Washington State Health Care Authority

Medicaid Provider Guide

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

A Billing Instruction

About This Guide

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

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Procedure code updates PN 12-96	January 1, 2013	Throughout guide	Deleted and replaced procedure codes	The agency has deleted and replaced various procedure codes throughout the document. Affected codes are listed on PN 12-96.
See PN 13-06	January 1, 2013	Mental Health Services for Children	Fee-for-Service clients Administration of services	Added reference to fee-for-service clients. Added section on the administration of services that was erroneously deleted in a prior publication.
See PN 13-06		General Guidelines	Billing	Added clarification concerning add-on codes. Removed two bullets and changed bullet starting with: “The agency pays…”
See PN 13-06	January 1, 2013	Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319	Procedure code updates and clarification	Added note box and changed procedure codes in tables.
See PN 13-06	January 1, 2013	Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis	Noncovered services	Removed bulleted list starting with: “Office visits (99201-99215).

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
		Codes 290.0-319		
See PN 13-06		For Clients of any Age	Deleted a paragraph	Deleted paragraph starting with: "The agency does not pay the same provider for psychiatric procedure…"
See PN 13-06	January 1, 2013	Prior Authorization	Deleted erroneous section and inserted correct section.	"Limitation Extension for Mental Health Services for Children" section was replaced with correct information
See PN 13-06	January 1, 2013	All	Housekeeping	The agency made housekeeping changes throughout the document

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print agency Provider Notices and Medicaid Provider Guides, go to the agency's Provider Publications website.

Table of Contents

Table of Contents 2

Resources Available 5

Client Eligibility 6

Who Is Eligible? 6

Are Clients Enrolled in an Agency Managed Care Plan Eligible? 6

Mental Health Services for Children 7

Mental Health Services for Children 7

How Are Mental Health Services for Children Administered? 7

Who May Provide Mental Health Services for Children? 8

What Is Required for Providers to Bill for Mental Health Services? 8

How Do I Enroll to Provide Mental Health Services to Children? 9

What Does the Agency Cover? 9

How Many Hours Will the Agency Pay For? 9

What do I do if the Client Has Exhausted the Maximum Benefit? 10

What Services Do the Regional Support Networks (RSN) Cover? 11

RSN Crisis Services 11

RSN Community Psychiatric Inpatient Services 11

RSN Access to Care Standards (ACS) 11

Coverage Table 13

Fee Schedule 13

Psychiatric Services by Psychiatrists and Psychiatric ARNPs 14

General Guidelines 14

Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319 15

Inpatient Hospital 15

Outpatient Hospital 15

Office 15

Other Psychiatric Services 16

Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319 16

Limitations for Inpatient Psychiatric Services 16
Limitations for Outpatient Psychiatric Services 17
Services Provided by Psychiatrists 17
For Clients 18 years of age and Younger 17
For Clients 19 years of age and Older 18
Services Provided by Psychiatric Advanced Registered Nurse Practitioners (ARNPs) 19
For Clients 18 Years of Age and Younger 19
For Clients of Any Age 20
Pharmacological Management (CPT code +90863) 21
Documentation Requirements 21
Involuntary Treatment Act (ITA) 22

Psychological Testing by Psychologists and Neuropsychologists 24
What Is Covered? 24
Psychological Evaluation 24
Psychological Evaluations for Clients Admitted on an Involuntary Admission 25
Developmental Testing 25
Coverage Table Psychological Testing 26
Neuropsychological Testing 26

Prior Authorization 31
What Is Prior Authorization? 31
Expedited Prior Authorization (EPA) 31
What Is the EPA Process? 31
How Is an EPA Number Created? 31
Expedited Prior Authorization Guidelines 32
Diagnoses 32
Documentation—What Documentation Is Required When Using Expedited Prior Authorization? 32
Which Services Require EPA? 32
Limitation Extensions 33
What Is a Limitation Extension? 33
How Do I Obtain Limitation Extension (LE) Authorization? 33
What Do I Do if a Fee-for-Service Client has Exhausted the Maximum Benefit? 33
Written/Fax Authorization 34
What Is Written/Fax Authorization? 34

