

Washington State Health Care Authority

Medicaid Provider Guide

Psychologist



Washington State
Health Care Authority

A Billing Instruction

About This Publication

This publication, by Health Care Authority (the Agency), supersedes all previous Agency *Psychologist Billing Instructions* published by the Department of Social and Health Services.

Note: The Agency 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

The effective date of this publication is: **07/01/2011**.

Revision History

This publication has been revised by:

Effective Date/ Reason for Change	Section/ Page No.	Subject	Change
July 1, 2011 July Rate and legislative changes	B.2	Psychological Testing	Information to be included in a prior authorization (PA) request for psychological testing for children.
	B.4	Prior Authorization	Information to be included in a PA request for psychological testing for adults and children who are not in school.
	B.9	Experience and Licensure Requirements	Experience and licensure requirements for mental health professionals to provide services to Agency clients.
	B.10	Requesting additional visits	How to request additional visits after a client has used the maximum 20-hour-per-calendar-year benefit.

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How Can I Get Agency Provider Documents?

To download and print Agency provider numbered memos and billing instructions, go to the Agency 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 *Agency 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	<p>See the <i>Agency Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
How do I obtain prior authorization or a limitation extension?	<p>For all requests for prior authorization or limitation extension, the following documentation is “required:”</p> <ul style="list-style-type: none"> • A completed, TYPED General Information for Authorization, 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Request form, 13-756, and all the documentation listed on this form and any other medical justification. <p>Fax your request to: 1-866-668-1214.</p> <p>See the <i>Agency Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>
Where do I get Agency forms?	<p>To view and download Agency forms, visit the Agency Forms and Records Management Service on the web: http://www.dshs.wa.gov/msa/forms/eforms.html</p>

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions.

Please refer to the Agency Glossary at:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/Glossary.pdf 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.

Agency - The Health Care Authority (the Agency).

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]

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 Agency *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 Agency Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a 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 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 Agency *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 Agency pays licensed psychologists for:

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

The Agency 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.

*Prior authorization requests for psychological testing **for children** must include the following information:*

A detailed review of the individualized education plan (IEP) outlining:

- The clinical issues or questions that have not been sufficiently addressed by the IEP, and what specifically is lacking;
- The aspects of the child's rehabilitation that are not improving or being addressed by the IEP;
- How testing will impact the treatment plan;
- Specific additional benefits that psychological testing will provide the client, considering what the IEP is already addressing;
- Other psych testing that has been done; and

Relevant consultations, from psychiatrists, neurologists, developmental pediatricians, etc.

*Prior Authorization requests for psychological testing **for adults and children who are not in school**, must include the following information:*

- The client's current diagnoses;
- Psychological testing that has been done in the past:
 - ✓ The documentation of the providers review of the reports produced by the testing;
 - ✓ Documentation of the providers review of the results of the previous testing(s);
 - ✓ If available, the report to review.
- Justification 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
- 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:

- 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 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:

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

Neuropsychological Testing

The Agency 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 Agency or the client meets the EPA criteria below.

Prior authorization requests for neuropsychological testing **for children**, the following information is required with your request:

A detailed review of the individualized education plan (IEP) outlining:

- The clinical issues or questions that have not been sufficiently addressed by the IEP, and what specifically is lacking;
- The aspects of the child's rehabilitation that are not improving or being addressed by the IEP;
- How testing will impact the treatment plan;
- Specific additional benefits that psychological testing will provide the client, considering what the IEP is already addressing;
- Other psych testing that has been done; and
- Relevant consultations, from psychiatrists, neurologists, developmental pediatricians, etc.

Prior authorization requests for neuropsychological testing **for adults and children who are not in school**, the following information is required with your request:

- The client's current diagnoses;
- 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);
 - ✓ If available, the report to review.

Psychologist

- 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, providers must be able to furnish credentials that demonstrate their expertise upon request.

<p>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.</p>	
Services(s)	Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.
Providers	<p>The Agency pays only “qualified” providers for administering neuropsychological testing to eligible Agency clients. To be “qualified,” providers must be:</p> <ul style="list-style-type: none"> • Currently licensed in Washington state to practice psychology and/or clinical neuropsychology; and • Either: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> ➤ 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.

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	<p>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.</p> <p>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.</p> <p>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.</p>
Criteria	<p>The following are four groups of criteria that apply in different circumstances.</p> <p>To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met.</p> <p>For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.</p> <p>Group 1</p> <ul style="list-style-type: none"> • 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.

Neuropsychological Testing (cont.)

Criteria (cont.)	<p>Group 2</p> <p>The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following:</p> <ul style="list-style-type: none"> • Client or family complaints; • A head CT (computed tomography scan); or • A mental status examination or other medical examination. <p>This suspected diagnosis is not confirmed or able to be differentiated from the following:</p> <ul style="list-style-type: none"> • Normal aging; • Mild concussion; • Depression; or • Focal neurological impairments. <p>A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.</p> <p>Group 3</p> <p>The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help:</p> <ul style="list-style-type: none"> • 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) <p>Group 4</p> <p>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).</p>
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Note: If the client does not meet the criteria in this section, the provider must request PA (see the *Important Contacts* section).

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 Agency 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 be eligible to provide and bill the Agency fee-for-service for mental health services, mental health professionals must:

- Be licensed by DOH;
- Be in good standing without restriction; and
- Have a minimum of two years experience in the diagnosis and treatment of children, youth, and their families (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:

- 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);
- 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 Agency 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?

What Do I Do if the Client has Exhausted the Maximum Benefit?

- **Fee-For-Service**

If 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 by either:

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

If the client meets Access to Care Standards, the provider must transition the client to a 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 Access to Care Standards, then the provider may request additional visits from the Agency.

For additional visits the provider must request and obtain a limitation extension from the Agency, in accordance with 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 Access to Care Standards.

Note: For the Agency to authorize payment, a completed Fax/Written Request Basic Information form, 13-756 must be submitted to the Agency (see *Important Contacts* section).

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

Note: For more information, including verification of the number of hours already paid by the Agency 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.

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 Agency 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 Agency on-line at:

<http://www.dshs.wa.gov/dbhr/mhcrisis.shtml>

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 Standard

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 Agency 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.

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To learn more about the ACS, visit the Agency on-line at:
<http://www.dshs.wa.gov/dbhr/mhpublications.shtml>

Coverage Table and Fee Schedule

CPT Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
<p>Note: Due to its licensing agreement with the American Medical Association (AMA), the Agency publishes only the official, brief CPT® procedure code descriptions. To view the entire descriptions, please refer to your current CPT book</p>				
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

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 of age 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 Agency 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 Agency **Psychologist Fee Schedule** on-line at:
<http://hrsa.dshs.wa.gov/RBRVS/Index.html>.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency *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 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; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Agency *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.