Washington State Health Care Authority

Washington Apple Health (Medicaid)

Mental Health Services Billing Guide

July 1, 2020

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

About this guide*

This publication takes effect July 1, 2020, 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
Outpatient Mental Health Services Coverage Table	Added LMHP and Psychiatric Ph.D.as covered providers for CPT Code 99354.	Correction

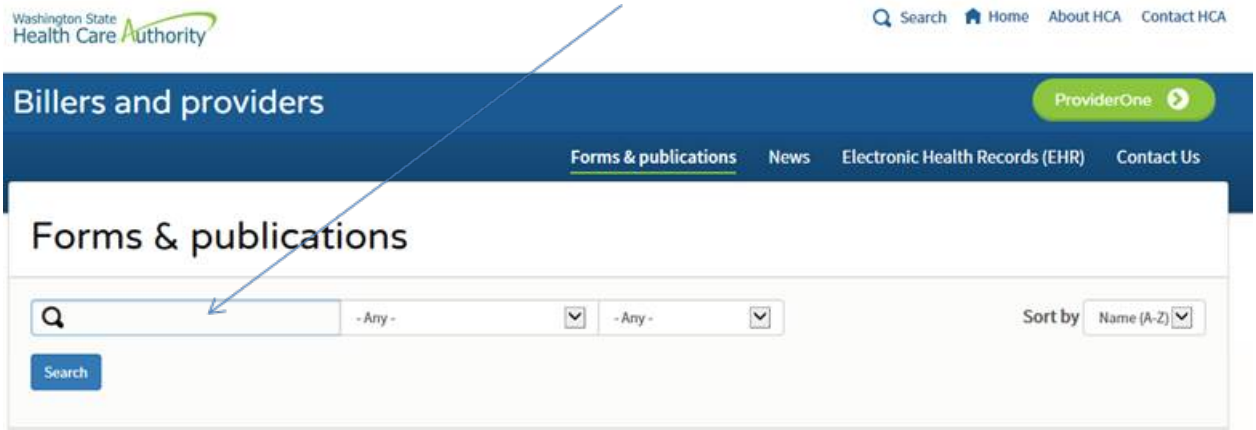
How can I get agency provider documents?

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).



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Resources

Topic	Resources
Obtaining prior authorization or a limitation extension	**Online submission:** Providers may submit prior authorization (PA) and limitation extension requests online through direct data entry into ProviderOne. See the agency's prior authorization webpage for details. **Fax/Written:** Providers who do not use the online submission may fax their written request to 866-668-1214, along with the following information: • 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?"
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) – Means an entity selected by the agency to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

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

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

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

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

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

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

Hospital – See WAC 182-500-0045.

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

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) that are available to Apple Health clients.

This billing guide is divided into two parts:

Part I describes:

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

Part II describes:

- The high acuity mental health services available to eligible American Indian/Alaska Native (AI/AN) clients with more complex treatment needs and not enrolled in an integrated managed care plan or a managed care plan's BHSO.

- How AI/AN clients must be in one of the recipient aid categories (RACs) listed in Part II of this guide. These mental health services are in addition to the lower acuity mental health services covered by the client's MCO or FFS program. Part II is only available if all three of the following criteria apply:

  - ✓ The client is in one of the RACs in Part II
  - ✓ The client is not enrolled in a BHSO/BH-ASO
  - ✓ The client is AI/AN

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 DOH-licensed behavioral health agencies
- Psychiatric inpatient hospitalization

National correct coding initiative

The agency follows the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists 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 (PAL) for child mental health

PAL toll-free number (866) 599-7257

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

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

PAL Family Referral Assistance Line

PAL Family Referral Line is (833) 303-5437

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

PAL for Moms

The PAL for Moms line is 877-725-4666

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

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

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:

1. Licensed professionals with individual Core Provider Agreements who accept payment on a fee-for-service (FFS) basis for providing services to people not enrolled with an integrated managed care organization (MCO) and whose condition is low acuity as determined by agency-enrolled licensed mental health provider.

2. MCOs under contract with the agency's Apple Health Managed Care program to provide integrated health care service for enrollees, which includes all levels of behavioral health services except crisis services.

3. MCOs under contract to provide higher-acuity behavioral health care services only through a BHSO for FFS clients. See How do providers identify the correct payer?

4. The contracted regional behavioral health administrative service organization (BH-ASO), which provides all crisis services for Apple Health clients and provides all behavioral health services for non-Apple Health clients regardless of ability to pay. See How do providers identify the correct payer?

Telemedicine and Coronavirus (COVID-19)

Refer to Physician-related/professional services billing guide, dated April 2020, for telemedicine policy. See the Health Care Authority's Information about novel coronavirus (COVID-19) webpage for updated information regarding COVID-19.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted integrated managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing all physical and behavioral 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.

If a client's benefit package indicates "Suspended – Inpatient Hospital Services Only" for the date of service, it means that the Jail Booking and Reporting System shows that the client was incarcerated for the date of service. Apple Health covers inpatient hospital services only for the suspension dates. All other services during the suspension timeframe are covered by the jail or state hospital. For more information or instructions on how to make corrections if the client was not incarcerated, see the agency's Medicaid suspension webpage. (RAC codes 8000 and 8500 do not mean anything in ProviderOne. These are just examples.)

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
MC: Medicaid	8500	SBP - Institutionalized Dates	04/19/2018	12/31/2999	
MC: Medicaid	1201	ABP	04/21/2018	12/31/2999	N05
MC: Medicaid	1201	Suspended - Inpatient Hospital Services Only	04/20/2018	04/20/2018	N05
MC: Medicaid	1201	ABP	06/01/2016	04/19/2018	N05

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.

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

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

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

> **Note:** Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:
>
> 1. By visiting the Washington Healthplanfinder's website 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 (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted integrated managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

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

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

> **Note:** A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

> **Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

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. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website:

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

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

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO plan covers only behavioral health treatment for those clients. Clients who are not eligible to be enrolled in an agency-contracted integrated managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

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

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

If a client does 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.

If an AI/AN client is not eligible to enroll in integrated managed care (e.g. Medicare dual eligible) but wants to enroll in managed care, then they are enrolled in the BHSO plan

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 integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

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

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under How do providers identify the correct payer?

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 an integrated managed care plan or BHSO and Part II: High acuity services for AI/AN fee-for-service clients. Use the following lists and ProviderOne screen shots below to identify the provider guide section appropriate for your client. The lists provide the names of MCOs and MCO BHSOs, as they appear in ProviderOne when viewing *Managed Care Information*. The screen shots demonstrate which organization is responsible for a client's medical benefits and behavioral health benefits.