How Do I Obtain Written/Fax Authorization? 34

Billing and Claim Forms 35

What Are the General Billing Requirements? 35

Completing the CMS-1500 Claim Form 35

Resources Available

Note: This section contains resources relevant to Mental Health Services for Children, Psychiatric and Psychological Services. For more resources, see the agency's *Resources Available* web page at.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency *Resources Available* web page.
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., Medicaid Provider Guides, Provider Notices, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extension, the following documentation is required: • A completed, TYPED General Information for Authorization form, 13-835. This request form MUST be the initial page when you submit your request. • A completed Fax/Written Request Basic Information form, 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214.
Where do I get agency forms?	Visit the agency's Forms webpage.
Definitions and Abbreviations	Please refer to WACs 182-531-0050 and the Medical Assistance *Glossary*.

Client Eligibility

Who Is Eligible?

Please see the agency's *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in an Agency Managed Care Plan Eligible?

[Refer to WAC 182-538-060 and 095]

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

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

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

Mental Health Services for Children

The agency covers all of the following:

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

Mental Health Services for Children

In accordance with legislation intended to improve access to mental health services for children who do not meet the Regional Support Network (RSN) Access to Care Standards (ACS), effective July 1, 2008, the agency expanded mental health services for eligible clients 18 years of age and younger.

How Are Mental Health Services for Children Administered?

Children's mental health services are available through the following:

- Regional Support Networks (RSNs) which are under contract with the Department of Social and Health Services' Division of Behavioral Health and Recovery for individuals whose condition meets the RSN Access to Care Standards.

- Managed Care Organizations (MCOs) which are under contract with the agency's Division of Health Care Services' Healthy Options program for individuals whose condition does not meet the RSN Access to Care Standards and who are enrolled in and receiving care from an MCO.

- Professionals with individual Core Provider Agreements who will accept payment on a Fee-For-Service (FFS) basis for individuals not enrolled with an MCO and whose condition does not meet the RSN access to care standards.

Who May Provide Mental Health Services for Children?

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

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

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

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

- Be licensed by DOH.

- Be in good standing without restriction.

- Have a minimum of two years experience in the diagnosis and treatment of children, youth, and their families. The experience may be a combination of pre and post licensure and may include supervised internships completed as part of a master's degree curriculum. The equivalent of one year of full-time experience must be under the supervision of a mental health professional trained in child and family mental health.

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

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

To enroll you must do all of the following:

- Obtain a National Provider Identifier (NPI) from the federal government.
- Complete a Core Provider Agreement.
- Write and sign a letter attesting to your experience in providing mental health services to children, youth, and their families as described above (the letter does not need to be notarized) If you are already an enrolled provider, you must send in this additional information to bill for these services.
- **Send all of these to Provider Enrollment. For more information,** contact Provider Enrollment (see Resources Available).

What Does the Agency Cover?

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

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

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

How Many Hours Will the Agency Pay For?

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

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

Note: For more information, including verification of the number of hours already paid by the agency for a client, providers can do either of the following:

- Review the Client Benefit Limitations section of the ProviderOne Billing and Resource Guide for step-by-step instructions for using the ProviderOne system to look up the hours paid.

- Send an email request to the agency from the agency's Contact Us! webpage with the "Selected Topic" of "Service Limits." The agency prioritizes these requests.

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

You can request a limitation extension. Please see the Prior Authorization section within this guide.

- **Fee-for-Service**

  See What Do I Do if a Fee-for-Service Client Has Exhausted the Maximum Benefit? Section within this guide.

- **Healthy Options Managed Care**

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

  ✓ The MCO ensure the provision of medically necessary healthcare services to individuals who are Medicaid and CHIP eligible, enrolled in the Healthy Options program, and assigned to the MCO.

