Washington State Health Care Authority

Washington Apple Health (Medicaid)

Mental Health Services Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, please email us about the broken link.

About this guide*

This publication takes effect **October 1, 2025,** and supersedes earlier billing guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

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

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

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

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Definitions	Added definition of critical incident	Clarification
Client Eligibility	Added information regarding services available through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit	To provide information about EPSDT services and accessibility
Intake evaluation and assessment	Intake evaluations must be initiated before providing other behavioral health services, except for services available prior to intake	Policy clarification
	Added new Note box stating the intake assessment requirement does not impact routine medical services.	Service clarification
	Added new Note box regarding use of diagnosis code Z03.89	Billing clarification

Subject	Change	Reason for Change
Outpatient mental health services coverage table	For CPT® codes 96138, 96139, and 96146, removed asterisks and added an "X" to the Psych Ph.D. provider column	Correction
Neuropsychological testing evaluation services	For Group 1 under Billing and Payment Criteria, changed patient age to 21 and older	Correction
Diagnosis for Young Children (Part I) Diagnosis for Young Children (Part II)	Revised Note box regarding diagnosis code Z03.89	Billing clarification
Critical incident reporting for Apple Health clients (fee-for-service) Part IV: Institutional Facility Charges Billed on 837I Format	New section about reporting critical incidents involving fee-for-service clients	New critical incident reporting policy
What are the general guidelines for billing professional services?	Removed "What is necessary prior to initiating services in a community mental health clinic?"	Incorporated this information into the intake evaluations and assessments section.
Intake evaluations and assessments	Revised section; removed language stating when medical services may begin Added Note box stating the intake assessment requirement does not impact routine medical services. Added Note box regarding diagnosis code Z03.89	Policy clarification
Individual treatment	Revised bullet regarding therapy and intervention treatment models: removed family therapy treatment model	Correction

Subject	Change	Reason for Change
How do I bill freestanding evaluation and treatment services provided to eligible Apple Health clients not enrolled in an integrated managed care plan or Apple Health Expansion who are in one of the RAC codes found in Part II?	Revised the list of evaluation and treatment services	To align with updated policy
Evaluation and treatment interim billing	Added instructions for claim preparation	Billing clarification
Authorization denials and enrollee rights of appeal Medicare/Medicaid dual eligibility and commercial (private) insurance	Removed pharmacy services and medically necessary ancillary services from the administrative day rate payment	To align with WAC 182-550-2590 and SHB 2051

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Table of Contents

Resources Available

Topic	Resources
Obtaining prior authorization or a limitation extension	**Online submission**: Providers may submit prior authorization (PA) and limitation extension (LE) requests online through direct data entry into ProviderOne. See HCA'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 on 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 HCA forms?"
Obtaining Apple Health forms	See HCA'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 HCA-managed care organizations	See the Apple Health Billers and Providers webpage.
Electronic billing	See the Apple Health Billers and Providers webpage.
Finding provider billing guides, fee schedules, and other HCA documents	See the Apple Health Billers and Providers webpage.
Third-party liability other than HCA managed care	See the Apple Health Billers and Providers webpage.

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.

Agency – See **Behavioral health agency**.

Apple Health client without a managed care plan – A person who is not assigned to a managed care plan, but who is still eligible for the Medicaid fee-for-service benefit administered by HCA.

Assessment – See WAC 182-538D-0200.

Behavioral Health Administrative Service Organization (BH-ASO) – An entity selected by HCA 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 agency – An entity licensed by the Department of Health to provide behavioral health services under Chapter 71.05, 71.24, or 71.34 RCW.

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

Critical incident - A serious, adverse event involving a person receiving services that occurs within a behavioral health facility. These incidents represent significant risks to the health, safety, rights, or well-being of the person or the broader public, and require immediate attention, possible intervention, and compliance.

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

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

Integrated Managed Care – 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.

Licensed mental health professional (LMHP) – See WAC 246-809 010. For more information, see the Note box following the Inpatient mental health services coverage table.

Managed care organization (MCO) – See WAC 182-538-050.

Medically necessary –See WAC 182-500-0070.

Mental health outpatient services - Services rendered by independently licensed or certified providers who do not access the Provider Entry Portal for billing services that are listed in Part I of this guide**.**

Mental health care provider (MHCP): - A person working in a behavioral health agency, under the supervision of a mental health professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. A person working as a mental health care provider must be a registered agency affiliated counselor and have a minimum of one year of education or experience in mental health or a related field.

Mental health professional (MHP) – See RCW 71.05.020.

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

National Provider Identifier (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 the 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 HCA or HCA's designee to provide psychiatric inpatient services to Medicaid-eligible individuals age 21 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.

Specialized mental health services – Services rendered to an Apple Health client without a managed care plan or behavioral health service organization (BHSO) through a licensed and certified Community Mental Health Center (CMHC). Non-tribal providers are enrolled through the Provider Entry Portal (PEP). Clients must have one of the Recipient Aid Categories (RAC) listed in Part II of this guide and cannot be enrolled in integrated managed care or behavioral health services only.

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

Program Overview

This billing guide describes mental health benefits administered through the Health Care Authority (HCA) that are available to Apple Health clients.

This billing guide is divided into four parts:

Part I describes:

- The set of mental health outpatient services for clients with less complex treatment needs covered by the client's integrated managed care organizations (MCOs) or Apple Health Expansion plan, or fee-for-service (FFS).
- Inpatient psychiatric services covered by FFS.

Part II describes:

- The specialized mental health services available to eligible FFS clients with more complex treatment needs and not enrolled in an integrated managed care plan or an Apple Health Expansion plan or a managed care plan's behavioral health services only (BHSO) program.
- How Apple Health clients not enrolled in a managed care plan 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 mental health outpatient services covered by the client's MCO or FFS program in Part I. Part II is available only if all the following criteria apply:
    - The client has one of the RACs in Part II
    - The client is not enrolled in a BHSO or integrated managed care program or Apple Health Expansion. See How are services administered?
    - The provider is a licensed and certified behavioral health agency that is enrolled in the provider entry portal (PEP)

Note: Tribes may use this section of the billing guide for all three types of Apple Health insurance.

Part III describes:

- Freestanding Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA's Division of Behavioral Health and Recovery (DBHR). **This information does not apply to any other facility.**

Part IV describes:

- How to bill a freestanding treatment and evaluation center.

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 have coverage for behavioral health services dependent on their eligibility coverage. These services may include:

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

When may a behavioral health agency bill for take-home naloxone?

A behavioral health agency may bill when an individual receives take-home naloxone from an:

- Inpatient setting upon discharge
- Outpatient clinic

Naloxone must be billed on a separate claim. See the **Prescription Drug Program Billing Guide** for more information.

National correct coding initiative

HCA 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 HCA to control improper coding that may lead to inappropriate payment. HCA 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. HCA adheres to the CMS MUEs for all codes.

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

HCA 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 Lines (PAL)

Washington has four telephone-based PAL programs to support and improve behavioral health care access at no cost for individuals, families, and providers across the state.

Children's mental health services

(866) 599-7257

Operated by Seattle Children's Hospital, this line supports primary care providers with questions about children's mental health care, such as diagnostic clarification, medication adjustment, and treatment planning.

Primary care providers are encouraged to call **(866) 599-7257**, Monday through Friday, 8 a.m. to 5 p.m. (Pacific), to be directly connected to a PAL child and adolescent psychiatrist.

Note: For more information, see the Partnership Access Line website.

Mental health referral services (MHRS) for children and teens

(833) 303-5437

Seattle Children's Hospital operates this program, which connects patients and families with available evidence-based, outpatient mental health services in their community. For more information, call **(833) 303-5437**, Monday through Friday, 8:00 a.m. to 5:00 p.m., or complete an online request.

Note: For more information, see the Mental Health Referral Services webpage.

Perinatal Psychiatry Consultation Line (PPCL) for Providers

(877) 725-4666

Previously known as PAL for Moms, the PPCL is staffed by perinatal psychiatry faculty. This service offers consultations for providers caring for pregnant or postpartum patients with behavioral health disorders. For information, call (**877) 725-4666,** Monday through Friday, 9 a.m. - 5 p.m., or email.

Note: For more information, see the Perinatal Psychiatry Consultation Line webpage.

Psychiatry Consultation Line (PCL)
(877) 928-7924

This program has been in operation since July 1, 2019, by the University of Washington. The PCL can help care providers in Washington who are seeking clinical advice regarding patients age 18 and older with mental health and/or substance use disorders. The program connects providers to faculty psychiatrists at UW Medicine.

Prescribing providers may call **(877) 928-7924** at any time. Non-prescribing providers may call Monday through Friday, 8 a.m. - 5 p.m. or may schedule a consultation.

Note: For more information, email the PCL or visit the University of Washington Clinical Care and Consultation webpage.

Additional mental-health-related services

The following covered services are explained in other HCA 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 the EPSDT Well-Child 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:

- 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) or Apple Health Expansion plan who need mental health outpatient services, as determined by an independently licensed and certified provider.
- Inpatient psychiatric services covered by FFS.
- MCOs under contract with HCA'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.
- MCOs under their BHSO contract-provide:
    - Specialized mental health care services through a BHSO for FFS clients. Services are provided by a community mental health center. The mental health claim must be billed with a billing taxonomy 261QM0801X or 251S00000X.

      Exception: FQHCs and Tribal Health Clinics must refer to respective program specific billing guides for direction on taxonomy billing requirements.
    - For mental health outpatient services, bill HCA as described in **Part I** of this guide.
- See **How do providers identify the correct payer**?
- The contracted regional behavioral health administrative service organization (BH-ASO) provides all crisis services for Apple Health clients and provides all behavioral health services for non-Apple Health clients regardless of ability to pay, within available resources. See **How do providers identify the correct payer**?

Telemedicine

Telemedicine is covered under HCA's Mental Health Services program. Refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth*, for more information on the following:

- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and *Clinical policy and billing for COVID-19*.

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Client Eligibility

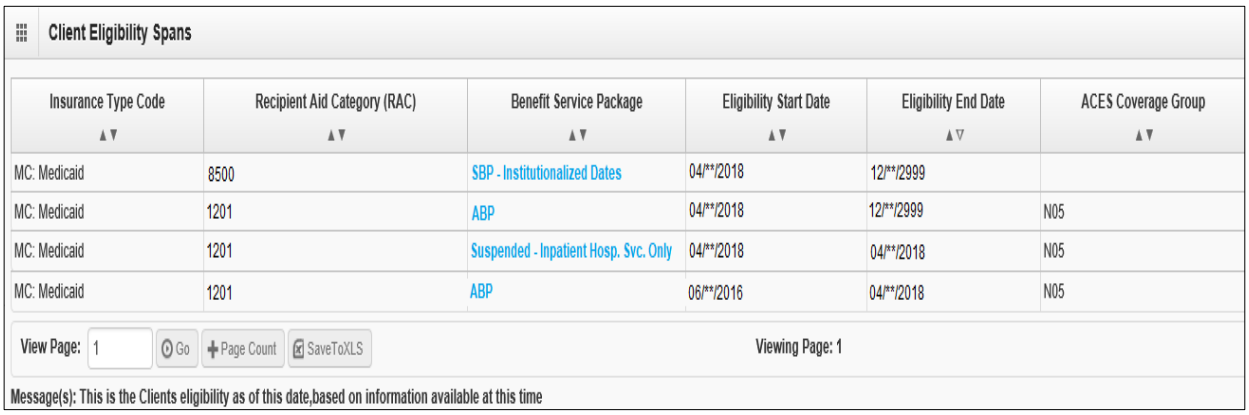
Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers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



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/**/2018	12/**/2999	
MC: Medicaid	1201	ABP	04/**/2018	12/**/2999	N05
MC: Medicaid	1201	Suspended - Inpatient Hosp. Svc. Only	04/**/2018	04/**/2018	N05
MC: Medicaid	1201	ABP	06/**/2016	04/**/2018	N05

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

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 HCA'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 HCA's **Program Benefit Packages and Scope of Services** webpage.

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

- **Online**: Go to **Washington Healthplanfinder** – select the "Let's get started" button. For clients age 65 and older or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports* (HCA 18-005) form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. 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.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

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 HCA's **Apply for or renew coverage webpage**, under *How to apply for or renew Apple Health (Medicaid) coverage*.

Clients' options to change plans

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

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

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

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the FFS program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

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's (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors (URM) program
- Age 20 and younger 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 team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting.**

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 Only (BHSO). For details, see How do providers identify the correct payer?

American Indian/Alaska Native (AI/AN) Clients

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

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

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) American Indian/Alaska Native webpage.

Early periodic screening, diagnosis, and treatment

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide and must follow the rules for the EPSDT program described in Chapter 182-534 WAC. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in WAC 182-501-0165.

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

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

This billing guide is divided into the following sections:

- Part I: Services for clients enrolled in an integrated managed care plan, Apple Health Expansion, BHSO, or fee-for-service
- Part II: Specialized mental health services for Apple Health clients without a managed care plan or BHSO
- Part III: Inpatient psychiatric civil commitments for 90+ days
- Part IV: How to bill a freestanding evaluation and treatment center

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.