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

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

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

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

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

Enrolled in Integrated Managed Care

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	06/01/2019	12/31/2999	N05	[redacted]		
MC: Medicaid	1203	CNP	09/01/2014	02/28/2019	N11	[redacted]		

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

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC MEDICAL	08/01/2019	02/28/2065
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC MEDICAL	07/01/2019	07/31/2019
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC MEDICAL	01/01/2019	02/28/2019
HM: Health Maintenance Organization	MC: Capitated	King County Behavioral Health Organization	105020602	(800) 790-8049		01/01/2017	12/31/2018
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options	105010201	(800) 869-7165		10/01/2014	12/31/2018

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Message(s):

Enrolled in a BHSO

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1104	CNP/QMB	05/01/2017	12/31/2999	S01	[redacted]		

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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	AMG Behavioral Health Services Only	201599811	(800) 600-4441		01/01/2019	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	King County Behavioral Health Organization	105020602	(800) 790-8049		07/01/2017	12/31/2018

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Message(s):

Enrolled in a PCCM

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1014	CNP	10/01/2019	12/31/2999	D01	[redacted]		
MC: Medicaid	1019	CNP	12/01/2015	09/30/2019	D02	[redacted]		

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

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	DAVID C WYNECOOP MEMORIAL CLINI	1[illegible]0743200	(509) 258-4517	DAVID C WYNECOOP MEMORIAL CLINI	12/01/2015	12/31/2999

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Message(s):

Enrolled in FFS

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	04/01/2019	12/31/2999	N05	[redacted]		

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Information Source Data

Name: WA State DSHS
Identification Code Qualifier: PI: Payor Identification
Primary Identifier: 77045
Contact Name: WA State DSHS Provider Relations
Communications Number: (800) 562-3022

Use PART II: High acuity services for AI/AN fee-for-service clients of this billing guide for the following examples:

FFS Medical - FFS Behavioral

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1201	ABP	01/01/2014	12/31/2999	N05			

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			

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

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	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			

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

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	NATIVE HEALTH OF SPOKANE	100781700	(509) 483-7535	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 How do providers identify the correct payer? table to identify the payer for a service based on the service type and the client's health care coverage.

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

Part I: Services for clients enrolled in an integrated managed care plan 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 an integrated managed care plan, or behavioral health services only (BHSO) for clients enrolled in these programs.

Crisis services

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

Tribal health clinics providing crisis services should refer to the Tribal Health Services Billing Guide.

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

Professional services delivered in an outpatient setting

Provider requirements

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

To be eligible to provide and bill the agency fee-for-service (FFS) for lower-acuity mental health treatment 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) with the agency and a 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 lower-acuity mental health services to clients age 18 and younger?

(WAC 182-531-1400)

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

With the exception of licensed psychiatrists and psychologists, qualified health care professionals who treat clients up to age 18 and younger must:

- Submit a *Mental Health Professionals Attestation* form HCA 13-951 to the agency, attesting they have a minimum of 100 actual hours of specialized study of child development and treatment and a minimum of one year of supervised experience in the diagnosis and treatment of clients age 18 and younger; or
- Be working under the supervision of a professional who meets these criteria.

Which professional services can be billed in an outpatient setting?

Note: For clients enrolled in managed care who are receiving outpatient mental health services, providers must follow the policies and referral procedures of the MCO.

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

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

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

Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
+90785	Psytx complex interactive		X	X	X	X		
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 w pt 30 minutes	30 min	X	X	X	X		
+90833	Psytx w pt w e/m 30 min	30 min	X	X	X	X		
90834	Psytx w pt 45 minutes	45 min	X	X	X	X		
+90836	Psytx w pt w e/m 45 min	45 min	X	X	X	X		
90837	Psytx w pt 60 minutes	60 min	X	X	X	X		
+90838	Psytx w pt w e/m 60 min	60 min	X	X				
90845	Psychoanalysis		X				Not CMHC	
90846	Family psytx w/o pt 50 min	50 min	X	X	X	X		
90847	Family psytx w/pt 50 min	50 min	X	X	X	X		
90849	Multiple family group psytx	40 min	X	X	X	X	Not in POS 24	
90853	Group psychotherapy	60 min	X	X	X	X		
90865	Narcosynthesis		X				Exclude POS 24	
90867	Tcranial magn stim tx plan		X	X			One per client, per year; **outpatient only**	

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

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Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
90868	Tcranial magn stim tx deli		X	X			30 visits in 7-week period followed by 6 taper treatments; **outpatient only**	
90869	Tcran magn stim redetermine		X	X			One per client, per year; **outpatient only**	
90870	Electroconvulsive therapy		X					
96110	Developmental screen w/score		X	X		X		
96112	Devel tst phys/qhp 1st hr		X			X		
96113	Devel tst phys/qhp ea addl		X			X		
96116	Neurobehavioral status exam					X		
96121	Nubhvl xm phy/qhp ea addl hr	60 min	X			X		
96130	Psycl tst eval phys/qhp 1st	60 min	X			X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96131	Psycl tst eval phys/qhp ea	60 min	X			X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96132	Nrpsyc tst eval phys/qhp 1st	60 min				X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA for 20yrs and older

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Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
96133	Nrpsyc tst eval phys/qhp ea	60 min				X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA 20 and older
96136	Psycl/nrpsyc tst phy/qhp 1st	30 min	X			X	See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X			X	See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96138	Psycl/nrpsyc tech 1st	30 min					See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96139	Psycl/nrpsyc tst tech ea	30 min					See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96146	Psycl/nrpsyc tst auto result						See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
99281	Emergency dept visit		X	X				
99282	Emergency dept visit		X	X				
99283	Emergency dept visit		X	X				
99284	Emergency dept visit		X	X				
99285	Emergency dept visit		X	X				
99218	Initial observation care	30 min	X	X				
99219	Initial observation care	50 min	X	X				
99220	Initial observation care	70 min	X	X				

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Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99226	Subsequent observation care	35 min	X	X				
99241	Office consultation	15 min	X	X				
99242	Office consultation	30 min	X	X				
99243	Office consultation	40 min	X	X				
99244	Office consultation	60 min	X	X				
99245	Office consultation	80 min	X	X				
99201	Office/outpatient visit new	10 min	X	X				
99202	Office/outpatient visit new	20 min	X	X				
99203	Office/outpatient visit new	30 min	X	X				
99204	Office/outpatient visit new	45 min	X	X				
99205	Office/outpatient visit new	60 min	X	X				
99211	Office/outpatient visit est	5 min	X	X				
99212	Office/outpatient visit est	10 min	X	X				
99213	Office/outpatient visit est	15 min	X	X				
99214	Office/outpatient visit est	25 min	X	X				
99215	Office/outpatient visit est	40 min	X	X				
99304	Nursing facility care init	25 min	X	X				
99305	Nursing facility care init	35 min	X	X				
99306	Nursing facility care init	45 min	X	X				
99307	Nursing fac care subseq	10 min	X	X				