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

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

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

RSN Crisis Services

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

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

RSN Community Psychiatric Inpatient Services

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

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

RSN Access to Care Standards (ACS)

In addition to providing crisis intervention services and community inpatient services, RSNs also manage the public mental health services that are delivered to individuals who are Medicaid or CHIP-eligible and who meet the ACS by:

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

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

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

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

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

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

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

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

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

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

Coverage Table

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

CPT® Code	Short Description	ICD-9 CM Diagnosis Code	Limitations
90791*	Psych diagnostic evaluation	Must be billed with these diagnosis codes: 290.0-319	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90832	Psytx pt&/family 30 minutes		
90834	Psytx pt&/family 45 minutes		
90837	Psytx pt&/family 60 minutes		
90847	Family psytx w/patient		
90853	Group psychotherapy		

*The agency pays for only one psychiatric diagnostic interview exam (CPT code 90791 or 90792) per client, per provider, per calendar year. This exam is included in the 20–hour per calendar year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization. A psychological evaluation (CPT code 96101) cannot be billed on the same day. When a client is seen for a psychiatric service as listed above and medication management is necessary, a psychiatric ARNP or physician can bill medication management (CPT code +90863) when provided with the appropriate CPT codes on the same day.

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

Fee Schedule

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

Psychiatric Services by Psychiatrists and Psychiatric ARNPs

[Refer to WAC 182-531-1400]

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

General Guidelines

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

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

  - ✓ Psychotherapy (CPT codes 90832-90837 and +[1]90838).
  - ✓ Family psychotherapy (CPT code 90847).
  - ✓ Group psychotherapy (CPT codes 90853).
  - ✓ Electroconvulsive therapy (CPT codes 90870).
  - ✓ Pharmacological management (CPT code +90863 – Not Covered in POS 21).

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

- The agency pays psychiatrists for the CPT codes when billed with ICD-9CM Diagnosis Codes 290.0-319.

[1] Use add-on codes with an appropriate CPT code (see CPT book for guidance). Add-on codes describe additional intra-service work associated with the primary service/procedure. Per the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA), add-on codes are always reported in addition to the primary service/procedure, and must never be reported as stand-alone codes. Add-on codes are eligible for reimbursement when reported in addition to the appropriate primary service by the same physician or other health care professional reporting the same federal Tax Identification Number.

- **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**
- Psychiatric sleep therapy is not covered.

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

Note: If billing for psychotherapy or other psychiatric services, please refer to the CPT book for appropriate coding.

Inpatient Hospital

Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Psychotherapy	90832-90837

Outpatient Hospital

Covered Procedure	CPT Codes
Emergency department visits	99281-99288
Observation	99218-99226, 99234-99239
Psychotherapy	90832-90838
Consultation	99241-99245

Office

Covered Procedure	CPT Codes
Office visits	99201-99215
Consultation	99241-99245
Psychotherapy	90832-90838

Other Psychiatric Services

Covered Procedure	CPT Codes
Case Management Service • Team Conferences • Telephone Calls	 99367 99441-99443
Domiciliary home or custodial care services	99324-99340
Home services	99341-99359
Nursing facility services	99304-99318
Other Psychiatric Services	+90863*, 90870
Other Psychotherapy	90845, 90847, 90853
Psychiatric Diagnostic Interview	90791, 90792

*** Use add-on codes with an appropriate CPT code (see CPT book for guidance).**

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

The agency does not cover Stand-by services (99360) for psychiatrists using ICD-9-CM diagnosis codes 290.0-319:

Limitations for Inpatient Psychiatric Services

- Admissions for acute, community psychiatric inpatient care require prior authorization (PA) from the designated Division of Behavioral Health and Recovery (DBHR) designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the PA from the DBHR designee. Please see the list of RSNs at the Division of Mental Health's web site: http://www.dshs.wa.gov/dbhr/rsn.shtml.