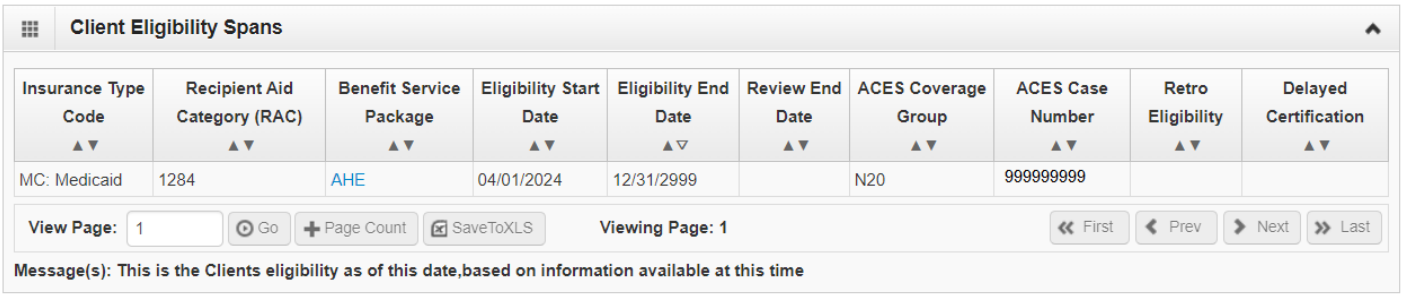
The following list of **integrated managed care plans** (as they appear in ProviderOne) cover physical health and mental health:

- WLP 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 **Apple Health Expansion plans** offered by the managed care organizations (as they appear in ProviderOne) cover physical health and mental health:

- CCC Apple Health Expansion
- CHPW Apple Health Expansion
- MHC Apple Health Expansion
- UHC Apple Health Expansion

Enrolled in Apple Health Expansion



Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	Review End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1284	AHE	04/01/2024	12/31/2999		N20	999999999		

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

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

- WLP 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/**/2019	12/**/2999	N05	999999999		
MC: Medicaid	1203	CNP	09/**/2014	02/**/2014	N11	999999999		

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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	08/**/2019	02/**/2065
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC	07/**/2019	07/**/2019
HM: Health Maintenance Organization	MC: Capitated	MHC Fully Integrated Managed Care	105010208	(800) 869-7165	HEALTHPOINT SEATAC	01/**/2019	02/**/2019
HM: Health Maintenance Organization	MC: Capitated	King County Behaviroal Health Org	105020602	(800) 790-8049		01/**/2017	12/**/2018
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options	105010201	(800) 869-7165		10/**/2014	12/**/2018

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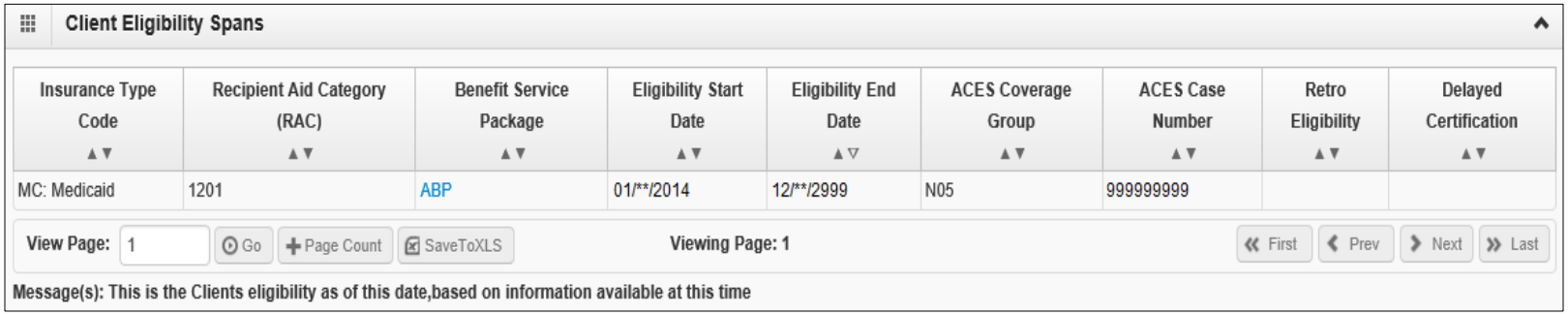
Message(s):

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	1201	ABP	01/**/2014	12/**/2999	N05	999999999		

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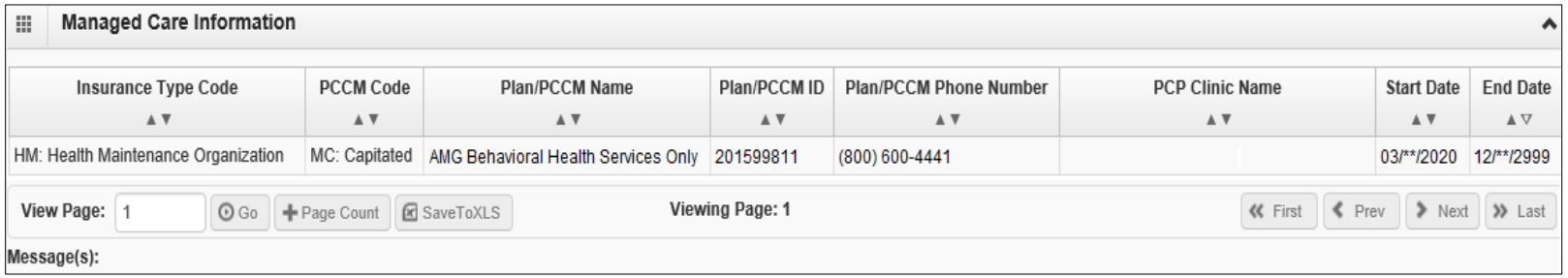
Message(s): This is the Clients eligibility as of this date,based on information available at this time



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	AMG Behavioral Health Services Only	201599811	(800) 600-4441		03/**/2020	12/**/2999

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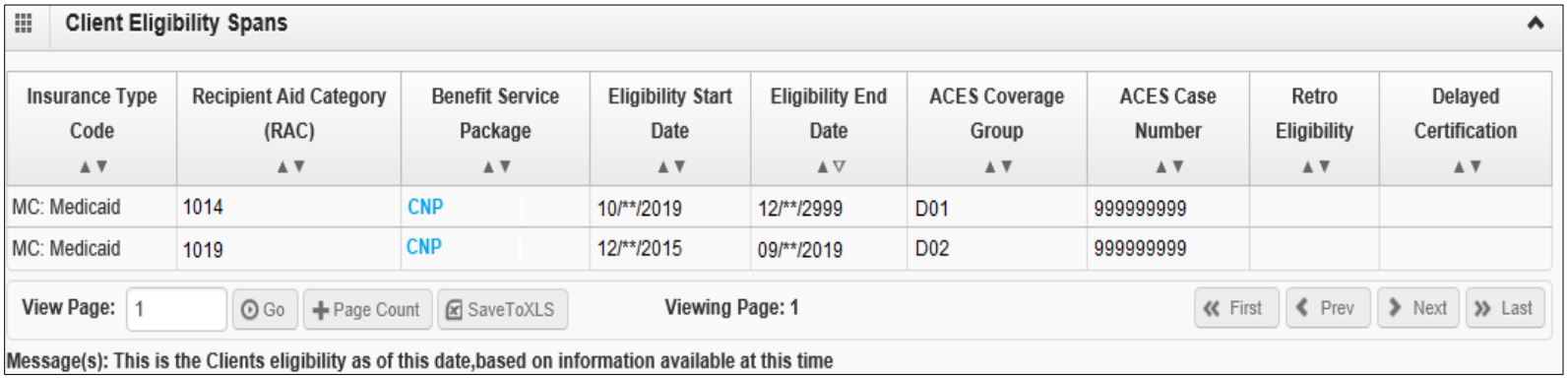
Message(s):

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/**/2019	12/**/2999	D01	999999999		
MC: Medicaid	1019	CNP	12/**/2015	09/**/2019	D02	999999999		

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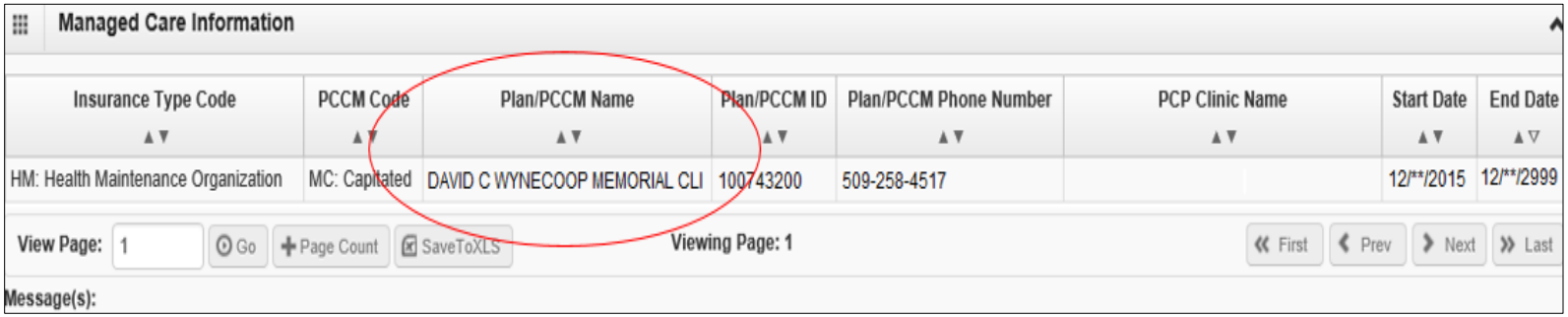
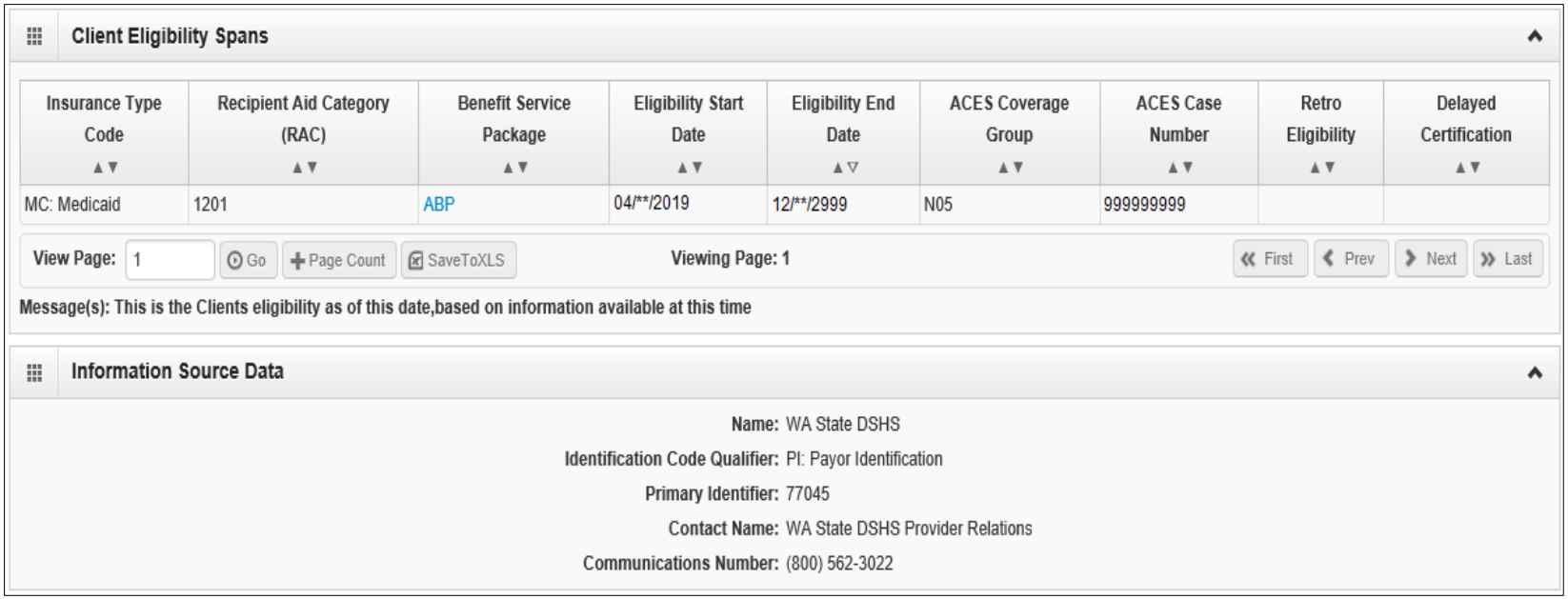
Enrolled in a PCCM



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/**/2019	12/**/2999	N05	999999999		

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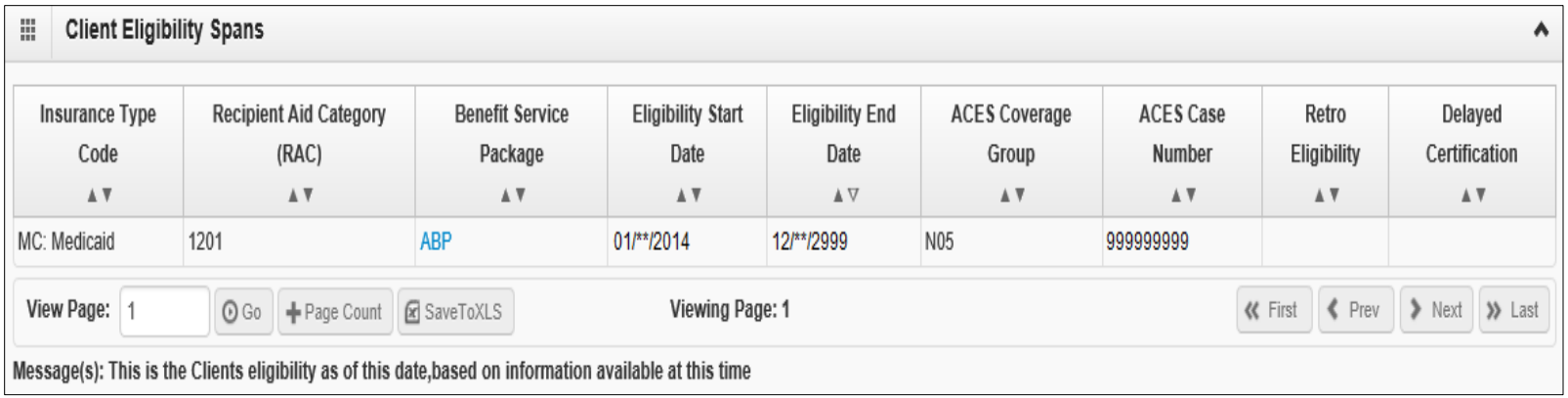
Message(s): This is the Clients eligibility as of this date,based on information available at this time

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: Specialized mental health services for Apple Health clients without a managed care plan 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/**/2014	12/**/2999	N05	999999999		

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

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/**/2014	12/**/2999	N05	999999999		

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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		06/**/2017	12/**/2045

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Message(s):

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, Apple Health Expansion, BHSO, or are Fee-for-Service

Part I describes mental health outpatient services and inpatient psychiatric professional services covered by managed care organizations (MCOs) or fee-for-service (FFS) rendered by independently licensed or certified providers without access to Provider Entry Portal.