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Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99308	Nursing fac care subseq	15 min	X	X				
99309	Nursing fac care subseq	25 min	X	X				
99310	Nursing fac care subseq	35 min	X	X				
99315	Nursing fac discharge day	30 min or less	X	X				
99316	Nursing fac discharge day	30 min or longer	X	X				
99324	Domicil/r-home visit new pat	20 min	X	X				
99325	Domicil/r-home visit new pat	30 min	X	X				
99326	Domicil/r-home visit new pat	45 min	X	X				
99327	Domicil/r-home visit new pat	60 min	X	X				
99328	Domicil/r-home visit new pat	75 min	X	X				
99334	Domicil/r-home visit est pat	15 min	X	X				
99335	Domicil/r-home visit est pat	25 min	X	X				
99336	Domicil/r-home visit est pat	40 min	X	X				
99337	Domicil/r-home visit est pat	60 min	X	X				
99339	Domicil/r-home care supervis	15-29 min	X	X				
99340	Domicil/r-home care supervis	30 min or longer	X	X				
99341	Home visit new patient	20 min	X	X				

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Outpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
99342	Home visit new patient	30 min	X	X				
99343	Home visit new patient	45 min	X	X				
99344	Home visit new patient	60 min	X	X				
99345	Home visit new patient	75 min	X	X				
99347	Home visit est patient	15 min	X	X				
99348	Home visit est patient	25 min	X	X				
99349	Home visit est patient	40 min	X	X				
99350	Home visit est patient	60 min	X	X				
+99354	Prolong e&m/psyctx serv o/p	1st hr	X	X	X	X		
+99355	Prolong e&m/psyctx serv o/p	Each 30 min beyond 1st hr	X	X				
99367	Team conf w/o pat by phys	30 min or longer	X	X				
99441	Phone e/m phys/qhp 5-10 min	10 min	X	X				
99442	Phone e/m phys/qhp 11-20 min	11-20 min	X	X				
99443	Phone e/m phys/qhp 21-30 min	21-30 min	X	X				
	+ Add-on code							
	*Includes independently licensed Social Workers, Marriage and Family Therapist, and Mental Health Counselors							
	***A psychiatric diagnostic interview exam (CPT code 90791 or 90792) and a psychological testing (CPT codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day, without prior authorization.							

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Services delivered outpatient for treatment-resistant depression

(CPT 90867, 90868, 90869, 90870)

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

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

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

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

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- 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 documentation exists supporting other treatments have been unsuccessful and treatment is provided by a psychiatrist.

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

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

See How do providers identify the correct payer?

Outpatient psychiatric services and limitations

See the Mental Health Services Coverage Table for covered mental health services. 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.

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

Documentation of medical necessity for drug monitoring must address all 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

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- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcomes

> **Note:** When a client sees a psychiatrist, P-ARNP, or a PMHNP-BC for psychiatric care and only drug monitoring is necessary, the practitioner may bill for either drug monitoring or an evaluation and management (E&M) visit for that date of service.
>
> Alternatively, when a psychiatrist, P-ARNP, or a PMHNP-BC provides psychotherapy and drug monitoring, the practitioner may bill an E&M visit and a qualifying psychotherapy service on that date of service.
>
> In accordance with the National Correct Coding Initiative (NCCI), drug monitoring and an E&M or psychotherapy service cannot be billed on the same day of service, by the same provider. For additional information, see NCCI.

Outpatient developmental testing

The agency pays for developmental testing (CPT® codes 96112 and 96113) when conducted by a psychologist or neuropsychologist.

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.

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- ✓ 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 testing and evaluation services

- Psychological assessments must include a complete diagnostic history, examination, and assessment. Testing cognitive processes, visual motor responses, and abstract abilities is accomplished by combining several testing procedures.

- To receive reimbursement for the testing and evaluation, 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® codes 96130 and 96131 when billing for psychological evaluation services from a psychologist or physician. Test selection, clinical decision making, and test interpretation are now billed under 96130 and 96131.

- Use CPT codes 96136 and 96137 billing for test administration and scoring by a psychologist or physician.

- Use CPT codes 96138 and 96139 for test administration and scoring by a qualified technician

- Psychological testing is limited to twelve units of any combination of codes 96130, 96131, 96136, 96137, 96138 or 96139 without prior authorization (PA) per client, per lifetime.

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Neuropsychological testing

- Neuropsychological evaluation includes interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation and interactive feedback to the patient, family member(s) or caregiver(s).

- Evaluation services must always be performed by the qualified professional prior to test administration, and may be billed on separate days.

- Use CPT® codes 98132 for the first hour of neuropsychological evaluation and 96133 for each additional hour provided on the same day.

- Use CPT codes 96136 for the first 30 minutes of testing and scoring by a psychologist or neuropsychologist and 96137 for each additional 30 minutes of testing and scoring provided on the same day.

- Use code 96138 for the first 30 minutes of test administration and scoring by a technician, and 96139 for each additional 30 minutes a technician is administering and scoring tests on the same day.

The agency reimburses for neuropsychological testing (CPT® codes 96132, 96133, 96136, and 96137):

- The provider is currently licensed in Washington State to practice psychology or clinical neuropsychology.
-
- The client is age 19 or younger.

- The client is age 20 or older and meets the expedited prior authorization (EPA) criteria. (See Services requiring EPA).

No prior authorization (PA) for neuropsychological testing of children age 19 or younger is required if billing 15 units or less of any combination of neuropsychological testing codes.

- If the child is in school, the provider must complete detailed review of the individualized education plan (IEP) outlining all 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

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- Other psychological testing that has been done
- Relevant consultations from physiatrists, neurologists, developmental pediatricians, etc.

Neuropsychological testing of people age 20 or older 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.

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Neuropsychological Testing	
Note: If the client does not meet the expedited prior authorization (EPA) criteria listed in this table, the agency requires prior authorization (PA) for the testing.	
Services	Neuropsychological testing of clients age 20 or 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	96132, 96133, 96133, 96136, 96137, 96138, 96139 and 96146 may be billed with EPA #870001207 if all the criteria in this section are met.
Billing and Payment Limits	This section describes four groups of criteria that apply to billing in certain circumstances. To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met. For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.

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Neuropsychological Testing	
	Group 1 All of the following must be met: • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy. • The patient is age 20 or older. • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder. • The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living). • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation.
	Group 2 The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following: • Client or family complaints • A head CT (computed tomography scan) • A mental status examination or other medical examination This suspected diagnosis is not confirmed or able to be differentiated from the following: • Normal aging • Mild concussion • Depression • Focal neurological impairments A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.

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Neuropsychological Testing	
	Group 3 The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help with either of the following: • Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors)
	Group 4 The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post-transplant protocol to prevent organ rejection).

What mental health services does the agency cover for youth?

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

What mental health services does 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.

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See this Apple Health webpage for resources that may be helpful for providing healthcare services to transgender people.

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

What mental health 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.

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

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

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

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

When is out-of-state outpatient care covered?

(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.

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

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Prior authorization and expedited prior 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 the agency 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 agency 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 for EPA, formal written PA is necessary.

EPA guidelines

Clinical information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code, or service will be denied.

EPA documentation

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

Services requiring EPA

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The following services require EPA:

EPA Code	Service Name	CPT/HCPCS /Dx Code	Criteria
870001207	Neuropsychological Testing	CPT: 96132, 96133, 96136, 96137, 96138, 96139 and 96146	Refer to Neuropsychological Testing. Up to 15 units for any of these codes combined in a calendar year for clients age 20 and older.

