Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medicaid Purchasing Administration (MPA)

Psychologist
Billing Instructions

About This Publication

This publication supersedes all previous Department/MPA *Psychologist Billing Instructions* published by the Medicaid Purchasing Administration, Washington State Department of Social and Health Services.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

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How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to the Psychologist program. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department 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 ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Request Form, DSHS 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Where do I get Department forms?	To **view and download** Department forms, visit the Department Forms and Records Management Service on the web: http://www1.dshs.wa.gov/msa/forms/eforms.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Alcohol & Drug Addiction Treatment & Support Act (ADATSA) - A state-funded program that provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Department - The state Department of Social and Health Services [the Department].

Maximum Allowable - The maximum dollar amount the Department will reimburse a provider for a specific service, supply, or piece of equipment.

Medical Identification card(s) – See *Services Card*.

Medically Necessary –
See WAC 388-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA. **For example:** 123456789WA.

Psychologist – This is defined as a person with a doctoral degree in clinical psychology from an accredited college or university, or who has been licensed as a psychologist as defined in RCW 18.83. [See also WAC 388-875-0020]

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Usual & Customary Fee – The fee that the provider typically charges the general public for the product or service.

Client Eligibility

Who Is Eligible?

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Department 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 medical 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:

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

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

What Is Covered?

The Department pays licensed psychologists for:

- Psychological evaluations;
- Developmental testing;
- Neuropsychological testing; and
- Mental Health Services for Children.

The Department will ***not*** reimburse for:

- Psychotherapy provided by a psychologist unless they are approved to provide mental health services for children; or

- Continuing care provided by psychologist or by staff employed by the psychologist for clients age 19 of age and older or for psychologists that 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.

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

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Psychological Evaluations for Clients Admitted on an Involuntary Admission

The Department 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:

- Write ITA in field 19 on the CMS-1500 claim form; and
- Include a copy of Form 13-821, Initial Certification Authorization for Admission to Inpatient Psychiatric Care.

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

Developmental Testing

The Department reimburses for developmental testing (CPT codes 96110 and 96111) only when:

- The provider is a psychologist or neuropsychologist; **and**
- The provider has obtained written/fax prior authorization from the Department.

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Neuropsychological Testing

The Department reimburses for neuropsychological testing (CPT codes 96118 and 96119) only when:

- The provider is a neuropsychologist; **and**
- The provider has obtained written/fax prior authorization from the Department or the client meets the EPA criteria below.

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

Note: If the client does not meet the EPA criteria listed in this section, the Department requires PA for the testing. In addition, the Department requires providers to request PA for testing that exceeds 15 hours per calendar year.	
Services(s)	Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.
Providers	The Department pays only "qualified" providers for administering neuropsychological testing to eligible Department clients. To be "qualified," providers must be: • Currently licensed in Washington state to practice psychology and/or clinical neuropsychology; and • Either: ✓ Board certified in clinical neuropsychology by the American Board of Clinical Neuropsychology; or ✓ 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; and ➢ 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.

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Neuropsychological Testing (cont.)

Billing Codes	96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.
Billing and Payment Limits	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.
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** • 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, dementia, neoplasm, or chemotherapy; • The patient is of working or school age (age 16 and 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); **AND** • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation.

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Neuropsychological Testing (cont.)

Criteria (cont.)	**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); or • 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; or • 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: • Guide the surgeon in the goal of sparing healthy brain tissue or sites that are critical to some major function such as language; or • 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).

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Mental Health Services for Children

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 Department fee-for-service for mental health services to children:

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

Note: Mental health professionals must meet the provider requirements listed in this section to be eligible to provide expanded services.

What are the requirements that providers must meet as mental health professionals?

To provide the services listed in Section E "Coverage," mental health professionals must:

- Be licensed by DOH and be in good standing without restriction.

- Have a minimum of two years experience in the diagnosis and treatment of children and youth, and their families; at least one of which is 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 Department without meeting this minimum experience requirement.

How do I enroll to provide mental health services to children?

To enroll you must:

- Obtain a National Provider Identifier (NPI) from the federal government;

- Complete a Core Provider Agreement (if you are already an enrolled provider you must send in this additional information to bill for these services);

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- 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); and

- **Send all of these to the Department Provider Enrollment (see the *Important Contacts* section). For more information,** contact Provider Enrollment (see the *Important Contacts* section).

What do I do if the client has exhausted the maximum benefit?

The Department will pay providers one psychiatric service 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 in these billing instructions. This may include some hours delivered by one provider and other hours delivered by another provider.

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

Fee-For-Service

For any additional fee-for service outpatient mental health services needed for clients who have exhausted their 20-hour-per-calendar-year benefit, the provider must request and obtain a limitation extension from the Department following the requirements found in WAC 388-501-0169 including:

- Justification of medical necessity;
- Description of services provided and outcomes obtained in treatment to date;
- Expected outcome of extended services.

For the Department to authorize payment, complete the DSHS Basic Information Form, DSHS 13-756, including the information above and must be faxed to the Department (see the *Important Contacts* section).

> **Note:** For more information, including verification of the number of hours already paid by the Department for a client, contact Provider Relations (see the *Important Contacts* section).

Healthy Options Managed Care

For any 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 MCO following the MCO identified requirements and process.

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What services are covered through the Healthy Options Managed Care Organizations?

The managed care organizations (MCOs) ensure the provision of medically necessary healthcare services to individuals who are Medicaid and SCHIP 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 Department on line at:
http://hrsa.dshs.wa.gov/HealthyOptions/

What services do the Regional Support Networks 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 Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/crisis.shtml

RSN Community Psychiatric Inpatient Services

RSNs authorize and pay for all medically necessary community psychiatric inpatient services (WAC 388-550-2600). To refer a client for community psychiatric inpatient services, contact your local RSN.

To find the appropriate RSN and contact information, visit the Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/rsnmap.shtml

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RSN Access to Care Standards

In addition to providing crisis intervention services and community inpatient services, the RSNs also manage the public mental health services that are delivered by the Division of Behavioral Health and Recovery (DBHR) licensed and RSN contracted community mental health agencies to individuals who are Medicaid or SCHIP eligible who also meet the Access to Care Standards (ACS). As resources allow, some medically necessary services may be provided to indigent clients who meet the ACS, however this is determined at the local level. The ACS are established by the department and are approved by the Centers for Medicare and Medicaid Services (CMS).

> **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 deemed 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 Department on-line at:
http://www1.dshs.wa.gov/Mentalhealth/publications.shtml

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Coverage Table and Fee Schedule

CPT Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Note: Due to its licensing agreement with the American Medical Association (AMA), the Department publishes only the official, brief CPT® procedure code descriptions. To view the entire descriptions, please refer to your current CPT book				
96101		Psycho testing by psych/phys		Limit 2 units per lifetime.
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

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Psychologists who are approved to provide mental health services for children may bill one psychiatric 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 Procedure Code	ICD-9 CM Diagnosis Code	Limitations
90801*	Must be billed with these diagnosis codes: 290.0-319	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90806		
90808		
90810		
90812		
90814		
90847		
90853		
90857		

*The Department pays for only one psychiatric diagnostic interview exam (90801 or 90802) 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 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 procedure code 90862 on the same day.

Note: Please note that this benefit is for children who do not meet the RSN's access to care standards. 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 Department/MPA **Psychologist Fee Schedule** on-line at:
http://hrsa.dshs.wa.gov/RBRVS/Index.html.

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Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department 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; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.