> **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

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

To be eligible to provide and bill HCA fee-for-service (FFS) for mental health outpatient treatment services, all mental health professionals must meet all the following:

- Be independently licensed by the Department of Health.
- Be in good standing without restriction.
- Have a current core provider agreement (CPA) with HCA 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 mental health outpatient services to clients age 18 and younger?

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

Except for licensed child psychiatrists, as defined in RCW 71.34.020, qualified health care professionals who diagnose and treat clients up to age 18 and younger must Submit a *Mental Health Professionals Attestation form HCA 13-951.*

Intake evaluation and assessment

A mental health intake evaluation and assessment, also known as a psychiatric diagnostic interview exam or intake evaluation, is a culturally and age-appropriate evaluation of a person's behavioral health and functional capacity within their community. The purpose of this assessment is to determine the medical necessity and appropriateness of services and to develop treatment recommendations. Intake evaluations must be initiated before providing any other behavioral health services, except for those specifically stated as available prior to an intake.

> **Note**: The mental health intake evaluation and assessment requirement does not impact the delivery of routine medical services.

Providers are allowed to complete and bill for one intake evaluation per client, per calendar year. For clients aged six and older, a limitation extension is required to conduct and bill for more than one mental health assessment per calendar year, per provider.

> **Note**: When a completed assessment indicates there is no mental health diagnosis, use Z03.89, "No diagnosis or condition."

> **Note**: For more information regarding intake evaluation and assessment of infants and young children age five and younger, see **Mental Health Assessments for Young Children.**

Which professional services can be billed in an outpatient setting?

> **Note**: For clients enrolled in an HCA-contracted managed care organization (MCO) who are receiving outpatient mental health services, providers must follow the policies and referral procedures of the MCO.
>
> If you are treating or evaluating an Apple Health client without a managed care plan who appears to need more intense services than you can provide, see **Part II** of this guide and contact **FFSquestions@hca.wa.gov** for a list of FFS behavioral health agencies.

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).

HCA 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.

Provider taxonomy tables

Nurse practitioners	Use taxonomy:
Psychiatric advanced registered nurse practitioner (P-ARNP) – board certified; or Psychiatric mental health nurse practitioner (PMHNP) – board certified	363LP0808X

Licensed mental health professionals (LMHPs)	Use taxonomy:
Licensed independent clinical social worker (LICSW) Licensed independent clinical social worker associate (LSWAIC)	104100000X
Licensed marriage and family therapist (LMFT) Licensed marriage and family therapist associate (LMFTA)	106H00000X
Licensed mental health counselor (LMHC) Licensed mental health counselor associate (LMHCA)	101YM0800X

Note: Licensed associates cannot bill Medicare. When billing for a client who has Medicare coverage, LSWAICs, LMFTAs and LMHCAs must use 101Y00000X. When a licensed associate is billing for a client who has Medicaid coverage, they must use either 101Y00000X or the appropriate taxonomy listed in the table above.

Outpatient mental health services coverage table

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

+ = Add-on code

C = The code is conditional; see Outpatient developmental testing.

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-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/group (using the same billing NPI), per calendar year. If there is medical necessity for more than one evaluation, a limitation extension (LE) is needed. For more information about psychiatric diagnostic interview exams of infants and young children, see Mental Health Assessments for Young Children	

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
90792	Psych diag eval w/med srvcs		X	X			One psychiatric diagnostic interview exam allowed per client, per provider/group (using the same billing NPI), per calendar year. If there is medical necessity for more than one evaluation, a limitation extension (LE) is needed. For more information about psychiatric diagnostic interview exams of infants and young children, please see Mental Health Assessment for Young Children	
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		

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
G2212	Prolonged office/OP	Each additional 15 mins	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**	
90868	Tcranial magn stim tx deli		X	X			Up to 60 treatment sessions, which include initial, tapering, and repeat sessions. **Outpatient only**	
90869	Tcran magn stim redetermine		X	X			One per client, per year; **outpatient only**	
90870	Electroconvulsive therapy		X					

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
96110	Developmental screen w/score		X	X		X	Must indicate screening outcome by including modifier. See the EPSDT Well Child Program Billing Guide or the Physicians-Related/Professional Services Billing Guide.	
96112	Devel tst phys/qhp 1st hr		X	C	C	X		
96113	Devel tsxt phys/qhp ea addl		X	C	C	X		
96116	Nubhvl xm phys/qhp 1st hr		X			X		
96121	Nubhvl xm phy/qhp ea addl hr	60 min	X			X		
96127	Brief emotional/ behav assmt		X	X	X	X	Must indicate screening outcome by including modifier. See the EPSDT Well Child Program Billing Guide or the Physicians-Related/Professional Services Billing Guide.	

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
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			X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	
96133	Nrpsyc tst eval phys/qhp ea	60 min	X			X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	
96136	Psycl/nrpsyc tst phy/qhp 1st	30 min	X			X	See limits under 96130 or 96132	
+96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X			X	See limits under 96130 or 96132	
96138	Psycl/nrpsyc tech 1st	30 min	X			X	See limits under 96130 or 96132	
+96139	Psycl/nrpsyc tst tech ea	30 min	X			X	See limits under 96130 or 96132	

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
96146	Psycl/nrpsyc tst auto result		X			X	See limits under 96130 or 96132	
99281	Emr dpt vst mayx req phy/qhp		X	X				
99282	Emergency dept visit sf mdm		X	X				
99283	Emergency dept visit low mdm		X	X				
99284	Emergency dept visit mod mdm		X	X				
99285	Emergency dept visit hi mdm		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				
99226	Subsequent observation care	35 min	X	X				
99241	Office consultation	15 min	X	X				

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
99242	Off/op consltj new/est sf 20	30 min	X	X				
99243	Off/op cnsltj new/est low 30	40 min	X	X				
99244	Off/op cnsltj new/est mod 40	60 min	X	X				
99245	Off/op cnsltj new/est hi 55	80 min	X	X				
99202	Office o/p new sf	15 min Must be met or exceeded	X	X				
99203	Office o/p new low	30 min Must be met or exceeded	X	X				
99204	Office o/p new mod	45 min Must be met or exceeded	X	X				
99205	Office o/p new hi	60 min Must be met or exceeded	X	X				
99211	Off/op est may x req phy/qhp		X	X				

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
99212	Office o/p est sf	10 min Must be met or exceeded	X	X				
99213	Office o/p est low	20 min Must be met or exceeded	X	X				
99214	Office o/p est mod	30 min Must be met or exceeded	X	X				
99215	Office o/p est hi	40 min Must be met or exceeded	X	X				
+G2212 **To be used with 99215 and 99205**	Prolong outpt/office vis	Additional 15 min	X	X				
99304	1st nf care sf/low mdm	25 min	X	X				
99305	1st nf care moderate mdm	35 min	X	X				
99306	1st nf care high mdm	50 min. Must be met or exceeded	X	X				

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
99307	Sbsq nf care mdm	10 min	X	X				
99308	Sbsq nf care low mdm	20 min Must be met or exceeded	X	X				
99309	Sbsq nf care moderate mdm 30	25 min	X	X				
99310	Sbsq nf care high mdm 45	35 min	X	X				
+G0317 **To be used with 99306 and 99310**	Prolong nursing fac eval 15M	15 min	X	X				
99315	Nf dschrg mgmt	30 min or less	X	X				
99316	Nf dschrg mgmt	30 min or longer	X	X				
99341	Home/res vst new sf mdm	15 min	X	X				
99342	Home/res vst new low mdm	30 min	X	X				
99344	Home/res vst new mod mdm	60 min	X	X				
99345	Home/res vst new high mdm	75 min	X	X				

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMH NP-BC	LMHP	Psych Ph.D.	Limits	EPA/PA
99347	Home/res vst visit est sf mdm 20	15 min	X	X				
99348	Home/res vs test low mdm 30	25 min	X	X				
99349	Home/res vs test mod mdm	40 min	X	X				
99350	Home/res vs test high mdm	60 min	X	X				
+G0318 **To be used with 99345 and 99350**	Prolong home eval add 15Ml	15 min	X	X				

Services delivered outpatient for treatment-resistant depression

(CPT® 90867, 90868, 90869, 90870)

HCA covers transcranial magnetic stimulation (TMS) as a medically necessary treatment of a major depressive disorder (MDD) when all the following are met:

- Failure of at least two different antidepressant medications from at least two separate classes at maximum tolerated dose for 4-12 weeks in separate trials.
- Used as the initial treatment of a depressive episode (up to 30 treatment sessions, including tapering) and is administered according to FDA-cleared protocol.
- Client has confirmed diagnosis of major depressive disorder (ICD-10 codes F32- F33.9)
- Client is age 18 or older.

The agency covers repeat TMS for MDD (up to 30 treatment sessions) when the client:

- Meets all medical necessity criteria;

- Maintains improvement in symptoms for at least six weeks following initial treatment session, and
- Has shown evidence of 30% or greater improvement on the Hamilton Depression Rating Scale, OR a minimally clinically important difference on a validated scale for depression, with most recent TMS treatment.

The agency does not cover TMS for treatment of obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), smoking cessation, and substance use disorder (SUD).

HCA 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. HCA pays for only one psychiatric diagnostic interview exam (CPT® codes 90791 or 90792) per client, per provider, per calendar year. Providers may submit a limitation extension (LE) request to HCA for more sessions. Include with the LE request any information that describes the medical necessity of the extra sessions. For more information about psychiatric diagnostic interview exams for young children, see Mental Health Assessments for Young Children.

> **Note:** A psychiatric diagnostic interview exam (CPT® code 90791 or 90792) and a psychological testing (CPT® codes 96130, 96131, 96136, 96137, 96138 or 96139) cannot be billed on the same day without prior authorization (PA). HCA reviews PA requests according to WAC 182-501-0165.

Medication management

Medication management is an essential aspect of treating the signs and symptoms of mental health conditions. Medication management involves a brief office visit for the selection, administration, and monitoring of medications to manage mental health symptoms. If 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 medication management.

Medication management:

- 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 an in-person 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 medication management

The medical record must be clear, concise, and complete. A checklist by itself is not accepted as complete documentation. The treatment provider must document in the medical record that medication management was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated medication management. These requirements are in addition to those in WAC 182-502-0020.

Documentation of medical necessity for drug monitoring must address all the following information in the client's medical record in legible format:

- Date and time
- Diagnosis – update at least annually
- Interim medication history
- Current symptoms and problems, including any physical symptoms
- Problems, reactions, and side effects, if any, to medications or ECT
- Current mental status exam
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcomes

Note: When a client sees a psychiatrist, P-ARNP, or a PMHNP-BC for psychiatric care and only medication management is necessary, the practitioner may bill for either medication management 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 medication management, 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), medication management 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

HCA pays for developmental testing (CPT® codes 96112 and 96113) when conducted by a licensed health care professional certified to administer and interpret the identified test.

What psychological testing does HCA cover?

HCA 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 the following criteria must be met:
  - The number of hours or units requested for testing does not exceed the reasonable time necessary to address the clinical questions with the identified measures.
  - The testing techniques are validated for the proposed diagnostic question or treatment plan.
  - The testing techniques do not represent redundant measurements of the same cognitive, behavioral, or emotional domain.

- The testing techniques are both validated for the age and population of the member.
- The instruments must meet all 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: HCA 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.
- Evaluation services must always be performed by the qualified professional prior to test administration and may be billed on separate days.
- To receive reimbursement for the testing and evaluation, the psychologist must keep a report in the client's file that contains all 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 CPT® codes 96130, 96131, 96136, 96137, 96138 or 96139 without prior authorization (PA) per client, per lifetime. Providers may request PA to exceed this limit. HCA reviews PA requests according to WAC 182-501-0165.

Neuropsychological testing evaluation services

- Neuropsychological testing evaluation services include 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).

- Use CPT® codes 96132 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 CPT® 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.
- HCA reimburses for neuropsychological testing (CPT® codes 96132, 96133, 96136, and 96137) when the provider is currently licensed in Washington State to practice psychology or clinical neuropsychology.
- See limitations in the **coverage table**. If billing more than 15 units, PA is required. HCA reviews PA requests according to **WAC 182-501-0165.**

Neuropsychological testing of children and youth in school requires 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
- Description of specific benefits neuropsychological testing will provide the client, what the IEP is already addressing, and how the proposed testing will improve the treatment plan
- Other psychological testing that has been done
- Relevant consultations from physiatrists, neurologists, developmental pediatricians, etc.

Neuropsychological testing of people age 20 or older requires all the following information:

- The client's current diagnoses
- If available, a copy of the reports produced by the testing for HCA 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: HCA 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. If the client does not meet the criteria listed in this section, HCA requires prior authorization (PA) for the testing. HCA reviews PA requests according to WAC 182-501-0165.

Providers

HCA pays only "qualified" providers for administering neuropsychological testing to eligible HCA 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 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-doctorate level, in the study and practice clinical neuropsychology and related neurosciences. (These two years must include supervision by a clinical neuropsychologist).

Billing and Payment Criteria

This section describes four groups of criteria that apply to billing in certain circumstances.

To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met.

For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.

Group 1

All the following must be met:

- The patient to be evaluated has, or is suspected to have, an acquired injury to the brain because of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy.
- The patient is age 21 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.

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 HCA cover for youth?

- All age-appropriate mental health services are available to children
- Depression screening is required for youth age 12 through age 18. Suggested tools and billing instructions can be found in the EPSDT Well-Child Program Billing Guide.

> **Note**: HCA covers medically necessary mental health outpatient services for young children regardless of the site of service setting, including when provided at Pregnant and Parenting Women (PPW) residential programs. These services must be billed under the child's ProviderOne client ID.

What mental health services does HCA cover for transgender clients?

Mental health treatment can be provided to a transgender client, the client's spouse, parent, guardian, or child, or a person with whom the client has a child in common, if the treatment is directly related to the client's care, is medically necessary and is in accordance with WAC 182-531-1400.

See the 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 outpatient services does HCA cover for young children (birth through age five)?

