Revision # 108

CATEGORY: MEDICAL EVIDENCE REIMBURSEMENTS

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Summary: Updated fee schedule and psychological testing options to reflect current policy.

MEDICAL EVIDENCE REIMBURSEMENTS

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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.

WAC 388-449-0015 What medical evidence do I need to provide?

For information regarding the Medical Care Services (MCS) program rules relating to required medical evidence, see WAC 182-508-0030 and attached clarifying information.

- How To Decide What Medical Evidence is Needed
- Medical Evaluations / Procedures
- Payment for Medical Evidence
- SSPS Codes
- Medical Evidence Fee Schedule

WAC 388-449-0015 What medical evidence do I need to provide?

You must give us medical evidence of your impairment(s) and how they affect your ability to perform regular and continuous work activity. Medical evidence must be in writing and be clear, objective and complete.

1. Objective evidence for physical impairments means:
    a. Laboratory test results;
    b. Pathology reports;
    c. Radiology findings including results of X rays and computer imaging scans;
    d. Clinical finding, including but not limited to ranges of joint motion, blood pressure, temperature or pulse; and documentation of a physical examination; and
    e. Hospital history and physical reports and admission and discharge summaries; or
    f. Other medical history and physical reports related to your current impairments.
2. Objective evidence for mental impairments means:
    a. Clinical interview observations, including objective mental status exam results and interpretation.
    b. Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
    c. Hospital, outpatient and other treatment records related to your current impairments.
    d. Testing results, if any, including:
        i. Description and interpretation of tests of memory, concentration, cognition or intelligence; or
        ii. Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.
3. Medical evidence sufficient for a disability determination must be from a medical professional described in WAC 388-449-0010 and must include:
    a. A diagnosis for the impairment, or impairments, based on an examination performed by an acceptable medical source defined in WAC 388-449-0010 within five years of application;
    b. A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-449-0005;
    c. Documentation of how long a condition has impaired your ability to perform work related activities;
    d. A prognosis, or written statement of how long an impairment will impair you ability to perform work related activities; and
    e. A written statement from a medical professional (defined in WAC 388-449-0010) describing what you are capable of doing despite your impairment (medical source statement) based on an examination performed within ninety days of the date of application or the forty-five days before the month of disability review.
4. We consider documentation in addition to objective evidence to support the acceptable medical source or treating provider's opinion that you are unable to perform substantial gainful employment, such as proof of hospitalization.
5. When making a disability decision, we don't use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.
6. We don't use symptoms related to substance abuse or a diagnosis of addiction or chemical

dependency when determining disability if we have evidence substance use is material to your impairment(s).

7. We consider substance use to be material to your impairment(s) if you are disabled primarly because of drug or alcohol abuse or addition.
8. If you impairment will persist at least sixty days after you stop using drugs or alcohol, we do not consider substance use to be material to your impairment.
9. If you can't obtain medical evidence sufficient for us to determine if you are likely to be disabled without cost to you, and you meet meet the other eligibility conditions in WAC 388-400-0060, we pay the costs to obtain objective evidence based on published payment limits and fee schedules.
10. We determine the likelihood of disability based solely on the objective information we receive. We are not obligated to accept another agency's or person's decision that you are disabled or unemployable.

CLARIFYING INFORMATION

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 determined 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 to 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.

4. Request medical records if available before authorizing new evaluations or services.

5. Use DSHS 14-150, Medical Evidence Request (Physical) and DSHS 14-150A, Medical Evidence

~~Request (Psychological) to communicate to the provider regarding our need for objective medical evidence and to explain we reimburse for services necessary to evaluate incapacitating conditions.~~

HOW TO DECIDE WHAT MEDICAL EVIDENCE IS NEEDED

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 ~~for a~~to determin~~ation of~~ disability.
    a. Document your reason for obtaining new medical evidence.
    b. Medical evidence ~~more~~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 Weschler 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. Obtain a report from records and authorize payment using the "report from records" service.
    b. Clearly document the ~~Explain~~ reason~~s~~ for obtaining any new testing or evaluations at review ~~in the ICMS (Inclusive Case Management System) case notes~~.

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 ICD-9 code for any impairment that affects work activity and is supported by objective findings.

f. History of drug and / or alcohol use.

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~~th~~ 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:

Chief complaint;	Diagnosis;
History of past & present illness;	Prognosis;
MSE (mental status exam);	Capability to manage funds;
Functional information;	Medical source statement, indicating what the

client can do despite the impairment.

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:**

a. Evaluation of ~~For a~~ personality disorders and general ~~claim of~~ mental disorders:

- MMPI-II: Minnesota Multiphasic Personality Inventory
- PAI-II: Personality Assessment Inventory.

b. Evaluation of depression:

- BDI-II: Beck Depression Inventory
- HAM-D: Hamilton Rating Scale for Depression

c. Evaluation of anxiety:

- BAI: Beck Anxiety Inventory
- HAM-A: Hamilton Rating Scale for Anxiety

d. Evaluation ~~For a claim~~ of a potential cognitive disorder:

- WAIS-III or WAIS IV: Weschler Adult Intelligence Scale (IQ)
- WMS-III: Weschler Memory Scale
- ~~TOMM: Test of Memory Malingering~~
- ~~REY: A 15-item memory test, often used to screen for malingering.~~
- Trails: Trail Making Test Parts A and B~~: Used to screen for cognitive impairment and deficits in executive functioning~~

e. ~~.~~ Evaluation of potential memory malingering:

- 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

~~Request s~~Subtest scores, statistical scores, and a~~the~~ narrative summary of all tests must be included~~that you request~~. ~~-~~The narrative summary of the test~~ing~~ results may eliminate ~~help prevent~~ the need~~purchase of~~ for an additional examination and testing ~~nother exam/testing~~ when the person applies for SSI. ~~Division of Disability Determination Services (DDS) calls this the "analysis of the information".~~

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

MHP (Mental Health Professional):

1. MHP reports may only be used as medical evidence for the purposes of determining incapacity for the Medical Care Services (MCS) 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. See the ABD / MCS Medical Evidence Desk Aid for additional clarification.

