Department of Social and Health Services

Olympia, Washington

Social Services Manual

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Category	Medical Evidence Reimbursements
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Summary

The main purpose of this revision is to notify field staff about the transition of billing claims from authorization through the Social Services Payment System (SSPS) to submittals to the ProviderOne system. This transition is scheduled to take effect on November 1, 2015.

Other changes to the Medical Evidence Reimbursements chapter are for clarity or to update the information and policies about which evaluation and diagnostic services are eligible for reimbursement.

The following dependent ("daughter") pages were created to give contractors or providers further detailed information, such as limits or fee schedules, about specific medical evidence services:

- Medical Evaluations and Diagnostic Procedures
- Mental Incapacity Evaluation Services
- Medical Records
- Medical Evidence to Support SSI Applications

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Medical Evidence Reimbursements

Purpose:

This section details ABD program medical evidence requirements and reimbursement rates. See WFHB 3.7.1.6 for information regarding reimbursement for medical evidence associated with for TANF / SFA ineligible parent time limit extensions.

Clarifying Information

NOTE: Effective 11/01/2015 all Providers will need to be enrolled with ProviderOne to claim and receive payment for Incapacity Evaluation services. Refer all medical providers to the ProviderOne billing system for claims with dates of service **after** 11/01/2015.

Please use the Social Service Payment System (SSPS) to reimburse for medical evidence with dates of service **before** 11/01/2015.

We will continue to use SSPS to reimburse for Medical Records (copies) and SSI Medical Evidence Transportation costs.

Medical evidence reimbursements described in this chapter are solely to pay the fees necessary to obtain objective medical evidence of an impairment that limits work activity. We do not pay for medical evidence to rule out medical conditions that do not impair work function.

If a person meets all of the non-disability eligibility requirements listed in WAC 388-400-0060, we reimburse for the costs of obtaining the objective evidence necessary to determine disability based on our published payment limits and fee schedules.

1. Clients must appear to be financially eligible for ABD cash before we authorize an evaluation or payment.
2. Payments do not apply to services authorized by DDDS (Division of Disability Determination Services) or medical examinations or reports required by court order or treatment placement.
3. Payments for medical evidence related to TANF cases are authorized in eJAS as support services (WFHandbook 2.2).
4. Request medical records if available before authorizing new evaluations or services.

How to Decide What Medical Evidence Is Needed

~~1.~~1) **Initial decision:** Current medical evidence for an initial decision must be based on an examination or findings from within 90 days of the date of application. Only request new medical evidence when available evidence is either older than 90 days or insufficient to determine of disability.

~~1.~~a) Document your reason for obtaining new medical evidence.

~~2.~~b) Medical evidence greater than 90 days old is acceptable when it is:

- ~~1.~~● A report that includes a diagnosis of a potentially disabling condition based on an examination by an acceptable medical source, defined in WAC 388-449-0010, within the last 5 years.
- ~~2.~~● Intelligence testing scores from a Wechsler Adult Intelligence Scale (WAIS - III or IV editions) administered after age 18;

3. A diagnostic imaging report such as an X-ray or MRI when referenced in an examination performed within 90 days of application.

2) **Review decision:** Current medical evidence for review decisions must be based on an examination or findings from within the past **45 days**.

a) If the client has seen his or her medical provider within the past 45 days, do not authorize a new evaluation. Generate a Physical Impairment referral type and request a ~~Obtain a~~ "report from records[PE(1]" from the provider. ~~and authorize payment using the "report from records" service.~~

b) Clearly document the reason for obtaining any new testing or evaluations at review.