Mental health treatment can be provided to children from birth through age five and to the child's parents or guardians if the treatment is directly related to the child's care, is medically necessary, and is in accordance with 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**: HCA 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. For suggested tools and billing instructions, see the EPSDT Well-Child Program Billing Guide.

Note: HCA covers medically necessary specialty mental health services for young children when provided at Pregnant and Parenting Women (PPW) residential programs. These services must be billed under the child's ProviderOne client ID.

Mental health assessments for young children

About this section

This section of the billing guide applies to mental health services for children from birth through five years of age. **This information does not apply for any other age group.**

Under RCW 74.09.520, for children from birth through age five, HCA allows otherwise eligible reimbursement for up to five sessions per client, per provider, per calendar year, to complete a mental health assessment (Psychiatric Diagnostic Evaluation). HCA also allows reimbursement for mental health assessments in home or community settings, including reimbursement for provider travel through a separate A-19 payment process only.

Apple Health mental health providers must use the current version of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™)* for mental health assessments and diagnoses for children from birth through five years of age.

Note: For more information, visit HCA's Mental Health Assessment for Young Children provider webpage.

Billing for multi-session mental health assessments for young children

Providers conducting mental health assessments (i.e., Psychiatric Diagnostic Evaluation) with children from birth through age five may conduct up to five sessions per client, per provider, within a calendar year. Providers must submit claims using the appropriate Psychiatric Diagnostic Evaluation CPT® codes for each session conducted with the child or the child's family for the purpose of the mental health assessment.

During the assessment process, providers may conduct caregiver-only sessions where only the caregiver/parent is present for some or all portions of the intake evaluation session. Caregiver-only sessions are allowed when the purpose of the session includes discussion of the client's history, cultural background, and description of the child and the family situation. These sessions also include an evaluation of the caregiver/parent's psychological functioning and history when the caregiver/parent is sharing sensitive information that should only be discussed without the child present.

Note: For clients age five and younger, a limitation extension is required to provide more than five mental health assessment sessions, per provider, per calendar year.

For clients age six and older, **a limitation extension** is required to provide more than one mental health assessment session, per provider, per calendar year.

Reimbursement for provider travel

Provider travel is eligible for reimbursement when providers conduct a mental health assessment for children from birth through age five in the home or in a community setting. Provider travel is reimbursed by mileage, using current mileage reimbursement rates from the Office of Financial Management. The following information must be included on any submitted claims to qualify for provider travel reimbursement.

Component	Mental health assessment	For childbirth through age five	In home or community setting
Claim Requirement	**CPT® Code**: • 90791 • 90792	**Client DOB**: • Less than or equal to 72 months before the date of service (younger than 6 years)	**Place of Service (POS) Code**: • 03: School • 04: Homeless Shelter • 12: Home • 99: Other Place of Service

Note: Claims with a U8 modifier, which identify services provided to Wraparound Intensive Services (WISe) participants by qualified WISe practitioners, are NOT eligible for mental health assessment for young children provider travel reimbursement. For more information, see **Wraparound with Intensive Services (WISe) monthly case rate.**

For clients enrolled in fee-for-service, providers should refer to the Fee-for-Service Mental Health Assessments for Young Children A-19 and Instructional Cover Sheet for guidance on submitting A-19 invoices and receiving reimbursement. For more information, see the **Mental Health Assessment for Young Children webpage**.

Note: For clients enrolled in an HCA-contracted managed care organization (MCO), providers must follow the policies and procedures of the MCO regarding provider travel reimbursement.

Diagnosis for Young Children

The DC:0-5™ Is the internationally accepted system for developmentally appropriate assessment and diagnosis of young children's mental health; however, other diagnostic manuals are often still necessary in our current behavioral health system. For Apple Health clinicians, federal Medicaid guidance requires that all claims be submitted with an ICD (International Classification of Disease) code. HCA

has published an interim Apple Health "DC: 0 – 5™ crosswalk," a reference guide for clinicians that helps convert DC: 0 – 5™ diagnoses to associated ICD diagnostic codes and DSM diagnoses. For more information, see the **Mental health Assessment for Young Children webpage**.

> **Note**: For initial assessment sessions when a diagnosis cannot be made or is unknown, use F99, "Mental disorder, not otherwise specified." For the final assessment session, use the most appropriate diagnosis code available.
>
> When the final assessment session indicates there is no mental health diagnosis, use Z03.89, "No diagnosis or condition."

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, refer to the DSHS Community Services Division (CSD) **Mental Incapacity Evaluation** Services webpage.

When is out-of-state outpatient care covered?

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**.

HCA 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 HCA 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:

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

Prior authorization and expedited prior authorization

Authorization is HCA's approval for certain 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 process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. HCA reviews PA requests according to WAC 182-501-0165. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment.

> **Note**: In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for bariatric surgery.

For examples on how to complete a PA request, see HCA's Billers, providers, and partners webpage.

What is expedited prior authorization (EPA)?

Expedited prior authorization (EPA) is HCA's streamlined process to eliminate the need for written prior authorization for certain medical services, procedures, and treatments that meet specific clinical criteria.

Key Points about EPA:

- Purpose: To allow providers to self-authorize services if they meet predefined clinical criteria.
- A complete EPA number is nine digits. The first five or six digits of the EPA number must be 87000 or 870000. The last three or four digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria.
- Billing:
    - Must include the EPA number in the authorization field when billing electronically.

- Claims will be denied if the EPA number is missing or incorrect.

> **Note**: HCA requires PA when there is no option to create an EPA number. HCA reviews PA requests according to WAC 182-501-0165.

Documentation:

- Providers must document how the EPA criteria were met in the client's medical record.
- This documentation must demonstrate medical necessity and be available for audit by HCA.
- If the documentation does not support the EPA criteria, HCA may deny the claim.

> **Note**: EPA does not apply to out-of-state care.

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. HCA reviews PA requests according to WAC 182-501-0165.

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

EPA billing requirements for evidence and research-based practices (EBP)

Providers delivering evidence- and research-based practices (EBPs), including programs such as Cognitive Behavioral Therapy (CBT) and the Positive Parenting Program (Triple P), must adhere to specific billing procedures.

Key Requirements:

- Data Collection Requirement:
  - HCA is legally required to collect data on the use of EBPs for clients age 17 and younger.
- EPA Number Usage:
  - When billing for EBP services delivered to clients age 17 and younger, providers must include the correct EPA number.

EPA numbers and other useful information about the importance of EBPs in delivering mental health services to children, how to use EBPs, and who can provide EBPs can be found in the EBP Reporting Guide.

What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

> **Note:** A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA criteria list for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service.

The request must state all the following:

- The name and ProviderOne Client ID of the client
- The provider's name, ProviderOne Client ID, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

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

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

How do I obtain written authorization?

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

Billing

> All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA'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 HCA's **Billers and Providers** webpage, under Webinars. See **Direct data entry of an institutional claim** or **Medical provider workshop** for professional claims.

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

What are the guidelines for billing professional services?

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

HCA 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. For clients age 20 and younger, additional evaluations may be covered if medically necessary, regardless of whether a significant change in the client's circumstances has occurred under **WAC 182-501-0165.** The provider must request a limitation extension from HCA prior to the evaluation to exceed the limit. For more information about psychiatric diagnostic interview exams of young children, see **Mental Health Assessment for Young Children.**

- HCA 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 Apple Health clients who have high intensity needs, refer to **Part II: Specialized mental health services for Apple Health clients without a managed care plan**.

For clients in an integrated managed care plan or Apple Health Expansion, 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**?

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

HCA 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.

- HCA pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. HCA 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.

HCA 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 HCA 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.

- 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 payer representative. See **How can I verify a patient's coverage for mental health services**? for more information.
- HCA 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.
  - HCA 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 HCA nor the BH-ASO pays for involuntary inpatient services for non-Apple Health clients provided outside of the state of Washington. Inpatient mental health services coverage table

Provider taxonomy tables

Nurse practitioners	Use taxonomy:
Psychiatric advanced registered nurse practitioner (P-ARNP) – board certified; or Psychiatric mental health nurse practitioner (PMHNP) – board certified	363LP0808X

Licensed mental health professionals (LMHPs)	Use taxonomy:
Licensed independent clinical social worker (LICSW) Licensed independent clinical social worker associate (LSWAIC)	104100000X
Licensed marriage and family therapist (LMFT) Licensed marriage and family therapist associate (LMFTA)	106H00000X
Licensed mental health counselor (LMHC) Licensed mental health counselor associate (LMHCA)	101YM0800X

Note: Licensed associates cannot bill Medicare. When billing for a client who has Medicare coverage, LSWAICs, LMFTAs, and LMHCAs must use 101Y00000X. When a licensed associate is billing for a client who has Medicaid coverage, they must use either 101Y00000X or the appropriate taxonomy listed in the table above.

Inpatient hospital mental health services coverage table

Coverage table legend and other descriptions

+ = Add-on code

C = The code is conditional; see Outpatient developmental testing.

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	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		

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
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	Devel tst phys/qhp 1st hr	60 min	X	C	X		
96113	Devel tst phys/qhp ea addl	60 min	X	C	X		
96116	Nubhvl xm phys/qhp 1st hr		X		X		
96121	Nubhvl xm phy/qhp ea addl hr	60 min	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	

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
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		X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	
96133	Nrpsyc tst eval phys/qhp eat	60 min	X		X	15 units any combination of 96132, 96133, 96136, 96137, 96138, 96139 and 96146	
96136	Psycl/nrpsyc tst phy/qhp 1st	30 min	X		X	See limits under 96130 and 96132	
+96137	Psycl/nrpsyc tst phy/qhp ea	30 min	X		X	See limits under 96130 and 96132	
96138	Psycl/nrpsyc tech 1st	30 min	X		X	See limits under 96130 and 96132	
+96139	Psycl/nrpsyc tst tech ea	30 min	X		X	See limits under 96130 and 96132	
96146	Psycl/nrpsyc tst auto result		X		X	See limits under 96130 and 96132	
99218	Initial observation care	30 min	X	X			
99219	Initial observation care	50 min	X	X			

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
99220	Initial observation care	70 min	X	X			
99221	1st hosp ip/obs sf/low 40	30 min	X	X			
99222	1st hosp ip/obs moderate 55	50 min	X	X			
99226	Subsequent observation care	35 min	X	X			
99231	Sbsq hosp ip/obs high 75	15 min	X	X			
99232	Sbsq hosp ip/obs moderate 35	35min must be met or exceeded	X	X			
99233	Sbsq hosp ip/obs high 50	50 min must be met or exceeded	X	X			
99252*	Ip/obs consltj new/est sf 35	35 min	X	X			
99253*	Ip/obs cnsltj new/est low 45	45 min	X	X			
99254*	Ip/obs cnsltj new/est mod 60	60 min	X	X			
99255*	Ip/obs consltj new.est hi 80	80 min	X	X			
99239	Hops ip/obs dschrg mgmt>30	30 min +	X	X			
+99356	Prolng svc i/p/obs 1st hour	1st hour	X	X		18 yrs and younger	

CPT® Code	Short Description	Duration	Psych MD	P-ARNP PMHNP-BC	Psych Ph.D.	Limits	EPA/PA
99357	Prolng svc i/p/obs ea addl	30 min	X	X		18 yrs and younger	
99367	Team conf w/o pat by phys	30 min or longer	X	X			

***** See the Physician-Related Services/Professional Health Care Services Fee Schedule for more information.

> **Note:** LMHPs are not eligible for reimbursement in an inpatient setting. HCA 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.

HCA pays for ECT for individuals age 19 and older when all 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 or Apple Health Expansion, bill the managed care organization.

Part II: Specialized Mental Health Services for Apple Health Clients Without a Managed Care Plan (MCO) or a Behavioral Health Service Organization (BHSO)

Specialized mental health services are rendered through a licensed and certified community mental health center (CMHC). Non-tribal providers are enrolled through the Provider Entry Portal (PEP). Clients must have one of the Recipient Aid Categories (RAC) listed in this section and cannot be enrolled in integrated managed care or Apple Health Expansion or behavioral health services only.

Note: Tribes may use this section of the billing guide for all three types of Apple Health insurance: fee-for-service, MCO, BHSO

Note: Part II specialized mental health services that are provided by a community mental health center to clients who have BHSO coverage listed under their eligibility are billed to the appropriate MCO BHSO plan. The mental health claims billed to the BHSO must be billed with a billing taxonomy 261QM0801X or 251S00000X. Mental health outpatient services rendered by independently licensed or certified providers for BHSO clients are billed as FFS claims and follow Part I of this billing guide.

Recipient aid categories

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	1194	1196-1207

Recipient Aid Categories (RACs)		
1209	**1211-1213**	**1214-1216**
1217-1225	**1236-1269**	**1274- 1281**
1288		

If the client requires specialized mental health services but does not have one of the RAC codes listed above, refer to the BH-ASO.

RAC codes with an asterisk (*) indicate those individuals who may have a spenddown.

For more information about spenddown including the step-by-step process and contact information, see the ProviderOne Billing and Resource Guide.

Provider eligibility

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

To be eligible to provide and bill HCA for specialized mental health services described above, the provider must meet all the following:

- Be licensed and certified by the Department of Health as a behavioral health agency (BHA) 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
- Be registered with the Provider Network through the provider entry portal (PEP). See the Contractor and provider resources webpage

  Exception: Tribal providers are not required to register through the PEP.

Critical incident reporting for Apple Health clients (fee-for-service)

Behavioral health agencies must report critical incidents involving Apple Health clients who are not enrolled in a managed care plan (fee-for-service clients) as follows:

- **Reporting deadline**: Incidents must be reported within one business day of the agency becoming aware of the incident.

- **Media coverage**: If an incident results in media coverage, the agency must report the incident as soon as possible and not later than the reporting deadline.
- **What form to use**: Critical Incident Form (HCA 82-0673)
- **How to report**: Providers must submit incident reports to: FFSquestions@hca.wa.gov.