❖ For managed care clients, see How do providers identify the correct payer?

EPA billing requirements for evidence and research-based practices

Evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively "EBPs") include programs such as cognitive behavioral therapy (CBT) and the Positive Parenting Program (Triple P). 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.

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Programs/Coding for Mental Health Professionals		
Anxiety		
Treatment Category	**Specific Treatment and Approved Trainings**	**EPA #**
Cognitive Behavioral Therapy (CBT) for children with anxiety (group, individual or remote)(151)		870001555
	• CBT4 CBT training (Coping Cat) (151) • Centre for Emotional Health (Cool Kids) (151) • Effective Child Therapy/ Society of Clinical Child & Adolescent Psychology (151) • Harborview CBT + Learning Collaborative (151) • The Reach Institute (CATIE trainings) (151) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (151)	870001555
	Cool Kids (032)	870001556
	Coping Cat (035)	870001557
	Coping Cat/Koala book based model (157)	870001558
	Coping Koala (158)	870001559
	Managing and Adapting Practice (MAP) (175)	870001560
	Modularized Approach to therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) (085)	870001561
Parent cognitive behavioral therapy (CBT) for young children with anxiety (187)		870001562

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Attention Deficit Hyperactivity Disorder		
Treatment Category	**Specific Treatment and Approved Trainings**	**EPA #**
Behavioral parent training (BPT) for children with ADHS	Barkley Model (003)	870001563
	New Forest Parenting Program (181)	870001564
Multimodal Therapy (MMT) for children with ADHD (091)		870001565
Depression		
Treatment Category	**Specific Treatment and Approved Trainings**	**EPA #**
Cognitive Behavioral Therapy (CBT) for children and adolescents with depression (153)		870001566
	• Acceptance and Commitment Therapy (ACT) for children with depression (153) • Effective Child Therapy/Society of Clinical Child & Adolescent Psychology (153) • Harborview CBT + Learning Collaborative (153) • The Reach Institute (CATIE trainings) (153) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type (below) (153)	870001566
	Coping with Depression – Adolescents (159)	870001567
	Managing and Adaptive Practice (MAP) (175)	870001568
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH – ADTC) (085)	870001569
	Treatment for Adolescents with Depression Study (197)	870001570
Blues Program (group CBT prevention program for high school students at risk for depression) (149)		870001571

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Disruptive Behavior (Oppositional Defiant Disorder or Conduct Disorder)		
Treatment Category	**Specific Treatment and Approved Trainings**	**EPA #**
Behavior parent training (BPT) for children with disruptive behavior disorders (148)		870001572
	• Coping Power Program (148) • Harborview CBT + Learning Collaborative (148) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (148) • Stop Now and Plan (SNAP) (148) • The Reach Institute (CATIE trainings) (148)	870001572
	Helping the Noncompliant Child (171)	870001573
	Incredible Years: Parent Training (073)	870001574
	Incredible Years: Parent Training + child training (076)	870001575
	Managing and Adapting Practice (MAP) (175)	870001576
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) (085)	870001577
	Parent Child Interaction Therapy (PCIT) for children with disruptive behavior problems (186)	870001578
	Parent Management Training – Oregon Model (treatment population) (188)	870001579
	Triple –P Positive Parenting Program: Level 4, Group (139)	870001580
	Triple – P Positive Parenting Program: Level4, Individual (140)	870001581
Brief Strategic Family Therapy (BSFT) (010)		870001582
Choice Theory/Reality Therapy (164)		870001583
Families and Schools Together (FAST) (046)		870001584

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Serious Emotional Disturbance		
Specific Treatment and Approved Trainings	**Specific Treatment and Approved Trainings**	**EPA #**
Dialectical Behavior Therapy (DBT) for adolescent self-harming behavior (160)		870001585
Multisystem Therapy (MST) for youth with serious emotional disturbance (SED) (180)		870001586
Intensive Family Preservation (HOMEBUILDERS) for youth with serious emotional disturbance (SED) (172)		870001587
Trauma		
Treatment Category	**Specific Treatment and Approved Trainings**	**EPA #**
Cognitive Behavioral Therapy (CBT) – based models for child trauma (155)		870001588
	• Harborview CBT + Learning Collaborative (155) • The Reach Institute (CATIE trainings) (155) • Teaching Recovery Techniques (TRT) (155) • Other Live Training: Provider can document that the training agenda covered all Essential Elements for this program type. (155)	870001588
	Classroom—based intervention for war-exposed children (013)	870001589
	Cognitive Behavioral Intervention for Trauma in Schools (016)	870001590
	Enhancing Resiliency Among Students Experiencing Stress (ERASE – Stress) (162)	870001591
	KID – NET Narrative Exposure Therapy for children (079)	870001592
	Managing and Adapting Practice (MAP) (175)	870001593
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH – ADTC) (085)	870001594

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	Trauma Focused CBT for children (136)	870001595
	Trauma Grief Component Therapy (137)	870001596
Child – Parent Psychotherapy (163)		870001597
Eye Movement Desensitization and Reprocessing (EMDR) for child trauma (043)		870001598

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

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

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.

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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 for one psychiatric diagnostic evaluation for a client, per provider, per calendar year, unless a significant change in the client's circumstances makes an additional evaluation medically necessary. In that event, the provider must request a limitation extension from the agency prior to the evaluation to exceed the limit.
- The agency pays for one or more individual or family/group psychotherapy visits per day (with or without the client), per client, when medically necessary.
- For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.

Professional services delivered in an inpatient setting

Note: For eligible AI/AN Apple Health clients who are **not** enrolled in an integrated managed care plan and who have high needs refer to Part II: High acuity services for AI/AN fee-for-service clients.

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

For more information, see:

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

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

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

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

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

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

Billing for inpatient professional services

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

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

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

  ✓ Enter SCI=I in the Claim Note section of the electronic professional claim for involuntary or SCI=V for voluntary admissions.

  ✓ Provide documentation that the client was admitted to an inpatient facility.

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- A day's rounds, along with any one of the following, constitute direct client care:
  - ✓ Narcosynthesis
  - ✓ Brief (up to one hour) individual psychotherapy
  - ✓ Multiple/family group therapy
  - ✓ Group therapy
  - ✓ ECT
- If an Apple Health client requires psychiatric hospitalization while out of state, the hospital must obtain authorization from the appropriate behavioral health designee. See How can I verify a patient's coverage for mental health services? for more information.
- The agency does not pay for services provided to Medical Care Services (MCS) program clients who are out of state, unless the services are provided in a bordering city listed in WAC 182-501-0175.
- **During an involuntary admission:**
  - ✓ A court may request another physician or P-ARNP evaluation.
  - ✓ 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.
- 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.

