contact information on the Behavioral Health Organization (BHO) Contacts for Services sheet
  - ✓ CSO and HCS Office Information List on the Community Services Offices webpage

> **Note:** If the client is eligible for mental health services, the BHO will appear under "Managed Care Information." See How can I verify a patient's coverage for mental health services?"

  - ✓ **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 Behavioral Health Organization (BHO) Contacts for Services sheet.)

> **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) webpage.

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 designated FIMC regions, 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 Apple Health 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 (no spaces within designated comment below):**

- **"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 **Apple Health** clients. Neither the agency nor the BHO representative pays for inpatient services for non-Apple Health clients if provided outside of the State of Washington. All claims for admissions to **out-of-state hospitals** are paid as "**voluntary legal status**" as the Involuntary Treatment Act applies only within the borders of Washington State.

- For all clients involuntarily detained under Chapter 71.34 or 71.05 RCW, 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.

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

Specialized mental health services are for eligible Apple Health clients not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) and have one of the following recipient aid categories (RACs):

1014-1023	1039	1046-1049
1052-1055	1059	1061
1065-1074	1083	1084
1086	1088-1091	1101-1111
1121	1122	1124
1126	1134	1146-1154
1156	1162-1069	1174-1177
1179	1180	1182-1207
1209	1211-1213	1217-1269

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) webpage 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 webpage 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 on a professional claim form or 837P. 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	H2013	Psychiatric health facility service, per diem (to be used in combination with Lodging, S9976)	TG
Freestanding Evaluation and Treatment Services	S9976	Lodging (to be used in combination with Psychiatric health facility service, H2013)	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

Prior authorization (PA) is not required for people who are not enrolled in a BHO, FIMC or BHSO plan, but are eligible for specialized mental health services.

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?

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 #870001369.

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

How do I bill freestanding evaluation and treatment services provided to Apple Health clients who are not enrolled in a BHO, FIMC, or BHSO?

See How do providers identify the correct payer?

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

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

Freestanding Evaluation and Treatment Services	H2013	Psychiatric health facility service, per diem (to be used in combination with Lodging, S9976)	TG
Freestanding Evaluation and Treatment Services	S9976	Lodging (to be used in combination with Psychiatric health facility service, H2013)	TG

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 clients who reside 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.
- 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.

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

When is out-of-state outpatient care covered?

(WAC 182-501-0182)

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

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.

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 webpage, under Webinars. See Direct data entry of an institutional claim or Medical provider workshop for professional claims.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

What are the guidelines for billing professional services?

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

- 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 (PA) 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 PA.

> **Note:** Do not enter any digits into the *Prior Authorization Number* field for services that do not require PA.

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 Behavioral Health Organization (BHO) Contacts for Services sheet.)

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) webpage.

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 (no spaces within designated comment below):**

- **"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.