Medical Evaluations / Procedures

1) **General physical evaluation:** A general physical evaluation should contain all of the following information:

a) Chief complaint or reason for the visit.

b) Medical history including onset date and treatment history.

c) Physical examination findings including vital signs, observations, a description of any abnormal findings, and range of motion (if appropriate).

d) Results of diagnostic testing and imaging (e.g. labs, X-rays, pulmonary function tests, etc.).

e) Diagnosis and International Classification of Diseases (ICD) code for any impairment that affects work activity and is supported by objective findings.

f) History of drug or alcohol use or abuse.

g) Description of how the medical condition affects the person's overall ability to perform basic work-related activities.

h) Prognosis including an estimate of how long the functional impairment will persist at the current, or a higher, level of severity.

i) Recommendations for additional testing or consultation.

j) Treatment recommendations.

k) Name, title and signature of the person performing the service.

l) Date of service.

m) Copies of all available chart notes, hospital discharge summaries, diagnostic reports, and other medical records from the past six months.

2) **Comprehensive physical evaluation (e.g. orthopedic, neurological):** A comprehensive physical evaluation contains all of the information listed under the general physical evaluation section above, in addition to:

a) Progression of symptoms such as motor loss, sensory loss or mental restrictions;

b) Description of any restrictions on personal care or daily activities caused by the condition; and

c) Copies of clinic records.

3) **Psychological and psychiatric evaluation:**

a) The **Psychological evaluation** is a diagnostic interview, including an MSE (mental status exam) and an assessment of daily living skills conducted by a licensed psychologist.

b) The **Psychiatric evaluation** is a diagnostic interview, including an MSE (mental status exam) and an assessment of daily living skills conducted by a licensed psychiatrist.

c) Both evaluation types result in a written report that must include:

1. Chief complaint;
2. Diagnosis;
3. History of past and present illness;
4. Prognosis;
5. Mental Status Exam
6. Capacity to manage funds
7. Functional Information; and
8. Medical source statement, indicating what the client can do despite the impairment.

~~4.~~4) **Psychological diagnostic testing is only reimbursed when necessary to establish a diagnosis or the severity of a mental health impairment and is limited to the following:**

~~1.~~a) Evaluation of potential personality disorders and general mental disorders:

- ~~i)~~• MMPI-II: Minnesota Multiphasic Personality Inventory
- ~~ii)~~• PAI-II: Personality Assessment Inventory.

b) Evaluation of depression:

- ~~i)~~• BDI-II: Beck Depression Inventory.
- ~~ii)~~• HAM-D: Hamilton Rating Scale for Depression.

c) Evaluation of anxiety:

- ~~i)~~• BAI: Beck Anxiety Inventory.
- ~~ii)~~• HAM-A: Hamilton Rating Scale for Anxiety.

d) Evaluation of a potential cognitive disorder:

- ~~i)~~• WAIS-III or WAIS IV: Wechsler Adult Intelligence Scale (IQ).
- • WMS-III: Wechsler Memory Scale.
- ~~ii)~~• TONI-4: Test of Nonverbal Intelligence, Fourth Edition
- ~~iii)~~• Trails: Trail Making Test Parts A and B.

e) Evaluation of potential memory malingering:

- ~~i)~~• REY 15-Item Memory Test.
- • TOMM: Test of Memory Malingering.

f) Evaluation of potential psychiatric illness malingering:

- • M-Fast: Miller Forensic Assessment of Symptoms Test.
- • SIRS: Structured Interview of Reported Symptoms.

~~ii)~~

~~iii) M-FAST: Miller Forensic Assessment of Symptoms Test.~~M-FAST: Miller Forensic Assessment of Symptoms Test.

~~iv)~~

Subtest scores, statistical scores, and a narrative summary of all tests must be included. The narrative summary of the test results may eliminate the need for ~~an~~ an additional examination and testing when the person applies for SSI.

NOTE: The examining psychologist determines which tests are clinically appropriate and must clearly document why each test is performed.

Mental Health Professional (MHP):

1. MHP reports may only be used as medical evidence for the purposes of determining incapacity for the HEN Referral program.
2. MHP reports may be used as *other evidence* to help determine severity and functional capacity for the purposes of an ABD disability determination, only after a diagnosis has been established by an *acceptable medical source* and we have obtained a current assessment of functioning from a doctor or other *treating medical source* listed in WAC 388-449-0010.
3. No reimbursement, other than copy fees, shall be authorized for MHP reports.