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

- Psychiatric diagnostic interview examinations (CPT codes 90791 and 90792) are limited to one in a calendar year per provider. PA is required if a second examination is needed because of a change in a client's condition or if the client has a change in legal status (i.e., voluntary to involuntary or involuntary to voluntary).

- CPT code +90863 is not covered in POS 21.

Limitations for Outpatient Psychiatric Services

Outpatient psychiatric services are not allowed for clients on the Aged, Blind, and Disabled (ABD) program, except for medication adjustment (CPT code +90863).

Services Provided by Psychiatrists

For Clients 18 years of age and Younger

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

CPT Code	Short Description	ICD-9 CM Diagnosis Code	Limitations
90791*	Psych diagnostic evaluation	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90792*	Psych diag eval w/med srvcs		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90832	Psytx pt&/family 30 minutes		
+90833**	Psytx pt&/fam w/e&m 30 min		
90834	Psytx pt&/family 45 minutes		
+90836**	Psytx pt&/fam w/e&m 45 min		
90837	Psytx pt&/family 60 minutes		
+90838**	Psytx pt&/fam w/e&m 60 min		
90845	Psychoanalysis		
90847	Family psytx w/patient		
90853	Group psychotherapy		
90865	Narcosynthesis		
90870	Electroconvulsive therapy		

***The agency pays for only one psychiatric diagnostic interview exam (90791 or 90792) per client, per provider, per calendar year. This exam is included in the 20–hour-per-calendar-year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization for the additional exam.**

**** Use add-on codes with an appropriate CPT code (see CPT book for guidance).**

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code +90863) on the same day. Psychiatrists can also bill other procedures listed under Other Psychiatric Services which are not subject to the 20-hour visit limitation.

Note: Pharmacological management is not subject to the 20-visit limitation. If billed in conjunction with psych services, the limitation applies to the psych services. To bill for pharmacological management, the provider must follow the policy outlined in this provider guide.

For Clients 19 years of age and Older

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

CPT Code	Short Description
90832	Psytx pt&/family 30 minutes
+90833*	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
+90836*	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
+90838*	Psytx pt&/fam w/e&m 60 min
90845	Psychoanalysis
90847	Family psytx w/patient
90853	Group psychotherapy

*** Use add-on codes with an appropriate CPT code (see CPT book for guidance).**

Note: Pharmacological management is not subject to the 12-visit limitation. . If billed in conjunction with psych services, the limitation applies to the psych services. To bill for pharmacological management, the provider must follow the policy outlined in this provider guide.

Services Provided by Psychiatric Advanced Registered Nurse Practitioners (ARNPs)

For Clients 18 Years of Age and Younger

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

PSYCHIATRIC ARNP CODE TABLE 1			
CPT Code	**Short Description**	**ICD-9 CM Diagnosis Code**	**Limitations**
90791*	Psych diagnostic evaluation	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90792*	Psych diag eval w/med srvcs		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90832	Psytx pt&/family 30 minutes		
+90833**	Psytx pt&/fam w/e&m 30 min		
90834	Psytx pt&/family 45 minutes		
+90836**	Psytx pt&/fam w/e&m 45 min		
90837	Psytx pt&/family 60 minutes		
+90838**	Psytx pt&/fam w/e&m 60 min		
90853	Group psychotherapy		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code +90863) on the same day. This code is not covered in POS 21.

Note: Pharmacological management is not subject to the 20-visit limitation. . If billed in conjunction with psych services, the limitation applies to the psych services. To bill for pharmacological management, the provider must follow the policy outlined in this provider guide.

***The agency pays for only one psychiatric diagnostic interview exam (90791 or 90792) per client, per provider, per calendar year. This exam is included in the 20–hour limitation unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization.**

**** Use add-on codes with an appropriate CPT code (see CPT book for guidance).**

When a psychiatric ARNP is performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate psychiatric CPT code that includes the E&M service (e.g., CPT code +90833).