An agency must submit a critical incident report for any of the following events:

- Abuse, neglect, or sexual/financial exploitation
- Arson
- Client's death
- Homicide or attempted homicide
- Kidnapping
- Media event where the client has attracted or is likely to attract media attention
- Medical emergency requiring 911 response and/or transport
- Perpetrator assault resulting in serious bodily harm
- Physical assault requiring medical attention
- Sexual assault
- Unauthorized leave from the contracted behavioral health facility during an involuntary detention

Crisis services

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

Crisis services provided for Apple Health clients who are not enrolled in a managed care plan are eligible for FFS billing when furnished by an authorized practitioner.

The following practitioners may furnish crisis stabilization services within their scope of practice as defined by state law:

- Mental health professional (MHP)
- Mental health care provider, under the supervision of an MHP
- Certified peer counselor, certified peer support specialist, or certified peer support specialist trainee under the supervision of an MHP
- Substance use disorder professional, under the supervision of an MHP

Crisis stabilization services

Crisis stabilization units

A facility must be licensed and certified by the Department of Health to be a crisis stabilization unit. Crisis stabilization units provide services that include:

- Stabilization units
- Medication assessments
- Medication management/monitoring, review and administration

Concurrent or auxiliary mental health or SUD services may be billed on the same day as stabilization when the staff providing the service is not part of the stabilization unit.

Taxonomy	Code	Modifier
261QM0801X	S9485	TG

Crisis relief centers

This is a 23-hour crisis relief center or home-like setting, which may include a "living room" model. Medication assessments, medication management/monitoring, and any medical services are billed separately as professional services.

Taxonomy	Code	Modifier
261QM0801X	S9484	TG

In-home stabilization services

For in-home stabilization services provided by a stabilization team, use the following:

Taxonomy	Code	Modifier
261QM0801X	H2019: Therapeutic behavioral services **or** H2011: Crisis intervention services	Use TG modifier followed by HA or HB

Mobile crisis modifiers

Agencies must use the TG modifier first on these claims, followed by either of these modifiers:

- Add modifier HA to track encounters for Child and Youth Mobile Crisis Response Teams
- Add modifier HB to track encounters for Adult Mobile Crisis Response Teams

Modifier guidance for endorsed crisis teams

Use the modifier ET when billing for:

- Endorsed Mobile Rapid Response Crisis Teams (EMRRCTs) and providers as defined in WAC 246-341-0901, 182-140-0020, and RCW 71.24.025.
- Endorsed Community-Based Crisis Teams (ECBCTs) and providers as defined in 182-140-0020 and RCW 71.24.903.

Endorsed crisis teams may consist of both adult and youth teams. For EMRRCTs, follow the HA and HB modifier guidance for mobile crisis teams. ECBCTs do not use the HA and HB modifiers, only the ET modifier.

Crisis Intervention codes H2011, H0038, and Crisis Stabilization Code H2019 must be billed with a TG modifier, followed by the ET modifier when submitted by EMRRCTs and ECBCTs.

Professional services

HCA covers professional services for medically necessary specialized mental health services, 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**.

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 HCA's ProviderOne Billing and Resource Guide.

All specialized mental health providers must bill as follows:

- Report modifier TG as the first modifier for specialized mental health services.
- Use billing taxonomy 261QM0801X.
- Do not bill with individual servicing provider NPIs. Bill with the clinic NPI and taxonomy only.
- Do not report specialized mental health services on the same claim form as Part I 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.

For professional charges during a psychiatric inpatient admission, see Professional services delivered in an inpatient setting in Part IV of this guide.

Outpatient specialized mental health services coverage table

State Plan Modality	CPT®/HCPCS Codes	Short 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 psytx w/o pt 50 min	TG
Family Treatment	90847	Family psytx w/pt 50 min	TG
Group Treatment Services	90849	Multiple family group psytx	TG
Group Treatment Services	90853	Group psychotherapy	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
High Intensity Treatment	H0040	Assertive comm treatment program, per diem	TG
High Intensity Treatment	H2022	Comm-based wrap-around service, per diem	TG
High Intensity Treatment	H2033	Multisystemic therapy for juveniles, per 15 minutes	TG
High Intensity Treatment	S9480	Intensive outpt psychiatric services, per diem	TG
Individual Treatment	90832	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 report	TG
Individual Treatment	H0004	Alcohol and/or drug services	TG
Individual Treatment	H0036	Comm psy face-to-face per 15 min	TG
Individual Treatment	H0046	Mental health services not otherwise specified	TG
Individual Treatment	H2014	Skills training and development, per 15 minutes	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Individual Treatment	H2015	comprehensive community support services, per 15 minutes	TG
Individual Treatment	H2017	Psychosocial rehabilitation services, per 15 minutes	TG
Intake Evaluation	90791	Psych diagnostic evaluation	TG
Intake Evaluation	90792	Psych diag eval w/med srvcs	TG
Intake Evaluation	99202	Office o/p new sf 15-29 min	TG
Intake Evaluation	99203	Office o/p new low 30-44 min	TG
Intake Evaluation	99204	Office o/p new mod 45-59 min	TG
Intake Evaluation	99205	Office o/p new hi 60-74 min	TG
Intake Evaluation **To be used with 99205 and 99215**	+G2212	Prolong outpt/office vis	TG
Intake Evaluation	99304	1st nf care sf/low mdm 25	TG
Intake Evaluation	99305	1st nf care moderate mdm 35	TG
Intake Evaluation	99306	1st nf care high mdm 50	TG
Intake Evaluation	99341	Home/res vst new sf mdm 15	TG
Intake Evaluation	99342	Home/res vst new low mdm 30	TG
Intake Evaluation	99344	Home/res vst new mod mdm 60	TG
Intake Evaluation	99345	Home/res vst new high mdm 75	TG
Intake Evaluation	H0031	MH health assess by non-md	TG
Medication Management	36415	Routine venipuncture	TG
Medication Management	96372	Ther/proph/diag inj sc/im	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Medication Management	99211	Office o/p est may x req phy/qhp	TG
Medication Management	99212	Office o/p est sf 10 min	TG
Medication Management	99213	Office o/p est low 20 min	TG
Medication Management	99214	Office o/p est mod 30 min	TG
Medication Management	99215	Office o/p est hi 40 min	TG
Medication Management	99307	Sbsq nf care sf mdm 10	TG
Medication Management	99308	Sbsq nf care low mdm 20	TG
Medication Management	99309	Sbsq nf care moderate mdm 30	TG
Medication Management	99310	Sbsq nf care high mdm 45	TG
Medication Management **To be used with 99306 and 99310**	+G0317	Prolong nursing fac eval 15M	TG
Medication Management	99347	Home/res vst est sf mdm 20	TG
Medication Management	99348	Home/res vst test low mdm 30	TG
Medication Management	99349	Home/res vst test mod mdm 40	TG
Medication Management	99350	Home/res vst test high mdm 60	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Intake Evaluation To be used with 99345 and 99350	+G0318	Prolong home eval add 15M	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	Alcohol and/or drug services	TG
Mental Health Services Provided in a Residential Setting	H0019	Alcohol and/or drug services	TG
Peer Services	H0038	Self-help/peer services, per 15 minutes	TG
Psychological Assessment	96110	Developmental screen w/score	TG
Psychological Assessment	96116	Nubhvl xm phys/qhp 1st hr	TG
Psychological Assessment	96121	Nubhvl xm phy/qhp ea addl hr	TG
Psychological Assessment	96130	Psycl tst eval phys/qhp 1st	TG
Psychological Assessment	96131	Psycl tst eval phys/qhp ea	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
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
Behavioral health care coordination and community integration	H0023	Alcohol and/or drug outreach	TG
Special Population Evaluation	T1023	Program intake assessment	TG
Stabilization Services	S9484	Crisis intervention per hour	TG
Stabilization Services	S9485	Crisis intervention mental h	TG
Therapeutic Psychoeducation	H0025	Beh health prevention education service	TG
Therapeutic Psychoeducation	H2027	Psychoeducational service, per 15 minutes	TG
Therapeutic Psychoeducation	S9446	PT education, noc group	TG
Room and Board	S9976	Lodging per diem	TG

State Plan Modality	CPT®/HCPCS Codes	Short Description	Required Modifier
Community Behavioral Health Service Per Month	T1041	Comm BH clinic svc per month	TG, U8

Intake evaluations and assessments

A mental health intake evaluation and assessment, also known as a psychiatric diagnostic interview exam or intake evaluation, is a culturally and age-appropriate evaluation of a person's behavioral health and functional capacity within their community. The purpose of this assessment is to determine the medical necessity and appropriateness of services, and to develop treatment recommendations.

Intake evaluations must be initiated before providing any other behavioral health services, except for services such as crisis services, stabilization services, or freestanding evaluation and treatment.

Note: For more information about psychiatric diagnostic interview exams of infants and young children, see Mental Health Assessments for Young Children.

Note: The mental health intake evaluation and assessment requirement does not impact the delivery of routine medical services.

Note: When the completed assessment indicates there is no mental health diagnosis, use Z03.89, "No diagnosis or condition."

Individual treatment

Individual treatment interventions are medically necessary services delivered in a wide variety of settings that promote recovery using therapeutic techniques.

These services:

- Are planned interventions designed to help achieve and maintain the maximum level of functioning for the person, as prescribed in the individual service plan.

- Are congruent with the age, strengths, and cultural framework of the individual
- Are conducted with the client, their family, or others at their behest who play a direct role in assisting the client to establish and/or maintain stability in daily life.
- Are conducted for the direct benefit of the client.
- Include cognitive and behavioral interventions designed with the intent to stabilize the client and return them to more independent and less restrictive treatment.
- Include individual therapy and intensive or brief intervention treatment models, as well as a multi-disciplinary team-based approach.
- Include therapeutic psychoeducation and skill building to develop the client's self-care/life skills and monitor the individual's functioning. These services:
    - May include developing the client's self-care/life skills
    - May include monitoring the client's functioning, counseling, and psychotherapy.
    - Are offered at the location preferred by the client and must be provided by or under the supervision of a mental health professional.
- Must be provided by practitioners within their scope of practice as defined by state law.

Medication Management

Medication management prescribes and/or administers psychiatric medications and reviews their side effects. This service may be provided in consultation with primary therapists, case managers, and/or natural supports without the client present, but the service must be for the client's benefit.

For CPT® code 36415 (routine venipuncture), submit with an-appropriate E/M medication management code. This submission need not be on the same date of service as the venipuncture.

Medication management may be provided by the following practitioners within their scope of practice as defined by state law:

- Licensed advanced registered nurse practitioner
- Licensed advanced registered nurse practitioner/psychiatric advanced
- Registered nurse practitioner
- Medical assistant – certified
- Licensed osteopathic physician
- Licensed osteopathic physician/psychiatrist
- Licensed pharmacist
- Licensed practical nurse

- Licensed physician assistant
- Licensed physician
- Licensed physician/psychiatrist
- Licensed registered nurse

Medication Monitoring

Medication monitoring involves one-on-one cueing, observing, and encouraging clients to take their psychiatric medications as prescribed. This service also includes reporting back to practitioners who perform medication management services. Medication monitoring is designed to facilitate medication compliance and positive outcomes.

These services may be provided by the following practitioners within their scope of practice as defined by state law:

- Mental health professional (MHP)
- Mental health care provider, under the supervision of an MHP
- Certified peer counselor, certified peer support specialist, certified peer support specialist trainee under the supervision of an MHP
- Medical assistant-certified
- Licensed osteopathic physician/psychiatrist
- Licensed osteopathic physician assistant
- Licensed pharmacist
- Licensed physician assistant
- Licensed physician/psychiatrist
- Licensed practical nurse
- Licensed registered nurse
- Nursing assistant registered/certified

Behavioral health care coordination and community integration (previously known as rehabilitative case management)

Behavioral health care coordination and community integration services offer a range of activities furnished to engage clients in treatment and assist them in transitioning from:

- Inpatient or residential treatment; or
- Non-permanent settings back into the broader community.

Activities include:

- Assessment for discharge or admission to community behavioral health care
- Integrated behavioral health treatment planning, resource identification, and linkage
- Collaborative development of individualized service planning that promotes continuity of care

These specialized, behavioral health community integration activities are intended to:

- Promote discharge
- Maximize the benefits of the transition plan
- Minimize the risk of unplanned readmission
- Increase the client's community tenure

Services focus on reducing the disabling symptoms of mental illness or substance use disorder. Services also focus on managing behaviors resulting from other medical or developmental conditions that jeopardize the client's ability to live in the community. Services are individualized interventions for the client or collateral contacts for the benefit of the client and may include skill-building to develop skills promoting community tenure. Services may be provided prior to an intake evaluation or assessment.

Services include:

- Liaison work between a behavioral health agency and a facility that provides 24-hour care.
- Peer Bridger program services, even when the services occur after discharge.
- Clinical staff visiting the facility and functioning as a liaison in evaluating clients for admission to outpatient services and monitoring progress towards discharge.
- Assessment for admission to behavioral health care.

What specialized mental health services does HCA cover for young children (birth through age five)?

Specialized mental health treatment may be provided to children from birth through age five and the children's parents or guardians if the treatment is directly related to the child's care and is medically necessary. Providers must bill mental health services for a newborn or child under the newborn or child's ProviderOne client ID.

> **Note**: HCA 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.

Mental Health Assessments for Young Children

About this section

This section of the billing guide applies to mental health services for children from birth through age five. **This information does not apply to any other age group.**

As directed by RCW 74.09.520(11), HCA pays for the following related to mental health and assessment and diagnosis of children from birth through five years of age:

- Up to five sessions, per client, per provider, per calendar year, to complete a mental health assessment (i.e., Intake Evaluation).
- Mental health assessments in home or community settings, including reimbursement for provider travel.

Additionally, Apple Health mental health providers must use the current version of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™)* for mental health assessments and diagnoses of children from birth through age five.

> **Note:** For more information, see HCA's Mental Health Assessment for Young Children provider webpage.

Billing for multi-session mental health assessments for young children

Providers conducting a mental health assessment (i.e., Intake Evaluation) with children from birth through age five may conduct up to five sessions per client within a calendar year. Providers must submit claims using the appropriate Intake Evaluation CPT®/HCPCS codes for each of the sessions conducted with the child and the child's family for the purpose of the intake evaluation.

