Department of Social and Health Services
Olympia, Washington

Social Services Manual

Revision # 56
Category / Medical Evidence Reimbursements
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Summary
The medical evidence chapter was revised to add clarifying information regarding appropriate providers, payments and when to request a expenditure approval.

Medical Evidence Reimbursements

Revised ~~October 28, 2007~~

April, 2009

Purpose: This ~~category~~ chapter describes when to request vendor services and how to make payments to vendors for incapacity and expedited Medicaid evaluation services.

~~This category covers the following topics:~~

- ~~Purpose of Medical Evidence Reimbursements~~

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

~~Purpose of~~Medical Evidence Reimbursements~~Clarifying Information~~

WAC 388-448-0030 (4) If you cannot get medical evidence without cost to you and you meet the eligibility conditions other than incapacity in WAC 388-400-0025, we pay the costs to obtain objective evidence based on our

published payment limits and designated fee schedules.

Medical evidence reimbursements described in this ~~category~~ chapter are solely to pay the fees to obtain objective medical evidence of an impairment that limits work activity. [COMMENT: I think this is too restrictive – we pay for evidence that may show that there is no incapacity. We also allow payment related to SSI Facilitation, which doesn't fit within this description.]

1. Clients must appear to be financially eligible for one of the following programs before we authorize payment:
   a. GAU (General Assistance Unemployable).
   ~~b. ADATSA Shelter.~~
   ~~c.~~b. GAX (General Assistance Expedited Medicaid).
2. We don't pay for ~~These payments do not apply to~~ services authorized by ~~DDDS (~~the Division of Disability Determination Services (DDDS) or for ~~to~~ medical examinations or reports ~~requested in~~ related to ~~ion to~~ placement in chemical dependency treatment or court orders.
3. Payments for medical evidence for TANF cases are completed in JAS as support services. See http://www1.dshs.wa.gov/ESA/wfhand/2_2.htm.
4. Request existing medical records before obtaining 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 that we need objective medical evidence and we reimburse for services necessary to evaluate incapacitating conditions. When requesting examinations or other diagnostic services attach a copy of the Statement of Health, Education and Employment (DSHS 14-050).

~~3.~~

~~1.~~ How to Decide What Medical Evidence Is Needed

~~1. Request existing medical records before authorizing new evaluations or services~~

~~Use DSHS 14-150, Medical Evidence Request (Physical) and DSHS 14-150A, Medical Evidence Request (Psychological) to communicate to the provider exactly what medical information you want and medical procedures you are authorizing.~~

~~When authorizing examinations or other diagnostic services, include specific details known about the client's condition, and follow the guidelines in this category for requesting specific tests.~~

~~2.~~1. **Initial decision:** Current medical evidence for initial incapacity decisions is a report containing objective findings based on an examination 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 an incapacity decision.
   a. Document your reason for obtaining new medical evidence.

b. Medical evidence more than 90 days old is acceptable when it is:

1. Intelligence testing scores from a ~~WAIS-III (~~Weschler Adult Intelligence Scale (WAIS - III or IV editions) administered after age 18;
2. Medical evidence used by DDDS to approve a NGMA (non-grant medical assistance) decision that is still in effect, where the medical information was obtained no longer than 12 months ago; or
3. For a client more than 50 years old, objective findings of a chronic, deteriorating condition based on an exam within the last 12 months.
4. A radiology report such as an X-ray or MRI when referenced in an examination performed within 90 days of application.

~~3.~~2. **Review decision:** Current medical evidence for review decisions is a report containing objective findings obtained within the past **45days**.

a. If the client has seen his 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. Explain reasons for obtaining any new testing or evaluations at review in the ICMS (Inclusive Case Management System) case notes.

Medical Evaluations / Procedures

The medical evidence fee is payment to the medical provider for specific services. Standards for incapacity and expedited Medicaid evaluations are in the Provider Handbook, which must be given to every provider. Review incapacity evaluations for the following information before you process the payment.

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 date the condition began, response to treatment, and any hospitalizations;
c. Physical examination findings including vital signs, description and explanation of abnormal findings, and range of motion (if done);
d. Results of diagnostic testing (lab work, x-rays, etc.);
e. Assessment/diagnosis with the severity of the diagnosed condition. The provider should not include any diagnosis based only on the person's complaints without supporting objective findings;
f. History of drug and / or alcohol use;
g. Rating of how the medical condition affects the client's overall ability to perform basic work-related activities. Basic work-related activities are sitting, standing, walking, lifting, handling, carrying, seeing, hearing, communicating, and understanding/following directions;
h. Prognosis and estimate of how long the person will be limited to the listed severity and functional rating;
i. Medications, equipment, and/or supplies prescribed or provided;
j. Recommendations for additional testing or consultation;
k. Recommended treatment;

l. Name, title and signature of the person performing the service;
m. Date of service; and
n. Copies of chart notes from the last six months, hospital summaries, medical records or lab results attached to DSHS 13-021, Physical Evaluation form or a narrative report.