For Clients of Any Age

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

PSYCHIATRIC ARNP CODE TABLE 2			
Covered Procedure	**CPT Code**	**ICD-9 CM Diagnosis Code**	**Limitations**
Office visits	99201-99215	Must be billed with these diagnosis codes: 290.0-319.	
Initial Hospital Care	99221-99223		
Subsequent Hospital Care	99231-99233		
Observation Hospital	99234-99239		
Psychiatric Diagnostic Interview	90791, 90792		
Pharmacological Management	+90863*		Not covered in POS 21.
Case Management Services • Team Conferences • Telephone Calls	99367, 99441-99443		

*** Use add-on codes with an appropriate CPT code (see CPT book for guidance).**

The agency does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. The agency pays one psychiatric diagnostic interview examination 90791 or 90792 once a calendar year. Office visits 99201 – 99215 cannot be billed for psychotherapy. CPT code +90863 must be provided in conjunction with an appropriate CPT code.

Pharmacological Management (CPT code +90863)

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with the potential for serious side effects. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a pharmacological management visit is the use of medication for relief of the client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that require discussion beyond minimal psychotherapy, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Pharmacological management (CPT code +90863):

- May be billed when prescribing the medication(s) and when reviewing the effects of the prescribed medication(s), with no more than minimal medical psychotherapy.
- Is intended for use for clients who are being managed primarily by psychotropic medications.
- Must be provided during a face-to-face visit with the client, unless it is part of a qualified telehealth visit.
- Must be provided in conjunction with an appropriate CPT code (see CPT book for guidance).
- CPT code +90863 is not covered in POS 21.

Documentation Requirements

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

Documentation of medical necessity for pharmacological management must address **all of the following** information in the client's medical record in legible format:

- Date and time.
- Diagnosis – update at least annually.
- Interim medication history.
- Current symptoms and problems, including any physical symptoms.
- Problems, reactions, and side effects, if any, to medications and/or ECT.

- Current mental status exam.
- Any medication modifications.
- The reasons for medication adjustments/changes or continuation.
- Desired therapeutic drug levels, if applicable.
- Current laboratory values, if applicable.
- Anticipated physical and behavioral outcome(s).

Involuntary Treatment Act (ITA)

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

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

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

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

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

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

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

- The agency pays for physician and/or psychiatric advanced registered nursing practitioner evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients.

- **Out-of-state hospitals** must obtain authorization from the appropriate DBHR designee for all Medicaid clients. Neither the agency nor the DBHR designee pays for inpatient services for non-Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the *Aged, Blind, & Disabled (ABD)* program. For these clients, the agency and the DBHR designee pay for inpatient psychiatric services provided in bordering cities and critical access border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

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

Psychological Testing by Psychologists and Neuropsychologists

What Is Covered?

The agency pays licensed psychologists for all of the following:

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

The agency will ***not*** reimburse for either of the following:

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

Psychological Evaluation

[Refer to WAC 388-865-0610]

- A psychological evaluation must include a complete diagnostic history, examination, and assessment. The testing of cognitive processes, visual motor responses, and abstract abilities is accomplished by the combination of several types of testing procedures.
- To receive reimbursement for the evaluation, the psychologist must keep a report in the client's file that contains all of the components of a psychological evaluation including test results and interpretation of results.
- Use CPT code 96101 when billing for psychological evaluations.

- Up to two (2) units of CPT code 96101 are allowed **without prior authorization** (PA) per client, per lifetime for clients 21 years of age and older.

- Up to seven (7) units of CPT code 96101 are allowed **with PA** per client, per lifetime for clients 20 years of age and younger.

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

Psychological Evaluations for Clients Admitted on an Involuntary Admission

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

When billing for ITA, do both of the following:

- Type SCI=I in field 19 on the CMS-1500 claim form or enter SCI=I in the claim note field of the 837P professional E-claim.