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 appeals process. These reports are a supplement to medical evidence already obtained by the Department and the consulting exams obtained by DDS. This service must be pre-approved by the SSI Facilitator. Use this service description to pay for the provider's time when either:

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

The medical provider must send you a detailed billing listing the service 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:

a. If there is a **new** potentially disabling condition, conduct an early ABD Disability Review and authorize payment according to the medical evidence fee schedule using SSPS code 6220.
b. 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:

I. Complete the DSHS 17-118 Request for Expenditure Approval.

II. List the medical evidence being requested and the credentials of provider (physician, psychologist, psychiatrist, neurologist, etc).

III. Explain why the evaluation or testing is necessary.

IV. If a SSI application was denied, list the reason for the denial.

V. Explain why DDDS will not pay for the evaluation or testing.

The 17-118 is then sent to Jennifer Peterson. If approved, payment is authorized using SSPS code 96220.

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

We use the Social Services 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 amount, whichever is less. Refer to the ~~Medical Evidence Fee Schedule~~Medical Evidence Fee Schedule below 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 .~~

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

MEDICAL EVIDENCE FEE SCHEDULE

Pay either the provider's usual and customary fee or the maximum payment in this fee schedule, whichever is less.

NOTE:	The maximum payment for all evaluation and report services includes the cost of providing chart notes and medical records.

Reason Code	Service Description	Maximum Payment
A	Medical records (copies) **Note:** Only pay additional charges, e.g., sales tax, when itemized on the bill. *Only pay when we could not provide the vendor with a postage-paid business reply envelope.	$ .30 per page, with a maximum of 150 pages. Additional charges allowed: $20 for handling or clerical fee Actual cost of sales tax Actual cost of postage*
B	Report from records	$31.00
C	General physical evaluation	$130.00
D	Comprehensive physical evaluation	$150.00
E	Comprehensive eye exam	$78.00
F	Goldman perimeter testing (visual field exam)	$59.00
H	Psychological evaluation, including MSE, and assessment of daily living skills. Clinical interview and correlation of any testing must be performed by a licensed psychologist. ~~*Only pay when the provider provides a receipt from a transcription service agency.~~	$130.00 ~~Actual cost of transcription services. Not to exceed $60.00*~~
I	Psychological diagnostic testing. **Correlation of test results must be completed by the psychologist or psychiatrist who conducted the clinical interview.**	
	• MMPI-II	• $50.00
	• PAI-II	• $50.00
	• BDI	• $10.00
	• HAM-D	• $10.00
	• BAI	• $10.00
	• HAM-A	• $10.00
	• WAIS-III or IV	• $120.00
	• WMS-III	• $120.00
	• ~~TOMM~~	• ~~$30.00~~
	• Rey	• $10.00
	• Trailmaking	• $10.00
	• TOMM	• $30.00
	• M-FAST	• $20.00

J	Psychiatric evaluation, including MSE, and assessment of daily living skills. ~~*Only pay when the provider provides a receipt from a transcription service agency.~~	$150.00 ~~Actual cost of transcription services. Not to exceed $60.00*~~
K	Diagnostic Procedures	
~~K~~L	Missed appointment or cancellation without 24-hour notice at a provider's office:	
	• Physical • Psychological • Do not pay more than $~~4~~30.00 total for a missed appointment. ~~Multiple~~Separate fees may not be paid for missed ~~the~~ evaluation and testing appointments. • ~~Missed appointment fees may not be paid for evaluations performed at a CSO.~~	• $30.00 • $~~4~~30.00
~~L~~	Special report for SSI administrative hearing purposes, **when approved by CSD ~~h~~Headquarters.** *Authorize using Service Code 96220 and Reason Code B. Clearly document CSD Headquarters approval in the case record.	• $60.00 / hour* • $15.00 per 15 minute increment* • Limited to 3 hours maximum*
~~M~~	SSI consultative narrative examinations, **when approved by CSD ~~h~~Headquarters:** • Narrative Psychological Evaluation • Narrative Psychiatric Evaluation • Comprehensive review of psychiatric history ~~Unduplicated, necessary psychological testing, paid per medical evidence fee schedule section (I).~~ *Authorize using Service Code 96220 and Reason Code H (psychologist) or J (psychiatrist). Clearly document CSD Headquarters approval in the case record.	• $180.00* • $218.67* • $60.00*

NOTE:	Mental health providers may choose to use DSHS form 13-865 or provide a narrative report. The psychological evaluation form 13-865 must be typed in order to be eligible for payment. ~~This requirement is clearly stated at the top on the form.~~

NOTE:	Psychological / Psychiatric Evaluations, psychological diagnostic testing, and psychological missed appointment fees are subject to the requirements and limitations identified in the CSD Mental Incapacity Evaluation contract. Reimbursement for the above noted services are limited to licensed psychologists and psychiatrists with a current CSD Mental Incapacity Contract. Do not authorize payment for Psychological / Psychiatric Evaluations, psychological diagnostic testing, or psychological missed appointment fees using SSPS.