2. **Comprehensive physical evaluation (e.g. orthopedic or 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. **Mental health evaluation completed by an MHP (mental health professional):**

The written report should include an MSE (mental status exam) and copies of the client's records. The evaluator must include information indicating they are a qualified MHP. If the evaluator does not indicate this, contact the evaluator to verify their status. If the person is not an MHP, do not authorize payment for the service.

4. **Psychological and psychiatric evaluation:**
   a. The **Psychological evaluation** is a diagnostic interview including an MSE and an assessment of daily living skills, conducted by a licensed psychologist.
   b. The **Psychiatric evaluation** is a diagnostic interview conducted by a licensed psychiatrist, or an Advanced Registered Nurse Practitioner when certified in psychiatric nursing.
   c. Both evaluation types result in a written report that must include:

Chief complaint;	Diagnosis
History of past & present illness	Prognosis
Mental status	Capability to manage funds
Functional information	Medical source statement, indicating what the client can do despite the impairment

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

a. For a general claim of mental disorder:
   - MMPI-II: Minnesota Multiphasic Personality Inventory ***or***
   - PAI-II: Personality Assessment Inventory.

b. For a claim of cognitive disorder:
   - WAIS-III: Weschler Adult Intelligence Scale
   - WMS-III: Weschler Memory Scale

- Rey: This is a 15-item visual memory test, often used to determine malingering
- Trailmaking: Used to determine cognitive damage

c. For a claim of depression:
- BDI-2: Beck Depression Inventory
- Hamilton Psychological Rating Scale for Depression & Anxiety

- Note: The examining psychologist determines which tests are appropriate and documents why each test performed is necessary. Diagnostic testing is not usually necessary at review.

~~After interviewing the client, determine what tests are necessary and request them with the psychological evaluation.~~

Request subtest scores, statistical scores, and the narrative summary of all tests that ~~you request~~are performed. The narrative summary of the testing may help prevent the purchase of another exam/testing when the person applies for SSI. Division of Disability Determination Services (DDDS) calls this the "analysis of the information".

6. Special report for SSI administrative 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 us and the consulting exams obtained by DDDS. This service must be pre-approved by the social services worker. 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.

In either case, 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.

7. Medical evidence at the initial application, reconsideration, or SSI administrative hearing level:

~~Historically, when a case reached the SSI administrative hearing level and it was determined that the medical evidence in the record was not adequate to support the disability claim, additional medical was obtained at that point.~~

We don't ~~no longer~~ routinely authorize and reimburse for evaluations ~~when a client reaches the SSI hearing level~~ when a client is in the SSI application process.~~.~~ We ~~must get~~need clear, objective medical evidence ~~early in the client's eligibility period, at the initial decision and at reviews.~~ to determine eligibility at application and to support an Expedited Medicaid (GA-X) referral. ~~In doing so, you should not need further evaluation when the client reaches the SSI hearing level. For situations~~ W~~w~~hen further evaluation or testing is necessary to support an SSI application at any stage, and **DDDS will not pay per their policy**, follow these procedures:

a. If there is **new** condition, conduct an incapacity review and authorize payment according to the medical evidence fee schedule with SSPS code 6220.
b. If this ~~**is not**~~ **isn't a new** condition, or if payment for medical evidence is outside of the medical evidence fee

schedule, ~~complete the DSHS 17-118.~~submit a ~~R~~request for e~~E~~xpenditure a~~A~~pproval:~~.~~

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.

~~You must state the reason you need the medical evaluation and the cost.~~ The 17-118 is then sent to headquarters staff. If approved, payment would be authorized with SSPS code 96224.

Example: A GA-X client 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. Request an expenditure request for an evaluation that meets DDDS consultative examination criteria.

Example: A GA-X client at SSI reconsideration needs medical evidence of a secondary impairment. The impairment was disclosed on the SSA application but not referenced in the SSI denial letter. Treatment has only been provided by a physician's assistant, and DDDS refuses to pay for an evaluation. Request an expenditure request for an evaluation that meets DDDS consultative examination criteria.

Example: An attorney has requested payment for an evaluation to support an SSI claim at hearing level. Submit an expenditure request and attach a copy of the attorney's request along with any additional information that supports the expenditure request.

~~b.~~

Payment for Medical Evidence

1. You must have an itemized bill with the provider's usual and customary fees before authorizing ~~-~~payment. The bill must be kept in the client's case file for audit purposes.
2. **Physician Services for Diagnostic procedures:** Diagnostic procedures include~~, for example,~~ laboratory work (examples include~~e.g.~~, urinalysis, blood chemistry tests), radiology, strength testing and similar services~~a wide variety of other procedures~~. For diagnostic procedures, pay the provider's usual and customary fee **or** the allowable maximum, **whichever is less**. The allowable maximums are found in the "Physician-Related Services Billing Instructions", issued by MAA (Medical Assistance Administration).