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

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

Developmental Testing

The agency reimburses for developmental testing (CPT codes 96110 and 96111) only when both of the following is true:

- The provider is a psychologist or neuropsychologist.

- The provider has obtained written/fax prior authorization from the agency.

Coverage Table Psychological Testing

CPT Code	Modifier	Short Description	EPA/PA	Policy/ Comments
Note: Due to its licensing agreement with the American Medical Association (AMA), the agency publishes only the official, brief CPT code descriptions. To view the entire descriptions, please refer to your current CPT book				
96101		Psycho testing by psych/phys	PA	Limit 2 units per lifetime for clients 21 years of age and older.
96101	UC	Psycho testing by psych/phys	EPA #: 870001315	Limit 7 units per lifetime for clients 20 years of age and younger with additional requirements (see EPA section).
96102		Psycho testing by technician		Not covered
96103		Psycho testing admin by comp		Not covered
96105		Assessment of aphasia		Not covered
96110		Developmental test, lim	PA	
96111		Developmental test, extend	PA	
96116		Neurobehavioral status exam	PA	
96118		Neuropsych tst by psych/phys	EPA #: 870001207	
96119		Neuropsych testing by tech	EPA #: 870001207	
96120		Neuropsych tst admin w/comp		Not covered

Neuropsychological Testing

The agency reimburses for neuropsychological testing (CPT codes 96118 and 96119) only when all of the following are true:

- The provider is a neuropsychologist.
- The provider has obtained written/faxed prior authorization from the agency.
- The client meets the EPA criteria below.

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

- The specific clinical issues and the IEP has not been or not sufficiently addressed.
- The aspects of the child's rehabilitation that are not improving.
- Specific additional benefits that psychological testing will provide the client, describing what the IEP is already addressing, and how the proposed testing will improve the treatment plan.
- Other psychological testing that has been done.
- Relevant consultations from physiatrists, neurologists, developmental pediatricians, etc.

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

- The client's current diagnoses.
- If available, a copy of the reports produced by the testing for the agency to review.
- Psychological testing that has been done in the past:
  - ✓ Documentation of the provider's review of reports produced by the testing.
  - ✓ Documentation of the provider's review of the results of the previous testing(s).
- An explanation detailing the essential medical knowledge that is expected to be gained from psychological testing.
- Specific details that the results of psychological testing will make in the day-to-day care of this client.

Note: The agency no longer requires providers who bill for neuropsychological testing to be board-certified; however, upon request providers must be able to furnish credentials that demonstrate their expertise.

<table>
<tr><th colspan="2">Neuropsychological Testing</th></tr>
<tr><td colspan="2">Note: If the client does not meet the EPA criteria listed in this section, the agency requires PA for the testing. In addition, the agency requires providers to request PA for testing that exceeds 15 hours per calendar year.</td></tr>
<tr><td>Services(s)</td><td>Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.</td></tr>
<tr><td>Providers</td><td>The agency pays only “qualified” providers for administering neuropsychological testing to eligible agency clients. To be “qualified,” providers must be both of the following:

• Currently licensed in Washington State to practice psychology and/or clinical neuropsychology.

• Either:

✓ Board certified in clinical neuropsychology by the American Board of Clinical Neuropsychology.

✓ Have adequate education, training, and experience as defined by having completed all of the following:

➢ A doctoral degree in psychology from an accredited university training program.
➢ An internship, or its equivalent, in a clinically relevant area of professional psychology.
➢ The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences. These two years must include supervision by a clinical neuropsychologist.</td></tr>
<tr><td>Billing Codes</td><td>96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.</td></tr>
<tr><td>Billing and Payment Limits</td><td>A qualified provider may bill 96118 alone if he or she administers the test. If a technician administers the test, 96119 must be billed with 96118 to account for the professional interpretation and report of test results.

Up to a maximum of 15 hours per calendar year for a combination of CPT 96118 and 96119 are allowed for patients who meet the criteria specified here.