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Inpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
+90785	Psytx complex interactive		X	X			
90791***	Psych diagnostic evaluation		X	X		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 w pt 30 minutes	30 min	X	X	X		
+90833	Psytx w pt w e/m 30 min	30 min	X	X	X		
90834	Psytx w pt 45 minutes	45 min	X	X	X		
+90836	Psytx w pt w e/m 45 min	45 min	X	X	X		
90837	Psytx w pt 60 minutes	60 min	X	X	X		
+90838	Psytx w pt w e/m 60 min	60 min	X	X	X		
90845	Psychoanalysis		X		X		
90846	Family psytx w/o pt 50 min	50 min	X	X	X		
90847	Family psytx w/pt 50 min	50 min	X	X	X		
90849	Multiple family group psytx	40 min	X	X	X		
90853	Group psychotherapy	60 min	X	X	X		
90865	Narcosynthesis		X				
90870	Electroconvulsive therapy		X				
96112	Developmental Testing 1st	60 min					

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Inpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
96113	Developmental Testing ea. add't hr.	60min	X		X		
96130	Psych testeval Physician/qhp 1st hr.	60 min	X		X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96131	Psycl tst eval phys/qhp ea	60 min	X		X	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 96146	
96132	Neuropsych Test. /Eval. 1st hr	60 min				15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA for 20yrs and older
96133	Neuropsych Test./Eval ea. add'l hr.	60 min	X		X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	EPA/PA 20 and older
96136	Psycl/nrpsyc tst phy/qhp 1st	30 min	X		X	See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X		X	See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96138	Psycl/nrpsyc tech 1st	30 min				See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96139	Psycl/nrpsyc tst tech ea	30 min			X	See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96146	Psycl/nrpsyc tst auto result					See limits under 96130 or 96132	EPA/PA for Neuropsych age 20 and older
96116	Neurobehavioral status exam				X		
99218	Initial observation care	30 min	X	X			

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Inpatient mental health services coverage table

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
99219	Initial observation care	50 min	X	X			
99220	Initial observation care	70 min	X	X			
99221	Initial hospital care	30 min	X	X			
99222	Initial hospital care	50 min	X	X			
99226	Subsequent observation care	35 min	X	X			
99231	Subsequent Hospital Care	15 min	X	X			
99232	Subsequent Hospital Care	25 min	X	X			
99233	Subsequent Hospital Care	35 min	X	X			
99251	Inpatient consultation	20 min	X	X			
99252	Inpatient Consultation	40 min	X	X			
99253	Inpatient Consultation	55 min	X	X			
99254	Inpatient Consultation	80 min	X	X			
99255	Inpatient Consultation	110 min	X	X			
99239	Hospital discharge day	30 min +	X	X			
+99356	Prolonged service inpatient 1st hr.	60 min	X	X		18 yrs and younger	
+99357	Prolonged service inpatient ea. add'l 30 min	30 min	X	X		18 yrs and younger	
99367	Team conf w/o pat by phys	30 min or longer	X	X			
	+ Add-on code						
	***A psychiatric diagnostic interview exam (CPT code 90791 or 90792) and a psychological testing (CPT codes 96130, 96131, 96136, 96137, 96138 and 96139) cannot be billed on the same day, without prior authorization.						

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Inpatient mental health services coverage table							
CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
	Note: LMHPs are not eligible for reimbursement in an inpatient setting.						

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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 inpatient for treatment-resistant depression

(CPT 90870)

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

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

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

The agency pays for ECT for individuals age 19 and older when all of the following are met:

- Documentation exists supporting other treatments have been unsuccessful
- Provided by a psychiatrist
- For inpatient ECT services:
  - ✓ For integrated managed care clients, bill the managed care organization.

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Institutional (facility) charges

Inpatient hospital psychiatric care criteria

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

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

Provider requirements

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

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

The agency pays for hospital inpatient psychiatric care, as defined in Chapters 246-320 and 246-322 WAC under inpatient psychiatric facility prospective payment rules when provided by**:**

- Free-standing psychiatric hospitals determined by the agency 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 crisis responder (DCR) or written order of the emergency physician;

- State-designated pediatric psychiatric units; or

- Facilities with state-contracted long-term beds

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

If a person is detained for involuntary care and a bed is not available in a facility certified by DOH, the state psychiatric hospitals (under the authority of DSHS) may, at their discretion, issue a **single bed certification** which serves as temporary certification (see WAC 182-538D-0526) allowing for inpatient admission to occur in that setting.

Voluntary treatment

Clients eligible for Apple Health

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

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

Clients not eligible for Apple Health

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

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

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

- Contacts the BH-ASO representative for authorization;
- Requests the BH-ASO to create a voluntary-based eligibility segment; and
- Provides the BH-ASO representative with the following information:
  - ✓ **Requesting Facility Name:**
  - ✓ **Client ProviderOne Number:** (If already in system)
  - ✓ **Client Name:** First, Last, Middle Initial
  - ✓ **Client Legal Gender:**
  - ✓ **Client Date of birth**
  - ✓ **Social Security Number** (if available)

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- ✓ **Washington county of residence** (If unavailable County of residence, provide out of state address, if applicable)
- ✓ **A brief summary of services and care to date** (if possible)
- ✓ **To and from dates of admittance** (if possible)

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

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 through the Parent Initiated Treatment process
Age 18 years and older:	May be admitted to treatment only with the client's voluntary and informed, written consent. In cases where the client has a legal guardian, the guardian's consent is required.
Members of Indian Tribes	The age of consent of the associated tribe supersedes the other requirements listed.

Involuntary treatment

Clients eligible for Apple Health

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

Clients not eligible for Apple Health

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

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

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

The admitting hospital:

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

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

Consent for involuntary admissions

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

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Authorization requirements for inpatient hospital psychiatric care (except eligible clients not enrolled in an MCO or MCO's BHSO who are in one of the RACs in Part II)

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

Contact the MCO. See How do providers identify the correct payer?

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

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

Medicare/Medicaid dual eligibility

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

- Although hospitals are not required to seek the MCO, MCO's BHSO, or BH-ASO representative's authorization for Medicare inpatient services, contact the appropriate Medicaid payer. See How do providers identify the correct payer?
- If the client with Medicare dual eligibility has exhausted the Medicare lifetime benefit at admission or during the course of the hospital stay, contact the appropriate Medicaid payer.

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Commercial (private) insurance

As with Medicare and Medicaid dual eligibility, contact the appropriate Medicaid payer. See How do providers identify the correct payer?

Changes in status

There may be more than one authorization needed during an episode of hospitalization. A request for authorization is required when there has been a change in a client's legal status, principal diagnosis, or hospital of service as indicated below. The MCO, MCO's BHSO, or BH-ASO 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, contact the appropriate Medicaid payer within 24 hours.
- **Change in Principal Diagnosis**: The situations below outline different scenarios and corresponding expectations when a change in principal diagnosis occurs. Contact the MCO, the MCO's BHSO, or BH-ASO.

  - ✓ 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 MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO 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 or BH-ASO 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 MCO, the MCO's BHSO, or the BH-ASO representative, follow requirements of the appropriate Medicaid payer. See How do providers identify the correct payer?

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Authorization denials and enrollee rights of appeal

Follow requirements of the appropriate Medicaid payer. See How do providers identify the correct payer?