~~a. When the allowable maximum is listed as "BR" (by report), pay 65% of the provider's billed fee.~~

a. Pay no more than $~~450~~ 250 **total** for all diagnostic procedures per client per initial **physical** evaluation if an MRI was not obtained.

b. Pay no more than $550 **total** for all diagnostic procedures per client per initial **physical** evaluation if an **MRI** was obtained.

c. If more than one MRI is needed, request an expenditure approval from headquarters.

b. When the provider is a critical access hospital and the allowable maximum is listed as "BR" (by report), pay 65% of the provider's billed fee. If more than one MRI is needed, request an expenditure approval from headquarters..

3. **Hospital Services for Diagnostic Procedures:** For outpatient diagnostic procedures done in a hospital setting, pay the usual and customary fee **or** the allowable maximum for the relevant CPT code, **whichever is less**.

   a. For most hospitals, use the Outpatient Hospital Fee Schedule.

   b. When the facility is a **Critical Access Hospital**, use the Outpatient Ppercentage [http://fortress.wa.gov/dshs/maa/HospitalPymt/Inpatient/CAHHospital.htm] as the allowable maximum.

   Note: Only one Magnetic Resonance Imaging (MRI) procedure is allowed, unless there an exception request is approved by state office in advance.

4. **Medical evidence other than diagnostic procedures:** Payments for these services are made according to the Medical Evidence Fee Schedule. Pay the provider's usual and customary fee or the amount shown in the fee schedule, **whichever is less**.
5. When you decide a client is eligible for GAU either initially or at review, complete the DSHS 14-332 (Disability Assessment) **before** paying for medical evidence. If a GAX / SSIF referral **is appropriate** per the 14-332, use service code 6220 to pay for the medical evidence. If a referral **is not appropriate**, use code 6020.

SSPS Codes

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 to exceed the allowable maximum, you must document the reasons approval, by the appropriate authority, to do for doing so in the case record. To exceed the allowable maximum the supervisor must enter a 9 in front of the SSPS service code.

SSPS Code	Use For	Exceed Maximum When
6020	Medical evidence when a referral to the SSIF **is not** appropriate per the DSHS 14-332 (Disability Assessment).	• Pre-authorized by the medical consultant; *or* • A case staffing is completed and payment is pre-authorized by the social services supervisor; *or* • Directed by an ALJ (Administrative Law Judge) as the result of a fair hearing. Approved by state office; or • Directed by an ALJ as the result of an Administrative hearing.

6220	Medical evidence when a referral to the SSIF **is** appropriate per the DSHS 14-332 (Disability Assessment).	• Approved by state office; or • ~~Pre-authorized by the medical consultant; or~~ • ~~A case staffing is completed and payment is pre-authorized by the social services supervisor; or~~ • Directed by an ALJ as the result of an ~~fair hearing~~Administrative hearing.~~.~~
6222	Additional medical evidence to determine eligibility for GAX when requested by the contracted physician.	• Requested by the GAX contractor; and • Approved by state office. ~~Pre-authorized by the social services supervisor.~~
6224	Obtaining records to support an SSI claim at the SSI initial claim, reconsideration, or ~~SSI~~ administrative hearing level, **when DDDS will not pay per their policy**.	• Approved by state office.

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 services in the fee schedule include~~payment for all services in the fee schedule includes the cost of copies of chart notes.

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
G	Mental Health Professional (MHP) evaluation, including MSE and	$60.00

	copies of client records	
H	Psychological evaluation, including MSE, and assessment of daily living skills. Evaluation and testing must be performed by a **licensed psychologist**	$130.00
I	Psychological diagnostic testing - must be performed by a **licensed psychologist**	
	• MMPI-II • PAI-II • WAIS-III or IV • WMS-III • Rey • BDI-2 • Hamilton • Trailmaking	• $50.00 • $50.00 • $120.00 • $120.00 • $10.00 • $10.00 • $10.00 • $10.00
J	Psychiatric evaluation	$150.00
L	Missed appointment or cancellation without 24-hour notice:	
	• Physical • ~~Psychological~~ • • Do not pay more than $40.00 total for a missed appointment. An evaluation and testing by the same provider is considered to be one appointment even is scheduled over multiple days.~~Psychological Testing (if an additional hour was scheduled for testing)~~	• $30.00 • ~~$40.00~~ • ~~$40.00~~
M	Special report for SSI administrative hearing purposes	• $60.00 / hour • $15.00 per 15 minute increment • Limited to 3 hours maximum
N	SSI consultative narrative examinations, **when approved by headquarters:** • Narrative Psychological Evaluation • Narrative Psychiatric Evaluation • Comprehensive review of psychiatric history Unduplicated, necessary psychological testing, paid per medical evidence fee schedule section (I).	• $180.00 • $218.67 • $60.00

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