Medical Evidence to Support SSI Applications:

Special report for SSI Hearing Purposes:

This is medical evidence given by a medical provider to be used at an administrative hearing when a client is involved in the Social Security disability determination appeal process. These reports are a supplement to medical evidence already obtained by the Department and the consulting exams obtained by DDDS. This

service must be pre-approved by the SSI Facilitator and authorized by CSD program[PE(2)] staff. Use this service description when requesting an expenditure approval, to~~to~~ pay for the provider's time when either:

1. The medical provider provides verbal information to the attorney, followed by a written report; or
2. The medical provider appears at an administrative hearing to offer testimony in person.

Medical providers must be enrolled in ProviderOne to claim reimbursement for these services. The ~~medical~~ provider must send you a detailed billing including~~listing~~ the service description ~~provided~~ and the amount of time spent providing the service. See Medical Evidence Fee Schedule for payment details.

Medical evidence at the SSI Initial, Reconsideration, or Hearing Level:

When an additional evaluation or testing is necessary to support an SSI application at any level of the application process, and **DDDS will not pay per their policy**, use the following procedures:

1. If there is a **new** potentially disabling condition, conduct an early ABD Disability Review. Generate a referral in ICMS using the appropriate 14-150 to ~~and~~ authorize payment according to the medical evidence fee schedule. ~~using SSPS code 6220.~~
2. If this **isn't a new** condition, or if payment for medical evidence is outside of the medical evidence fee schedule, submit a request for expenditure approval:
    1. Complete the DSHS 17-118. Request for Expenditure Approval.
    2. List the medical evidence being requested and the credentials of provider (e.g. physician, psychologist, psychiatrist, neurologist, etc.).
    3. Explain why the evaluation or testing is necessary.
    4. If a SSI application was denied, list the reason for the denial.
    5. Explain why DDDS will not pay for the evaluation or testing.

The 17-118 is then sent to Jennifer Peterson[PE(3)]. If approved, headquarters staff(?) [PE(4)]will ~~payment is~~ authorize the provider to~~d~~ submit a claim using the ProviderOne billing system.~~SSPS code 96220.~~ If you obtain approval from the CSD Headquarters to exceed the allowable maximum, you must clearly document the approval in the case record.

EXAMPLE An ABD cash recipient with a mental illness has missed multiple DDDS consultative exams despite coordination with DDDS to arrange transportation. DDDS has refused to schedule another consultative examination. Submit an expenditure request for an evaluation that meets DDDS consultative examination criteria.

SSPS ~~Codes~~

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~~We use the Social Service Payment System (SSPS) to reimburse for medical evidence unless stated otherwise in this chapter.~~ Most services are paid using SSPS Service Code 6220. Refer to SSPS Manual Appendix H for details regarding available Service Codes and how to use them.

Pay either the provider's usual and customary fee or the maximum payment, whichever is less. Refer to the Medical Evidence Fee Schedule for maximum payment amounts.

~~If you obtain approval from the CSD Headquarters to exceed the allowable maximum, you must clearly document the approval in the case record and enter a 9 in front of the SSPS service code when authorizing payment.~~

SSPS Code	Use For
6220	Client is approved ABD ~~Client is approved for Incapacity (HEN Referral)~~
6220	Client is approved for Incapacity (HEN Referral) ~~Client is not Disabled or Incapacitated (denied)~~
6220	Client is not Disabled or Incapacitated (denied) ~~Client is approved ABD~~

NOTE: Please remember to use SSPS to reimburse the cost of Medical Records (copies) according to the posted fee schedule. Medical Records (copies) claims will not be reimbursed using the ProviderOne billing system.

Medical Evidence Fee Schedules

Medical Evaluations/Procedures

Mental Incapacity Evaluation services

Medical Records

Medical Evidence to Support SSI Applications [PE(5)]