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

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

- **Retrospective certification for admission to inpatient psychiatric care (PA):** The PA subsystem is also used for retrospective certifications and provides the MCO, MCO's BHSO, or BH-ASO 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. An MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative was contacted), the hospital must submit a separate

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request for authorization. The MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative within 30 days of discharge. The MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative mutually agree to the appropriateness of the administrative day.

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

- **Extensions for youth waiting for children's long-term inpatient program (CLIP):** The MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative may authorize or deny extensions or authorize administrative days. Hospitals and MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative may *not* authorize administrative days. The hospitals and MCO, MCO's BHSO, or BH-ASO representatives are encouraged to work together to find less restrictive alternatives available to meet the treatment needs for these youths. However, any less-restrictive placements would need to be ITA-certified (either as a facility or through the single bed certification). Additionally, since the ITA court papers indicate the name of the facility in which the youth is to be detained, the court

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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) and warrants extended care in the most intensive and restrictive setting; **OR**
  - ✓ The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); **OR**
  - ✓ The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care and was admitted on a voluntary basis.
- **Provision of required clinical data:** In order for the MCO, MCO's BHSO, or BH-ASO representative to make medical necessity determination, the hospital must provide the requisite agency **-required clinical data** for initial and extended authorizations. While MCO, MCO's BHSO, or BH-ASO representatives may use different formats for collection of this clinical data, the data set that is required is the same regardless of which MCO, MCO's BHSO, or BH-ASO 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.

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- **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 MCO, MCO's BHSO, or BH-ASO representative.

> **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
  - A copy of the minor's certified 180-day court order

- **Discharge summary and Review of Admissions:** Within two weeks of transfer from the hospital to a CLIP program, a copy of the completed discharge summary must be submitted by the hospital to the CLIP Administration and to the facility where the child is receiving treatment. ***All*** *referral materials* should be sent to the CLIP Administration at the following address:

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

  Under the conditions of the At Risk/Runaway Youth Act, as defined in Chapter 71.34 RCW, hospitals must provide the MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative. The MCO, MCO's BHSO, or BH-ASO 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.

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- **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

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- 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 eligible clients in one of the RACs listed in Part II and not enrolled in an MCO or MCO's BHSO)

General billing of institutional claims for inpatient hospital psychiatric care

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

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

- Hospitals must contact the appropriate MCO, MCO's BHSO, or BH-ASO so that the MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative.

- Each claim for inpatient psychiatric care must include an **authorization number**. The MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO 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

- 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 MCO, MCO's BHSO, or BH-ASO 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.

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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 MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative on behalf of the agency.
- The principal diagnosis on the hospital claim is a medical diagnosis.

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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 MCO, MCO's BHSO, or BH-ASO representative requests the creation of an ITA-related eligibility segment (previously called ITA-Q).

- **Out-of-state hospitals** must obtain authorization from the appropriate MCO, MCO's BHSO, or BH-ASO representative for all **Apple Health** clients. Neither the agency nor the MCO, MCO's BHSO, or BH-ASO 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 BH-ASO 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.

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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.

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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.

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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 agency. 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.

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Clinical data required for initial certification

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

History	
Risk Factors by HX	Prior hospitalizations, CLIP, foster care, suicide attempts, ER use, legal system involvement, homelessness, substance abuse TX, and enrollment in MH system.
Presenting Problems	
Mental Status	Diagnosis, thought content, risk of harm to self or others, behavioral presentation.
Co-Morbidity Issues	Substance abuse HX/current, toxicity screen results, developmental disability, medical issues.
Other System Issues	Jail hold, other legal issues, DDD/MH Cross System Crisis Plan.
Actions Taken to Prevent Hospitalization	
Less Restrictives	Involvement of natural supports, outpatient services including medication management, CM, PACT team, WRAP-Around, etc. Consultation with Crisis Plan, DD/MH Cross-System Crisis Plan, or Advanced Directive.
Rule Outs	Malingering, medical causes, toxicity, hospitalization in lieu of homelessness or inability to access outpatient services.
Anticipated Outcomes for Initial Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of hospitalization.
Discharge Plan	Anticipated length of stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

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Clinical data required for extension certification

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

Course of Care	
Treatment Rendered	*All* inpatient services rendered since admission (medical and psychiatric tests, therapies, and interventions performed including type and frequency) and client response to treatment thus far.
Changes	Changes in diagnoses, legal status, TX plan, or discharge plan.
Current Status	
Mental Status	Diagnoses Axis I-V, thought content, risk of harm to self or others, behavioral presentation.
Medical Status	Diagnoses, labs, behavioral presentation, withdrawal.
Anticipated Outcomes for Continued Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of continued stay and justification of why a less restrictive alternative is not appropriate at this time.
Discharge Plan	Anticipated length of continued stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

Inpatient psychiatric civil commitments for 90 days or longer

This section of applies to free-standing Evaluation & Treatment (E&T) facilities and E&T units within community hospitals that have a current (active) contract directly with the agency. **This information does not apply to any other facility**.

The identified population are clients mandated by a court process for a civil commitment stay of 90-180 days. (See Section 204P of the enacted 2018 Washington State Budget, Chapters 246-320 and 246-322 WAC, and RCW 71.05.)
The agency pays for inpatient bed capacity in freestanding E&T facilities and E&T units in community hospitals that provide inpatient psychiatric care, as defined in Chapters 246-320 and 246-322 WAC. (See individual contract-specific language for the pre-determined number of beds.)

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The Department of Health (DOH) must license and certify all contracted facilities under WAC 388-865-0511, and facilities must meet the general conditions of payment criteria in WAC 182-502-0100.

Recoupment of payments

The agency recoups any inappropriate payments made to hospitals.

Authorizations for inpatient psychiatric admissions civil commitments for 90 days or longer

The contracted requesting facility must contact the agency at LTCAuths@HCA.wa.gov using the contracted facility's secure email system to report the change in stay from 14 days per a court order to 90 days or longer per a court order *within 48 hours of admission*. The contracted requesting facility will request an end to the initial authorization. The agency will create a new authorization in ProviderOne for the new episode of care and provide the facility with an authorization number. A pdf copy of the **court documentation** must be included in the email or faxed to the agency at 360-763-4702. Court documentation **cannot contradict** the facility's location. For example, if a specific facility is mentioned, the documentation must reflect that facility. If a facility is not specifically identified, the person can transfer to a facility in his or her home county if clinically appropriate.

The contracting requesting facility must provide the agency with the following required information to create an authorization number:

- Client's full name (confirm correct spelling)
- Client's date of birth (DOB)
- Client's ProviderOne ID number (ending with "WA")
- Provider NPI number
- Begin date/anticipated end date for authorization
- ICD 10 Diagnosis
- Additional insurance, if any (i.e. Medicare or private insurance).

Send communications to LTCAuths@hca.wa.gov. If communication contains personal health information, use the contracted facility's secure email system.