During the assessment process, providers may conduct caregiver-only sessions where only the caregiver/parent is present for some or all portions of the intake evaluation session. Caregiver-only sessions are allowed when the purpose of the session includes discussion of the client's history, cultural background, and description of the child and the family situation. These sessions also include an evaluation of the caregiver/parent's psychological functioning and history when the caregiver/parent is sharing sensitive information that should only be discussed without the child present.

> **Note:** For clients age five or younger, a limitation extension is required for more than five mental health assessment sessions, per provider, per calendar year.
>
> For clients age six and older, a limitation extension is required to provide more than one mental health assessment session, per provider, per calendar year.

Reimbursement for Provider Travel

HCA pays for provider travel when providers conduct a mental health assessment for children from birth through age five in the home or in a community setting. Provider travel is paid by mileage, using current mileage reimbursement rates from the Office of Financial Management. The following information must be present on any submitted claims to qualify the claims for provider travel reimbursement.

Component	Mental health assessment	For childbirth through age five	In home or community setting
Claim Requirement	**CPT®/HCPCS Code**: • 90791 • 90792 • H0031	• Client DOB: • Less than or equal to 72 months before the date of service (younger than 6 years)	• Place of Service (POS) Code: • 03: School • 04: Homeless Shelter • 12: Home • 99: Other Place of Service

Note: Claims with a U8 modifier, which identify services provided to Wraparound Intensive Services (WISe) participants by qualified WISe practitioners, are NOT eligible for MHAYC provider travel reimbursement. For more information, please refer to **Wraparound with Intensive Services (WISe) monthly case rate.**

For clients enrolled in fee-for-service, refer to the Fee-for-Service Mental Health Assessments for Young Children A-19 and Instructional Cover Sheet for guidance on submitting A-19 invoices and receiving payment. See the **Mental Health Assessment for Young Children webpage for more information**.

Note: For clients enrolled in an HCA-contracted managed care organization (MCO), providers must follow the policies and procedures of the MCO regarding provider travel

Diagnosis for Young Children

The DC:0-5™ is the internationally accepted system for developmentally appropriate assessment of young children's mental health; however, other diagnostic manuals are often still necessary in our current behavioral health system. For Apple Health clinicians, federal Medicaid guidance requires that all claims be submitted with an ICD (International Classification of Disease) code. HCA has published an interim Apple Health "DC: 0 - 5™ crosswalk," a reference guide for clinicians that helps to convert DC: 0 – 5™ diagnoses to associated ICD diagnostic codes and DSM diagnoses. For more information, see the Mental Health Assessment for Young Children webpage.

> **Note**: When a mental health diagnosis cannot be made or is unknown during the multi-session assessment process, use F99 "Mental disorder, not otherwise specified". When a provider has adequate information to provide a diagnosis, use the most specific ICD-10 code available.
>
> When the final assessment session indicates there is no mental health diagnosis, use Z03.89, "No diagnosis or condition."

Wraparound with Intensive Services (WISe) monthly case rate

Wraparound with Intensive Services (WISe) is a range of services for eligible Apple Health 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.

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 HCA's **ProviderOne Billing and Resource Guide**. All approved WISe providers must bill as follows:

- Continue to bill as usual for services provided to a person receiving WISe. Bill all services using the TG modifier followed by the U8 modifier.
- Using the information in the **chart,** bill the monthly case rate for WISe once per month, per person , starting with the first date of service on a single claim. The monthly case rate must be billed after a client receives a service listed on the **Specialized Mental Health Fee Schedule.**
- For information about billing and Health Insurance Portability and Accountability Act (HIPAA), see the **HIPAA Electronic Data Interchange (EDI)**.

Exclusions:

- WA-PACT
- New Journeys
- High intensity treatment
- Intensive residential treatment
- Mental health services provided in a residential setting,
- Intensive outpatient and partial hospitalization
- Per diem codes

Intensive residential treatment teams

Intensive Residential Treatment teams (IRT) is a Medicaid-funded range of service components that includes individualized, intensive, coordinated, comprehensive, culturally competent, and outreach-based services for adults age 18 and older living in adult family homes and assisted living facilities licensed by the Home and Community Living Administration.

IRT services are delivered by a multi-disciplinary, mental health staff who work as a team and provide most of the treatment, rehabilitation, and support services clients need to achieve their goals. The team provides services with extended availability and a greater number of contacts than available for most outpatient services. Services are provided to the client where they live, and the team coordinates with the facility where the client lives to better work with the client.

- Inclusions:
  - Criteria for entry to this program are specified on the **IRT webpage**.

Note: Bill with taxonomy 261QM0801X on 837P format. Services are provided by staff who are members of an IRT team and are billed by an approved agency. Services are limited to once per client, per calendar month with the applicable HCPCS code S0311, and modifier HK.

- The following services are excluded from IRT programs:
  - Day Support
  - High Intensity Treatment
  - WA-PACT
  - WISe
  - New Journeys
  - Mental health services are provided in a residential setting
  - Intensive outpatient treatment and partial hospitalization
  - Other per diem codes

Intensive outpatient (IOP) and partial hospitalization programs (PHP)

Intensive Outpatient Treatment (IOP) and Partial Hospitalization Programs (PHP) refers to distinct and structured behavioral health programs that provide intensive outpatient services through active treatment as an alternative to inpatient care. The program models are more intense than those ordinarily received in a doctor's or therapist's office, but the client returns home after each treatment period.

These programs provide active treatment that incorporates an individualized treatment plan and include a multidisciplinary approach to a person's care. They offer an array of services that include:

- Individual and group counseling, as well as family counseling, if appropriate;
- Medical and wellness services, such as medical monitoring, medication management, and nutritional support

The intensity (i.e., frequency and duration of services, as well as the array or menu of services) differs depending on the behavioral health condition(s) being treated and the client's unique person driven treatment needs.

Intensive outpatient models must be at least 9-12 hours a week. There must be at least three sessions each week, occurring on separate days. Partial hospitalization models must average 15-20 hours of services a week, with an average of four to five hours per day, four to five days per week. Refer to the **Outpatient Billing Guide** for hospital billing instructions.

Exclusions

Clients who receive the following services are not eligible to also receive IOP/PHP services:

- Wraparound intensive services (WISe)
- WA-PACT
- New Journeys
- High intensity treatment
- Intensive residential treatment
- Mental health services provided in a residential setting
- Day support
- Other per diem codes

Billing for IOP/PHP for behavioral health agencies

Taxonomy	Code and description	Modifier
251S00000X	H0035: Mental Health Partial Hospitalization; treatment less than 24 hours	HK*
251S00000X	S9480; Intnsv. O/P psychiatric srvs, per diem	HK*

* Modifier HK must be the primary modifier.

For hospital billing, refer to the **Outpatient Hospital Billing Guide**.

Intensive Behavioral Health Treatment Facilities (IBHTFs)

Intensive Behavioral Health Treatment Facilities (IBHTFs) are designed to provide ongoing care to clients who no longer benefit from treatment at state hospitals but need further treatment and support to fully integrate back into their community.

IBHTFs are meant to be step-down facilities for someone who has stabilized at an inpatient facility before placement. IBTHFs are long-term facilities, with the expected length of stay estimated to be one year. For IBHTF requirements, see WAC 246-341-1137.

Clinical services at IBHTFs are provided by Psychiatric Care Providers (PCP), Mental Health Professionals (MHP), Registered Nurses (RN), Mental Health Care Providers (MHCP), Certified Peer Counselors (CPC), Certified Peer Support Specialist (CPSS), Certified Peer Support Specialist Trainee (CPSST), and Substance Use Disorder Professionals (SUDP). With support from the clinical team, clients develop care plans to work through specific barriers in their lives and to work to a higher level of independence.

For services provided in an IBHTF, bill as follows:

- Use billing taxonomy: 251S00000X on an 837p format
- Use per diem code: T2048
- A client must be age 18 or older and meet medical necessity level of care
- Service is payable is POS 56
- Room and board is included in the daily rate.

New Journeys

New Journeys is an evidence-informed, coordinated specialty care treatment model for older youth and young adults who are experiencing a first episode of psychosis. New Journeys is more intensive than regular outpatient services. This treatment model is curated specifically to meet the needs of those in the early stages of psychosis when they are first diagnosed. Treatment goals focus on functional recovery and are defined by what is meaningful to the youth and their family. Routine outcome monitoring or measurement-based care is used by teams throughout care to inform youth and families of progress, improve outcomes, and to drive practice improvements.

Entry to New Journeys is specified in the HCA/DBHR New Journeys Policy, Program, and Procedure Manual and defined specifically by age and diagnoses.

New Journeys services must be billed as follows:

- Use billing taxonomy: 261QM0801X on 837p format
- Use HCPCS code T2022 and modifier HT- Limit 1 per client, per calendar month, for 1-6 months

- Use HCPCS code T2023 and modifier HT -Limit 1 per client, per calendar month, for 7 - 24 months
- Each set of services is limited to once per client, per lifetime
- There is a client age restriction of at least age 15 through age 40 (under age 41)

If the service intensity threshold described below is met, use HCPCS code H2041, modifier HT, and billing taxonomy 261QM0801X on 837p format. A member of the New Journeys team must attest to this service.

Tier	Encounters
Tier 1	Up to 7 or fewer services per month
Tier 2	Up to 5 or fewer service encounters per month
After Tier 2 (greater than 24 months up to 5 years)	Bill for each service completed per month, up to a maximum of 5 in any given month

Or

If services are greater than the above, the team-based rate is billed as follows using taxonomy 261QM0801X:

Tier	Services	Code and Modifier
Tier 1	8 or more services per month. Limit 1 per client, per calendar, for 0 -6 months	T2022 - HT
Tier 2	6 or more services per month. Limit 1 per client, per calendar, month for 7 – 24 months	T023 - HT

Each set of services is limited to once per client, per lifetime.

Services are limited to clients who are at least age 18 through age 40.

Exclusions

The following services are excluded from New Journeys:

- Per diem codes
- High intensity treatment
- Wraparound intensive services (WISe)
- WA-PACT
- Intensive residential treatment
- Mental health services provided in a residential setting
- Intensive outpatient and partial hospitalization

For more information, see the New Journeys Fact Sheet and the **New Journeys website.**

Peer services

Peer services provide scheduled activities that promote wellness, recovery, self-advocacy, development of natural support, and community living skills. Certified peer counselors, certified peer support specialists, and certified peer support specialist trainees provide services as noted in the Individualized Service Plan or without an Individualized service plan when provided during or after a crisis episode.

Certified peer counselors, certified peer support specialists, and certified peer support specialist trainees:

- Work with adults, youth, and the parents/caregivers of youth who receive or have received behavioral health services.
- Draw upon their experiences to help peers find hope and make progress toward recovery and wellness goals.
- Model skills in recovery and self-management to help individuals meet their self-identified goals.
- Must provide peer counseling services under the supervision of a substance use disorder professional (SUDP) or mental health professional (MHP) who understands recovery; the expertise of clinical supervisors and peers should be aligned with the needs of the populations they serve.

Certified peer counselors, certified peer support specialists, and certified specialist support trainees may provide self-help/peer services (HCPCS code H0038), as well as the following services:

- Crisis intervention
- Mental health services not otherwise specified
- Skills training and development
- Comprehensive community support services
- Oral medication administration, direct observation
- Medication training and support
- Patient education, nonphysicians provider, group, per session
- Behavioral health outreach services

Peer respite facilities

Mental health peer respite is an alternative support for people who are in psychiatric distress. Peer respite facilities provide support services in a short-term, overnight environment.

Peer support may be provided on a one-on-one basis or through group peer support. Mental health peer respite is further outlined in WAC 246-341-0725.

Facility Inclusions

Peer respite facilities are limited to individuals who are:

- Age 18 or older
- Experiencing psychiatric distress but who are not detained or involuntarily committed under Chapter 71.05 RCW
- Voluntarily seeking respite services

Room and board are included.

Exclusions

Peer respite facilities do not provide medical services, such as prescribing medication or management/oversight of medication management. However, an outside provider may furnish and bill for concurrent or auxiliary professional services.

Billing information:

Bill with taxonomy	Procedure Code	Modifier	Limit	Place of Service
261QM0801X	H0045	TG	Seven days, per calendar month, per provider	16

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see **Paperless Billing at HCA**. For providers approved to bill paper claims, see HCA'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 HCA'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.

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.

Professional mental health services delivered in an inpatient hospital setting on an 837P

Prior authorization (PA) is **not** required for eligible Apple Health clients without a managed care plan or behavioral service organization.

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

- HCA pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. HCA considers services rendered during rounds to be direct client care services and may include up to one-hour individual psychotherapy, family/group therapy, and electroconvulsive therapy.
- One ECT or narcosynthesis per client, per day only when performed by a psychiatrist.

How do I bill 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, HCA 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 or Apple Health Expansion 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.
- HCA 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.
- HCA 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).

HCA 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.

HCA reviews PA requests according to **WAC 182-501-0165**.

When HCA 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**.

Occupational therapy services for behavioral health conditions

For information about billing for occupational therapy services, refer to the **Outpatient Rehabilitation Billing Guide.**

Washington State Health Care Authority

Part III: Inpatient Psychiatric Civil Commitments for 90+ Days

About this section

This section of the billing guide applies to freestanding Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA's Division of Behavioral Health and Recovery (DBHR). **This information does not apply to any other facility.**

The identified population are clients mandated by court process for a civil commitment stay that is 90 to 180 days (reference **Washington State Budget Proviso Language from Section 204(1)(p) of the enacted 2018 Budget**, Chapters **246-320** and **246-322** WAC, and RCW **71.05**).

> **Note:** More information on substance use disorders (SUD) is available on **HCA's billing guides and fee schedules webpage**.

HCA pays for inpatient bed capacity in free-standing E&T facilities, psychiatric hospitals, and E&T units in acute care 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.) For services not identified in these two WAC chapters, see the **Physicians Related Services/Health Care Professional Services Billing Guide** or the **Pharmacy Special Services Fee Schedule.**

The Department of Health (DOH) must license and certify all contracted facilities in accordance with Chapters **246-320, 246-322**, and **246-341** WAC and facilities must meet the general conditions of payment criteria in WAC **182-502-0100.**

Recoupment of payments

HCA recoups any inappropriate payments made to contracted facilities providing 90- to 180-day civil commitment beds.