Note: If the client does not meet the criteria in this section or requires more than 15 hours of testing, the provider must request PA.</td></tr>
</table>

Neuropsychological Testing	
Criteria	The following are four groups of criteria that apply in different circumstances. To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met. For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met. **Group 1** All of the following must be met: • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy. • The patient is age 16 or older. • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder. • The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living). • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation. **Group 2** The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following: • Client or family complaints. • A head CT (computed tomography scan). • A mental status examination or other medical examination. This suspected diagnosis is not confirmed or able to be differentiated from the following: • Normal aging. • Mild concussion. • Depression. • Focal neurological impairments.

Neuropsychological Testing	
	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 general surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post transplant protocol to prevent organ rejection).

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

Prior Authorization

What Is Prior Authorization?

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

Expedited Prior Authorization (EPA)

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

What Is the EPA Process?

The agency or the agency's designee's EPA process is designed to eliminate the need for written/fax authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling provider to create an "EPA" number when appropriate.

How Is an EPA Number Created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the criteria set that indicates what procedure you are billing for and what information qualifies for use of the EPA criteria. Enter the EPA number on the billing form in the authorization number field when billing a paper claim form or when billing electronically. With HIPAA 5010 implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in *field 19* of the paper claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

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

If you are billing multiple authorization (prior/expedited) numbers on an electronic batch claim (837P) or DDE professional claim, HIPAA 5010 only allows on authorization (prior/expedited) at the claim level. For correct process of the claim, enter the authorization (prior/expedited) for the service to the appropriate service **line** of the claim.

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

Expedited Prior Authorization Guidelines

Diagnoses

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

Documentation—What Documentation Is Required When Using Expedited Prior Authorization?

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

Which Services Require EPA?

Services requiring EPA are noted in this Guide as follows:

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
870001207	Neuropsychological Testing	**CPT:** 96118 and 96119	Refer to Neurological Testing
870001315	Psychological Testing	**CPT:** 96101 UC	Up to 7 hours for clients 20 years of age and younger for whom psychological testing is required to determine a definitive diagnosis for autism spectrum disorder and service is provided at a Center of Excellence. Providers must bill with a UC modifier.

Limitation Extensions

What Is a Limitation Extension?

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

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

How Do I Obtain Limitation Extension (LE) Authorization?

Obtain an LE by using the Written/Fax Authorization process on the following pages.

What Do I Do if a Fee-for-Service Client has Exhausted the Maximum Benefit?

If a fee-for-service client needs additional visits after they have used their 20-hour-per-calendar-year benefit, the provider must determine if the client meets the regional support network (RSN) Access to Care Standards (ACS) by either:

- Referring the client to the RSN; or
- Reviewing the ACS and evaluating the client against those standards.

If the client meets the ACS, the provider must transition the client to an RSN-contracted community mental health provider for continued treatment. If needed, the provider may request up to three transition visits.

If the RSN determines the client does not meet the ACS, the provider may use the limitation extension process to request additional visits from the agency.

Limitation extensions must be requested according to the requirements found in WAC 182-501-0169 including:

- Justification of medical necessity;
- Description of services provided, and outcomes obtained in treatment to date;
- Expected outcome of extended services
- A copy of the RSN assessment, or documentation of provider review indicating the client would not likely meet the ACS.

Note: For the agency to authorize payment for an LE, a completed Fax/Written Request Basic Information form, DSHS 13-756 must be submitted to the agency (see Resources Available section).

Written/Fax Authorization

What Is Written/Fax Authorization?

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

How Do I Obtain Written/Fax Authorization?

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

Note: Please see the agency's *ProviderOne Billing and Resource Guide* for more information on requesting authorization.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the agency *ProviderOne Billing and Resource Guide*. These billing requirements include, but are not limited to, all of the following:

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

Completing the CMS-1500 Claim Form

Note: Refer to the agency *ProviderOne Billing and Resource Guide* for general instructions on completing the CMS-1500 Claim Form.