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Billing for inpatient psychiatric admissions for civil commitments of 90 days or longer

Under the new authorization number, both community hospitals and free-standing E&T facilities must use the following claim instructions to bill for these services on an electronic institutional claim form (837i):

Community hospitals

Community hospitals must bill Medicare and any other third-party insurance prior to billing Medicaid. Retroactive billing **is** allowed for charges not covered by Medicare or third-party insurance. The agency reimburses the contracted facility the amount that is not covered by the private insurer up to the contracted daily-occupied rate.

Freestanding E&T facilities

Medicare does not cover services billed by freestanding E&T facilities. Providers must document in the client's record that this benefit is not covered by Medicare and bill Medicaid as the primary payer.

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

Enter dates at the line level

Billing for clients not eligible for Medicaid

Billing is according to the involuntary treatment section in this guide. Send the following information to the HCA representative at LTCAuths@hca.wa.gov upon admittance to a contracted 90- or 180-day bed:

Name: First, Last, Middle Initial
- ✓ **Date of birth**
- ✓ **Social Security Number** (if available)
- ✓ **WA County of residence**

Unoccupied Beds

The agency uses an A-19 invoice voucher to reimburse contracted sites for days that the beds are empty and waiting to be filled.

Use the invoice voucher template provided to your facility. Send the completed and signed invoice voucher to the agency representative at LTCAuths@hca.wa.gov. Information on the invoice voucher must include the bed number and the dates the bed was unoccupied.

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Part II: High acuity services for AI/AN fee-for-service clients

Specialized mental health services are for eligible Apple Health clients who need high acuity care and who are not enrolled in an integrated managed care plan. Eligible clients have one of the following recipient aid categories (RACs):

1014-1023	1039	1046-1049
1052-1055	1059	1061
1065-1074	1083-1084	1086
1088-1089	1091	1101-1111
1121-1122	1124	1126
1134	1146-1153	1162-1169
1174-1175	1196-1207	1209
1217-1225	1236-1269	

If the client requires high acuity care but does not have one of the RAC codes listed above, refer to the BH-ASO.

Crisis services

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

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

Tribal health clinics providing crisis services should refer to the Tribal Health Services Billing Guide.

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Provider eligibility

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

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

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

Professional services

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

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State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
High Intensity Treatment	H2033	Multisystemic therapy for juveniles, per 15 minutes	TG
High Intensity Treatment	S9480	Intensive outpt psychiatric services, per diem	TG
Individual Treatment	90832	Psytx w pt 30 minutes	TG
Individual Treatment	90833	Psytx w pt w e/m 30 min	TG
Individual Treatment	90834	Psytx w pt 45 minutes	TG
Individual Treatment	90836	Psytx w pt w e/m 45 min	TG
Individual Treatment	90837	Psytx w pt 60 minutes	TG
Individual Treatment	90838	Psytx w pt w e/m 60 min	TG
Individual Treatment	90889	Preparation of reports of patient psychiatric status, hex, TX, or progress for other individuals, agencies, or ins. carriers	TG
Individual Treatment	99354	Prolong e&m/psyctx serv o/p	TG
Individual Treatment	99355	Prolong e&m/psyctx serv o/p	TG
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

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State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
Intake Evaluation	99344	Home visit	TG
Intake Evaluation	99345	Home visit	TG
Intake Evaluation	99354	Prolong e&m/psyctx serv o/p	TG
Intake Evaluation	99355	Prolong e&m/psyctx serv o/p	TG
Intake Evaluation	99356	Prolonged service inpatient	TG
Intake Evaluation	99357	Prolonged service inpatient	TG
Intake Evaluation	H0031	Mental health assessment, by non-physician	TG
Medication Management	96372	Therapeutic, prophylactic or diagnostic injection	TG
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

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State Plan Modality	CPT/HCPCS Codes	Brief Description	Required Modifier
Psychological Assessment	96103	Psychological testing, by computer w/interpretation by professional	TG
Psychological Assessment	96112	Devel tst phys/qhp 1st hr	TG
Psychological Assessment	96113	Devel tst phys/qhp ea addl	TG
Psychological Assessment	96130	Psycl tst eval phys/qhp 1st	TG
Psychological Assessment	96131	Psycl tst eval phys/qhp ea	TG
Psychological Assessment	96132	Nrpsyc tst eval phys/qhp 1st	TG
Psychological Assessment	96133	Nrpsyc tst eval phys/qhp ea	TG
Psychological Assessment	96136	Psycl/nrpsyc tst phy/qhp 1st	TG
Psychological Assessment	96137	Psycl/nrpsyc tst phy/qhp ea	TG
Psychological Assessment	96138	Psycl/nrpsyc tech 1st	TG
Psychological Assessment	96139	Psycl/nrpsyc tst tech ea	TG
Rehabilitation Case Management	H0023	Behavioral health outreach service	TG
Special Population Evaluation	T1023	Screening for appropriateness for spec program	TG
Stabilization Services	S9484	Crisis intervention mental health services, per hour	TG
Stabilization Services	S9485	Crisis intervention mental health services, per diem	TG
Therapeutic 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
Community Behavioral Health Service Per Month	T1041	Monthly Case Rate provided for WISe per youth, per month	TG

Wraparound with Intensive Services (WISe) monthly case rate

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

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

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

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

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

For general billing information, see the instructions in the agency's ProviderOne Billing and Resource Guide. All approved WISe providers must bill as follows:

- Continue to bill as usual for services provided to child receiving WISe.
- Using the information in the chart, bill the monthly case rate for WISe: once per month, per child, starting with the first date of service on a single claim.
- For information about billing and Health Insurance Portability and Accountability Act (HIPAA), see the HIPAA Electronic Data Interchange (EDI).

Billing

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.

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What are the general guidelines for billing professional services?

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

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

For general billing information, see the instructions in 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 are high acuity.
- Use billing taxonomy 261QM0801X.
- Do not bill with individual servicing provider NPIs. Bill with the clinic NPI and taxonomy only.
- Do not report high acuity services on the same claim form as low acuity care services.

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

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.

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Services delivered in an inpatient hospital setting

Prior authorization (PA) is **not** required for eligible AI/AN people who are not enrolled in an integrated managed care plan.

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

- 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.

Inpatient professional psychiatric services provided to an eligible Apple Health client not enrolled in an integrated managed care plan

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 an integrated managed care plan.