Billing for professional services

For 90- to 180-day HCA-contracted beds, bill the appropriate Managed Care Organization. For more information, see **Part II: Specialized Mental Health Services for Apple Health Clients Without a Managed Care Plan.**

Authorizations for inpatient psychiatric admissions civil commitments 90 days or longer in an HCA-contracted bed

When an inpatient civil commitment stay changes from 14-days to 90+ days, the contracted requesting facility requests an end to the initial authorization from the original provider, and the DBHR representative creates a new pre-authorization in ProviderOne for the new episode of care. The DBHR representative then provides the facility with a pre-authorization number. The contracted requesting facility must include a portable document format (PDF) version of the **court documentation** clearly showing that the individual is legally committed for 90+ days during the range of the request. Court documentation **must not contradict** the facility's location.

> **For example,** if a specific facility is mentioned, then the documentation must reflect the facility the individual is in. If a facility is not specifically identified, the individual may transfer to a facility in their home county if deemed clinically appropriate.

When an individual is admitted into a contracted bed, the contracted site must provide the individual's information using a created or current Secure Access Washington (SAW) account. (See Obtaining an authorization.) HCA requires this information for everyone admitted to a 90- or 180-day state contracted civil commitment bed, so HCA can create the prior authorization in the Provider One system. This information is provided to the facility when it becomes a contracted site.

Obtaining an authorization

When an individual is admitted into a contracted bed:

- Log into the provider's SAW account and select the "Make a Request" link. Under All Categories, select Admission/Demographic Form.
- Completely fill in each field with the required information in the Admission/Demographic Form.
- Using the blue rectangle located at the bottom of the form, attach the appropriate 90- or 180-day civil commitment court order. To include additional court orders, please attach each one individually.
- After uploading the form and any attachments, select "Submit," located at the top right of the screen.
- After clicking "Submit," a ticket will confirm the submission.

Division of Behavioral Health and Recovery (DBHR) staff are notified of the submission and process the admission requests in chronological order.

If an individual who is to be admitted to a 90- or 180-day bed has Medicaid coverage that is inactive, contracted facilities must take steps to re-activate the individual's Medicaid coverage. Medicaid coverage is imperative to ensure that individuals may access outpatient services upon discharge to ensure their success upon returning to their community. Work with individuals' community service office (CSO) to help individuals have their Medicaid coverage re-activated.

If Medicare coverage is a factor, include this information in the authorization request. Add an Involuntary Treatment Act (ITA) segment to the request if the individual does not have either active Medicaid or has dual Medicare/Medicaid coverage.

Discharge documents from an HCA-contracted 90- or 180-day civil bed

When a person is discharged from a contracted bed:

- Log into the SAW account and select the "Make a Request" link.
- Under "All Categories," select the "Notice of Discharge" form. Completely fill in each field with the required information.
- Use the paper clip located at the bottom of the form to attach any additional court orders, such as a Less Restrictive Alternative Order.
- After uploading the form and any attachments, select "Submit," located on the top right of the screen.

DBHR staff are notified of the submission and process the discharge requests in chronological order.

Discharges include transfers out of an HCA-contracted bed for medical care. A Notice of Discharge form must be submitted the day the person leaves the HCA-contracted bed to receive care from an alternate facility or medical bed in the same facility. When the person returns to the HCA-contracted bed, a new Admission/Demographic form must be submitted with a new start date.

Requesting an extension or continued stay for an admitted individual with a current/active authorization number

When an individual with a current authorization needs their inpatient stay extended:

- Log into the SAW account and select the "Make a Request" link.
- Under "All Categories," select the "Extension Request Form." Completely fill in each field with the required information.
- Use the paper clip located at the bottom of the form to attach the additional court orders, i.e. a 90- or 180-day civil commitment order or an Order of Continuance.

- After completing the necessary fields on the form and uploading any attachments, select "Submit," located on the top right of the screen.

DBHR staff are notified of the submission and process the extension request in chronological order.

Billing for Part III services

Medicaid Billing

Acute Care Hospitals

When prior authorization (PA) has been received, acute care hospitals contracted for the 90+-day inpatient care bill for inpatient services the same as they do for shorter stays.

The published current rate when the person is admitted into an HCA contracted 90- or 180-day civil commitment facility is the rate HCA pays for the whole stay; the rate is not adjusted.

Acute care hospitals must bill Medicare and any other third-party insurance before billing Medicaid. HCA allows retroactive billing for charges not covered by Medicare or third-party insurance according to WAC 182-502-0150.

The following specific claim instructions relate to billing services on an electronic institutional claim form (837I):

Name	Entry
Taxonomy	282N00000X
Revenue Code	0124

Acute care and psychiatric hospital billing for the civil commitment 90- or 180-day program

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see "Paper Claim Billing Resource."

Does HCA allow interim billing?

Interim and split bills are a series of claims for a course of treatment when a client is expected to remain in the facility for an extended period.

Interim and split billing is required:

- On a monthly basis
- Upon discharge

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under **Learn how to use ProviderOne**, select **Webinars**.

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.**

The following claim instructions relate to the long-term acute care program and are the only appropriate code(s) for this billing instruction:

Name	Code Entry	To Be Used For:
Place of Service	21	Acute Care Hospital
Place of Service	51	Psychiatric Hospital

Interim billing is allowed to occur monthly and must include the following type of bill code structure:

- 112 – initial interim bill
- 113 – continuing interim bill
- 114 – final interim bill

The new claim should not include charges from earlier claims. Include the current month's units only. Do not include the previous month's units. Admission date should be true to the admit date.

> **Note:** This section does not apply to evaluation and treatment centers. For evaluation and treatment billing guidance, see **Part IV: Billing for Institutional Facility Charges.**

HCA reimburses for Medicare crossover claims according to WAC 182-502-0110. See **Appendix J: Medicare crossover claim payment methodology**.

> **Note:** Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:
>
> "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.

Psychiatric Hospitals

Under the PA, psychiatric hospitals contracted for the 90+-day inpatient care bill for inpatient services the same as they do for shorter stays.

The published current rate when the person is admitted into an HCA contracted 90- or 180-day civil commitment facility is the rate HCA pays for the whole stay; it does not adjust.

Psychiatric hospitals must bill Medicare and any other third-party insurance before billing Medicaid. HCA allows retroactive billing for charges not covered by Medicare or third-party insurance according to WAC 182-502-0150.

The following specific claim instructions relate to billing services on an electronic institutional claim form (837I):

Name	Entry
Taxonomy	283Q00000X
Revenue Code	0124

Psychiatric hospitals may bill inpatient psychiatric claims for these services every 30 days but must not bill these claims as separate 30-day claims. Adjust the initial claim submitted for the first 30 days and resubmit it to include the additional 30 days/additional days until the client is discharged. **Psychiatric hospitals must still bill all other inpatient services in 60-day intervals.**

HCA reimburses for Medicare crossover claims according to WAC 182-502-0110. See Appendix J: Medicare crossover claim payment methodology.

> **Note:** Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:
>
> "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.

Free-Standing Evaluation and Treatment Centers (E&Ts)

Under the PA, free-standing E&Ts contracted for the 90+-day inpatient care bill for inpatient services in Provider One.

The published current rate when the person is admitted into an HCA contracted 90- or 180-day civil commitment facility is the rate HCA pays for the whole stay; it does not adjust.

Medicare does not cover services billed by freestanding E&T facilities. Free-standing E&Ts must document in the client's record that this benefit is not

covered by Medicare, bill Medicaid as primary, and give this information to the DBHR representative authorizing the client's stay.

As identified in this guide, the daily per diem rate includes all the following:

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

Evaluation and treatment interim billing

Evaluation and treatment centers may submit monthly interim claims.

- Make sure dates of service do not overlap on the new claim or a duplicate edit will post.
- Continue to bill according to authorization.
- Continue to bill type 8,6, X and taxonomy of 320800000X.

The following specific claim instructions relate to billing services on an electronic institutional claim form (837I):

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

Note: Enter dates at the line level.

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

"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.

No Identified Insurance

Providers must request an ITA segment for the following:

- Individuals with Active Apple Health—QMB-only coverage
- Individuals who are not eligible for Apple Health
- Individuals with Medicare-only coverage
- Individuals whose private insurer has denied coverage

Submit an authorization request. (See **Obtaining an authorization.**) If there is no Provider One ID set up for the individual, submit the request as 000000000WA.

Billing for individuals not eligible for Medicaid who have Commercial/Private Insurance

Community Hospitals & Free-Standing E&T's

As with Medicare and Medicaid dual eligibility, contact the appropriate payer.

Part IV: Institutional Facility Charges Billed on 837I Format

Critical incident reporting for Apple Health clients (fee-for-service)

Behavioral health agencies must report critical incidents involving Apple Health clients who are not enrolled in a managed care plan (fee-for-service clients) as follows:

- **Reporting deadline**: Incidents must be reported within one business day of the agency becoming aware of the incident.
- **Media coverage**: If an incident results in media coverage, the agency must report the incident as soon as possible and not later than the reporting deadline.
- **What form to use**: Critical Incident Form (HCA 82-0673)
- **How to report**: Providers must submit incident reports to:

  FFSquestions@hca.wa.gov.

An agency must submit a critical incident report for any of the following events:

- Abuse, neglect, or sexual/financial exploitation
- Arson
- Client's death
- Homicide or attempted homicide
- Kidnapping
- Media event where the client has attracted or is likely to attract media attention
- Medical emergency requiring 911 response and/or transport
- Perpetrator assault resulting in serious bodily harm
- Physical assault requiring medical attention
- Sexual assault
- Unauthorized leave from the contracted behavioral health facility during an involuntary detention

How do I bill freestanding evaluation and treatment services provided to eligible Apple Health clients not enrolled in an integrated managed care plan or Apple Health Expansion who are in one of the RAC codes found in Part II?

HCA covers freestanding evaluation and treatment (E&T) services for behavioral health agencies (BHAs) licensed and certified by the Department of Health.

At a minimum, E&T services include the following:

- A comprehensive assessment
- Nursing care
- Behavioral health treatment modalities, including:
  - Individual, family, and milieu therapy
  - Psycho-educational groups
  - Medication management
- Discharge planning involving the client, family, and significant others to ensure continuity of mental health care
- Concurrent/auxiliary services

  The following services may be billed after admission when the staff providing the service is not assigned to the facility:
  - Behavioral health care coordination and community integration
  - Peer support

> **Note:** Evaluation and treatment centers may bill for pharmacy and over-the-counter medications charges outside of the per diem.

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

When a client is admitted into an evaluation and treatment facility and their Apple Health coverage changes mid-stay (i.e., fee-for service to managed care), the bill must be split based on the client's coverage at the time of the service, splitting covered and noncovered days.

- The claim form has two service lines. Bill as follows:
  - FFS days as covered
  - MCO days as noncovered

- Example: A client is enrolled in fee-for-service during admission and their coverage changes the next month to a managed care plan. The facility must split the billing as follows:
  - Bill fee-for-service for the first month of service
  - Bill the appropriate managed care plan after that

Evaluation and treatment interim billing

Evaluation and treatment centers may submit monthly interim claims.

- The new claim must include only charges for the current month's units. Do not carry forward units from prior months.
- Use the true admit date on the claim.
- Dates of service must not overlap with those on prior claims.

Continue to use bill type 8,6, X and taxonomy 320800000X.

> **Note:** Checking a client's eligibility each month is highly recommended.

See the **Inpatient Hospital Billing Guide** for information about billing for noncovered and covered days.

EPA for inpatient evaluation and treatment

EPA Code	Service Name	Criteria
870001612	Voluntary Admissions for Apple Health clients without a managed care plan	Voluntary Admissions for Apple Health clients without a managed care plan. Use this EPA when the patient agrees to admission for treatment. Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all of the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Place of service

EPA Code	Service Name	Criteria
870001613	Involuntary Admissions for Apple Health clients without a managed care plan	Use this EPA when the patient has been detained through the **Involuntary Treatment Act**. Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see **Services requiring EPA**) must be all of the following: • Medically necessary (as defined in WAC **182-500-0070**) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Place of service

Note: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:

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

Claims for voluntary or involuntary portions of an episode of care must be billed separately.

Services requiring EPA for fee-for-service inpatient psychiatric care

The following services require EPA:

EPA Code	Service Name	CPT®/HCPCS/Dx/Revenue Code	Criteria
870001610	Inpatient psychiatric hospital involuntary detention	Revenue Code: 0114, 0124, 0134, 0144, 0154, 0204	Refer to Billing for inpatient hospital psychiatric care Effective January 1, 2020
870001611	Inpatient psychiatric hospital voluntary	Revenue Code: 0114, 0124, 0134, 0144, 0154, 0204	Refer to Billing for inpatient hospital psychiatric care Effective January 1, 2020

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 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 must 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, except for 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

HCA pays for hospital inpatient psychiatric care, as defined in WAC 182-550-2600 under inpatient psychiatric facility prospective payment rules when provided by any of the following:

- Free-standing psychiatric hospitals determined by HCA 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 182-550-2600) 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
- Facilities with state-contracted long-term beds

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 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 HCA's ProviderOne Billing and Resource Guide.

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

Clients not eligible for Apple Health

The BH-ASO may pay for these services, if resources are available, for a person 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 must:

- Contact the BH-ASO representative for authorization
- Request the BH-ASO to create a voluntary-based eligibility segment
- Provide 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 the information above for both ITA and Voluntary.

Age of consent for voluntary inpatient hospital psychiatric care

Age group or members	Criteria
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 group or members	Criteria
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. HCA'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.

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 must:

- Contact the BH-ASO
- Request the BH-ASO to create an ITA-based eligibility segment; and
- Provide 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 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.

Authorization requirements for inpatient hospital psychiatric care

> **Note**: To determine the correct payer (MCO, MCO's BHSO or BH-ASO), See How do providers identify the correct payer?

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

Contact the MCO.

> 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 HCA's Interactive Voice Response System at 1-800-562-3022.
>
> Services provided to blind and disabled clients in a certified public expenditure (CPE) hospital must be billed FFS to HCA through ProviderOne. To process those claims, the CPE hospital must obtain prior authorization from the MCO and submit that information to HCA 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:

- If the client is enrolled with a BHSO, contact the BHSO for authorization requirements for secondary payment.

- If the client is not enrolled in an MCO, see expedited prior authorization.
- If the client with Medicare dual eligibility has exhausted the Medicare lifetime benefit at admission or during the hospital stay, contact the appropriate payer.

Commercial (private) insurance

As with Medicare and Medicaid dual eligibility, contact the appropriate 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 change of hospital indicated below. The appropriate payer representatives must respond to hospital requests for authorization within the timelines below:

- **Change in legal status**: If a client's legal status changes from involuntary to voluntary, contact the appropriate 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 appropriate payer.
    - 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 their hospitalization, the appropriate payer representative must be notified of the initial discharge from psychiatric care and a new authorization may be 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 inpatient psychiatric care, the hospital from which the client is being transferred must contact the appropriate payer representative regarding 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 and is transferred from one facility to another, the client's current medical, psychiatric, and copies of any ITA or court papers must accompany the client. The appropriate payer representative is 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 payer.

Authorization denials and enrollee rights of appeal

Follow requirements of the appropriate payer.

Enrollees may request an administrative hearing conducted by HCA after receiving notice that an adverse benefit determination by the appropriate payer has been upheld. If the appropriate payer 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 HCA.

The appropriate payer 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 appropriate payer 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.

Retrospective certification for admission to inpatient psychiatric care (PA): The PA subsystem is also used for retrospective certifications and provides the appropriate payer 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. The appropriate payer representative on behalf of HCA 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 appropriate payer 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 appropriate payer representative was contacted), the hospital must submit a separate request for authorization. The appropriate payer 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 appropriate payer representative within 30 days of discharge. The appropriate payer representative must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

- **Administrative days**: Administrative days may be paid when all 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 appropriate payer representative mutually agree to the appropriateness of the administrative day.

Agencies may bill for the administrative day rate payment. The agency may pay for pharmaceuticals when they are provided during administrative days.

Extensions for youth waiting for children's long-term inpatient program (CLIP): The appropriate payer representative cannot deny an extension request for a child or youth who has been detained under ITA and is waiting for a CLIP admission 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 admission to CLIP, who is in a community psychiatric hospital on a voluntary basis, the appropriate payer representative may authorize or deny extensions or authorize administrative days. Hospitals and appropriate payer representatives are encouraged to work together to find less restrictive alternatives for these children.
- **Involuntary**: For a youth waiting for admission to CLIP, who is in a community psychiatric hospital on an involuntary basis, extensions may not be denied, and the appropriate payer representative may not authorize administrative days. The hospitals and appropriate payer 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 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 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 182-500-0070); **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**: For the appropriate payer representative to make medical necessity determination, the hospital must provide the requisite HCA-**required clinical data** for initial and extended authorizations. While appropriate payer representatives may use different formats for collection of this clinical data, the data set that is required is the same regardless of which appropriate payer representative is certifying the need for inpatient psychiatric care.

Institutional charges for inpatient hospital psychiatric admissions on an 837I

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 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

HCA 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 HCA 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 allowing for inpatient admission to occur in that setting.

Voluntary treatment

For clients who are not enrolled in an integrated managed care plan or Apple Health Expansion, 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 HCA.

Age of consent for voluntary inpatient hospital psychiatric care:

Age/Member	Criteria
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. HCA 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.

General authorization requirements for fee-for-service inpatient hospital psychiatric care

If an Apple Health FFS client is not enrolled in an integrated managed care plan or Apple Health Expansion and has one of the RAC codes listed at the beginning of this section, and the stay requires inpatient psychiatric services, the hospital may submit a claim for medically necessary inpatient care using one of the EPA numbers shown below.

Each claim for inpatient psychiatric care must include an EPA number. 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.

Note: HCA's ProviderOne Billing and Resource Guide provides information on how to "Check Status of an Authorization."

Billing inpatient psychiatric services for eligible Apple Health clients without a managed care plan

EPA Code	Service Name	Criteria
870001610	Involuntary Treatment Act Admissions for Apple Health clients without a managed care plan	Use this EPA when the patient is detained under the Involuntary Treatment Act (ITA) in chapters 71.05 and 71.34 RCW Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • 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, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service

EPA Code	Service Name	Criteria
870001611	Voluntary Admissions for Apple Health clients without a managed care plan	Use this EPA when the patient agrees to admission for treatment. Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • 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, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service

Authorized (covered) days: Authorized days are determined by the appropriate payer representative utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim must match authorized days in the ProviderOne PA record.

Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	$xx.xx	
0xx4		$xx.xx

Hospitals must bill any **administrative days** and associated covered charges for services rendered on these days, with the appropriate revenue codes on a separate claim. See the Inpatient Hospital Billing Guide for payable revenue codes.

Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144, 0154, or 0204.

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

> **Note**: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:
>
> "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.

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, HCA will coordinate benefits based on applicable adjudication rules.

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

Agencies may bill for the administrative day rate payment. The agency may pay for pharmaceuticals when they are provided during administrative days.

Additional requirements

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

- For Inpatient Hospital Psychiatric Admissions, "Medically Necessary," or "Medical Necessity" is defined as follows:
  - Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND**
  - Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170); **AND**
  - The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning; **AND**

- The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association) that is considered a principal covered diagnosis (see Diagnostic Categories) and warrants extended care in the most intensive and restrictive setting; **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (chapter 71.05 or 71.34 RCW); **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (chapter 71.05 or 71.34 RCW) but agreed to inpatient care.

Referral to the children's long-term inpatient program (CLIP): Children and youth ages 6-17 can be referred to CLIP voluntarily or via a 180-day Involuntary Treatment Act (ITA) court. 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 payer representative. For additional information, refer to the **CLIP Administration webpage**.

HCA **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. **Send all** *referral materials* to CLIP Administration at the following address:

  Children's Long-Term Inpatient Program (CLIP)
  2142 10th Avenue W
  Seattle, WA 98119
  206.298.9654

  *All referral materials can also be **emailed** to the CLIP program. Any information being sent via email that includes PHI must be sent via secure email.

  Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the appropriate payer 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 appropriate payer representative. The representative must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- **Referral packet**: A referral packet concerning the ITA-committed child must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
    - A certified copy of the court order and the 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist
    - A diagnosis by a psychiatrist, including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association
    - An admission evaluation including:
        - Medical evaluation
        - Psychosocial evaluation
    - The hospital record face sheet
    - Other information about medical status including:
        - Laboratory work
        - Medication records
        - Consultation reports
    - An outline of the child's entire treatment history
    - All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility
    - A brief summary of child's progress in treatment to date, including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment
- **Submitting other background information for CLIP referrals**: During the 20 days following the 180-day commitment hearing, the committing hospital must arrange to have the following background information submitted to the CLIP Administration. Submit all 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 involvement, and detail of treatment history, as well as less restrictive options being considered

  - HCA 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.

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

- **Referral to the children's long-term inpatient program (CLIP)**: Children and youth ages 6-17 can be referred to CLIP voluntarily or via a 180-day Involuntary Treatment Act (ITA) court. 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 payer representative. For additional information, refer to the CLIP Administration webpage.

> **Note**: HCA **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. **Send all referral materials** to 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

  All referral materials can also be **emailed** to the CLIP program. Any information being sent via email that includes PHI, must be sent via secure email.

  Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the appropriate payer 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 appropriate payer representative. The appropriate payer representative must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- **Referral packet**: A referral packet concerning the ITA committed child must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
  - A certified copy of the court order and the180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist
  - A diagnosis by a psychiatrist, including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association
  - An admission evaluation including:
    - Medical evaluation
    - Psychosocial evaluation
  - The hospital record face sheet

- Other information about medical status including:
  - Laboratory work
  - Medication records
  - Consultation reports
- An outline of the child's entire treatment history
- All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility
- A brief summary of child's progress in treatment to date, including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment

- **Submitting other background information for CLIP referrals**: During the 20 days following the 180-day commitment hearing, the committing hospital must arrange to have the following background information submitted to the CLIP Administration. Submit all 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.
  - HCA case records, including placement history form, individualized service plans (ISPs), court orders, DYCF Comprehensive Family Assessments court reports, 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

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.

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

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

For Apple Health clients without a managed care plan, each claim for inpatient psychiatric care must include an **expedited prior authorization (EPA) number**. For clients with managed care eligibility, bill the appropriate MCO. The appropriate payer representative that authorized the hospital admission must provide an authorization number. 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 bill a new claim and use the appropriate EPA number depending on voluntary or involuntary status.
- A new authorization or EPA must be used when there is a change in any of the below:
    - 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**: HCA'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 appropriate payer representative utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim must match authorized days in the ProviderOne PA record.
- Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	$xx.xx	
0xx4		$xx.xx

- Hospitals must bill any **administrative days** and associated covered charges for services rendered on these days with the appropriate revenue codes. For payable revenue codes, see the Inpatient Hospital Billing Guide.
- Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144, 0154, or 0204.
- Per coding standards, hospitals must report **all current ICD diagnosis codes at the highest level of specificity**.

> **Note**: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:
>
> "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.

EPA for billing inpatient psychiatric services for eligible Apple Health clients without a managed care plan or behavioral health services organization (BHSO)

EPA Code	Service Name	Criteria
870001610	Involuntary Treatment Act Admissions for Apple Health clients without a managed care plan	Use this EPA when the patient is detained under the Involuntary Treatment Act (ITA) under chapters 71.34 and 71.05 RCW Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • 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, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service

EPA Code	Service Name	Criteria
870001611	Voluntary Admissions for Apple Health clients without a managed care plan	Use this EPA when the patient agrees to admission for treatment. Inpatient psychiatric care for all fee-for-service Apple Health clients (see **Services requiring EPA**) must be all the following: • Medically necessary (as defined in **WAC 182-500-0070**) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • 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, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service

Claims for psychiatric services when the principal diagnosis falls outside of the appropriate payer 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 an appropriate payer representative on behalf of HCA.
- The principal diagnosis on the hospital claim is a medical diagnosis.

Splitting claims

When the focus of care shifts from medical to psychiatric services or from psychiatric to medical services, psychiatric services and acute medical services must be billed on separate claims.

Billing instructions specific to involuntary treatment

- HCA will process claims for services provided to detained clients who have applied for Apple Health and were denied if the BH-ASO representative submits a ticket to ProviderOne for the creation of an ITA-related eligibility segment (previously called ITA-Q).
- **Out-of-state hospitals** must obtain authorization from the appropriate payer representative for all **Apple Health** clients. Neither HCA nor the appropriate payer 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, HCA 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**: 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 will 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 HCA for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on HCA 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect HCA to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect HCA to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*

Description	DRG	Per Diem	RCC	CPE	CAH
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

* HCA pays line item by line item on some claims (RCC, CPE, and CAH). HCA does not pay for line items that Medicare has already paid. HCA pays by the stay (DRG claims) or the day (Per Diem) on other claims. HCA calculates the payment and then subtracts what Medicare has already paid. HCA recoups what it paid as secondary on the Medicare claim.

**The claim note should be one of the following:

- SCI=I No Part A benefits
- SCI=V No Part A benefits
- SCI=I Part A benefits exhausted prior to stay
- SCI=V Part A benefits exhausted prior to stay

What HCA 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 HCA (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 exceeding the outlier payment."
2. HCA 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 HCA on an 837I transaction:
   - 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. HCA may pay an amount using the following formula:
   - HCA's allowed amount for the entire stay minus Medicare's payment minus HCA'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 HCA to contact the biller for additional information.

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 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 HCA.

Recoupment of payments

HCA 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 detoxification program admissions associated with HCA. See the **Hospital-Based Inpatient Detoxification Billing Guide**.
- For people admitted involuntarily under chapter 71.05 or 71.34 RCW, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities do not apply.
- For people with Medicare and Medicaid dual eligibility, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities does not apply until the lifetime Medicare benefit has been exhausted.

Clinical data required for initial certification

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

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 Restrictive Alternatives - Involvement of natural supports, outpatient services including medication management, CM, PACT team, WRAP-Around, etc. Consultation with Crisis Plan, DD/MH Cross-System Crisis Plan, or Advanced Directive.
- Rule Outs - Malingering, medical causes, toxicity, hospitalization in lieu of homelessness or inability to access outpatient services.

Anticipated Outcomes for Initial Stay

- Proposed TX Plan - Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of hospitalization.
- Discharge Plan - Anticipated length of stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

Clinical data required for extension certification

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

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

Part III applies to free-standing Evaluation & Treatment (E&T) facilities, psychiatric hospitals, and E&T units within acute care hospitals that have a current (active) contract directly with HCA. **This information does not apply to any other facility**. See Part III: Inpatient Psychiatric Civil Commitments for 90+ Days for more information.

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

All the following must occur for hospitals to be paid for providing inpatient hospital psychiatric care for clients who are not enrolled in an integrated managed care plan or Apple Health Expansion:

- 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 the appropriate revenue codes 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 diagnosis codes at the highest level of specificity**.

> **Note**: Use one of the following special claims indicators in the Billing Note section in ProviderOne to indicate whether the days billed were voluntary or involuntary:
>
> "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 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**: 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 will 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 HCA for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on HCA 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect HCA to reduce the hospital stay payment by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect HCA to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*

Description	DRG	Per Diem	RCC	CPE	CAH
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

* HCA pays line item by line item on some claims (RCC, CPE, and CAH). HCA does not pay for line items that Medicare has already paid. HCA pays by the stay (DRG claims) or the day (Per Diem) on other claims. HCA calculates the payment and then subtracts what Medicare has already paid. HCA 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 HCA 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 HCA (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. HCA 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 HCA:

- 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. HCA may pay an amount using the following formula:

- HCA's allowed amount for the entire stay minus Medicare's payment minus HCA'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 HCA 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 CM.), the claim will be reviewed prior to a payment decision. Providers must submit the claim with adequate documentation to support payment as a medical necessity (i.e., history and physical, discharge summary, and physician orders).

> **Note**: If the client is covered by an MCO, the required documentation and claim must be submitted to the client's MCO. Do not send these claims to HCA.

Recoupment of payments

HCA recoups any inappropriate payments made to hospitals.