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

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

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:

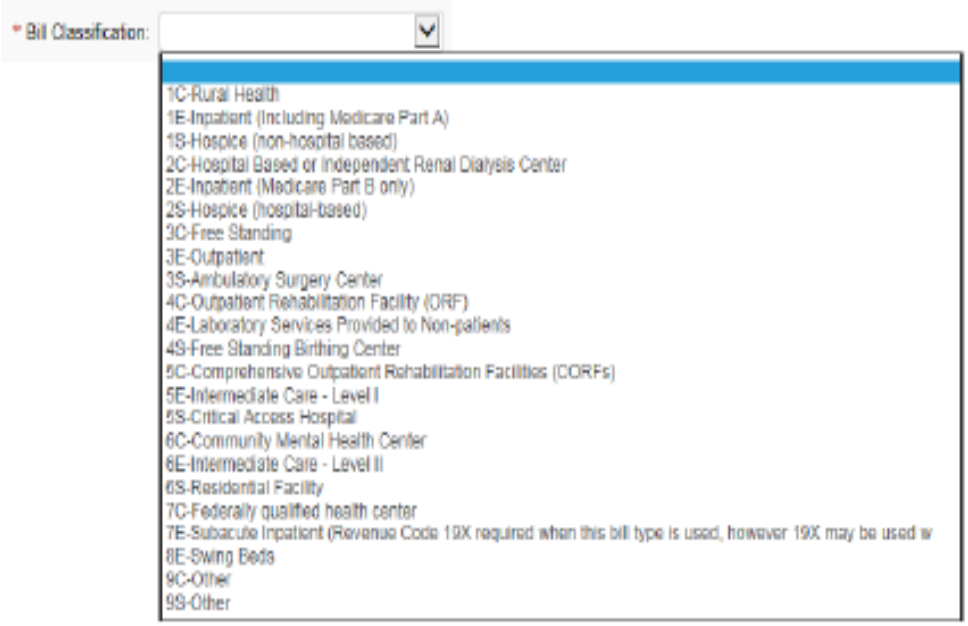
- An evaluation;
- Stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals; and
- Discharge planning involving the individual, family, and significant others to ensure continuity of mental health care.

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

Taxonomy	320800000X
Revenue code	1001
Bill type/classification:	86X*

Enter dates at the line level

*The X is a placeholder. For example, if the facility is a community health center, replace the X with C for a bill classification of 86C.



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

See How do providers identify the correct payer?

Professional services for involuntarily admitted clients

For Involuntary Treatment Act (ITA) admissions under Chapters 71.34 and 71.05 RCW, 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 integrated managed care region. See How do providers identify the correct payer?
To bill for psychiatric services under the ITA follow these guidelines:

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

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

  - ✓ Enter SCI=I in the Claim Note section of the electronic professional claim.
  - ✓ Provide documentation that the client was admitted to an inpatient facility.

- A day's rounds, along with any one of the following, constitute direct client care:

  - ✓ Narcosynthesis
  - ✓ Brief (up to one hour) individual psychotherapy
  - ✓ Multiple/family group therapy
  - ✓ Group therapy
  - ✓ ECT

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

- 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.

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- The agency does not cover services provided outside the State of Washington under the Involuntary Treatment Act (Chapter 71.05 RCW and Chapter 182-538D WAC), including services provided in designated bordering cities.

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.

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

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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 the agency to meet the federal definition of an Institution for Mental Diseases (IMD), which is: "a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services"

- Medicare-certified, distinct psychiatric units

- Hospitals that provide active psychiatric treatment (see WAC 246-322-170) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician

- State-designated pediatric psychiatric units

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

If a person is detained for involuntary care and a bed is not available in a facility certified by DOH, the state psychiatric hospitals (under the authority of DSHS) may, at their discretion, issue a **single bed certification** which serves as temporary certification (see WAC 182-538D-0526) allowing for inpatient admission to occur in that setting.

Voluntary treatment

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

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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 through the Parent Initiated Treatment process
Age 18 years and older:	May be admitted to treatment only with the client's voluntary and informed, written consent. In cases where the client has a legal guardian, the guardian's consent is required.
Members of Indian Tribes:	The age of consent of the associated tribe supersedes the requirements above.

Involuntary treatment

Only people age 13 and older (see "Age of consent for voluntary inpatient hospital psychiatric care" above) may be detained under the provisions of the Involuntary Treatment Act (ITA) as defined by Chapters 71.05 and 71.34 RCW. 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 an integrated managed care plan and are in one of the RAC codes at the beginning of this section.

If an Apple Health FFS client not enrolled in an integrated managed care plan requires inpatient psychiatric services, the hospital may submit a claim for medically necessary inpatient days of care or administrative days without PA.

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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.

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

Additional requirements

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

- For 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

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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).

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 MCO, MCO's BHSO, or BH-ASO 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 MCO, MCO's BHSO, or BH-ASO representative. The

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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

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- **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.

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Billing for inpatient hospital psychiatric care

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

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 an integrated managed care plan:

- 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. When a patient is on administrative days, the provider may bill for pharmacy services and pharmaceuticals in addition to the administrative day rate.

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

- Per coding standards, hospitals must report **all ICD 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.

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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 the hospital stay payment 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

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* 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.

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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).

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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.

Authorizations for inpatient psychiatric admissions civil commitments for 90 days or longer

The contracted requesting facility must contact the agency at LTCAuths@hca.wa.gov using the contracted facility's secure email system to report the change in stay from 14 days per a court order to 90 days or longer per a court order *within 48 hours of admission*. The contracted requesting facility will request an end to the initial authorization. The agency will create a new authorization in ProviderOne for the new episode of care and provide the facility with an authorization number. A pdf copy of the **court documentation** must be included in the email or faxed to the agency at 360-763-4702. Court documentation **cannot contradict** the facility's location. For example, if a specific facility is mentioned, the documentation must reflect that facility. If a facility is not specifically identified, the person can transfer to a facility in his or her home county if clinically appropriate.

The contracting requesting facility must provide the agency with the following required information to create an authorization number:

- Client's full name (confirm correct spelling)
- Client's date of birth (DOB)
- Client's ProviderOne ID number (ending with "WA")
- Provider NPI number
- Begin date/anticipated end date for authorization
- ICD 10 Diagnosis
- Additional insurance, if any (i.e. Medicare or private insurance).

Send communications to LTCAuths@hca.wa.gov. If communication contains personal health information, use the contracted facility's secure email system.

Billing for inpatient psychiatric admissions for civil commitments of 90 days or longer

Under the new authorization number, both community hospitals and free-standing E&T facilities must use the claim instructions below to bill for these services on an electronic institutional claim form (837i).

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Community hospitals

Community hospitals must bill Medicare and any other third-party insurance prior to billing Medicaid. Retroactive billing **is** allowed for charges not covered by Medicare or third-party insurance. Community hospitals must use the psychiatric taxonomy on file in ProviderOne and use revenue code 0124 for authorizations.

Free-standing E&T facilities

Medicare does not cover services billed by freestanding E&T facilities. Providers must document in the client's record that this benefit is not covered by Medicare and bill Medicaid as the primary payer.

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

Enter dates at the line level

Billing for Unoccupied Beds

The agency reimburses providers for unoccupied beds at a rate identified in the contract. For occupied community hospital rates, see the inpatient provider rates (IPPS) fee schedule on the agency's hospital reimbursement webpage. For occupied free-standing E&T rates, see the mental health service fee schedule (specialized mental health services) on the agency's provider billing guides and fee schedules webpage.

These beds are not linked to a client, and the agency reimburses using a provided A19 Invoice Voucher. Each month the contracted requesting facility must submit to the agency the number of empty beds and the number of days the beds were empty.

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