Department of Social and Health Services

Olympia, Washington

Social Services Manual

Revision #

CATEGORY Medical Evidence Reimbursements

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Summary : The TOMM was added to the fee schedule. The Beck and Hamilton inventories were removed, and MSE guidelines were added.

MEDICAL EVIDENCE REIMBURSEMENTS

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

WAC 388-448-0030 What medical evidence do I need to provide?

WAC 388-448-0030
Effective May 1, 2010

WAC 388-448-0030 What medical evidence do I need to provide?

You must provide medical evidence that clearly shows if you have an impairment and how that impairment prevents you from being capable of gainful employment. 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; or
    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 an incapacity determination must be from a medical professional described in WAC 388-448-0020 and must include:
    a. A diagnosis for the impairment, or impairments, based on an examination performed within twelve months of application;
    b. A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-448-0010 (5);
    c. Documentation of how the impairment, or impairments, is currently limiting your ability to work based on an examination performed with the ninety days of the date of application or the forty-five days before the month of incapacity review; and
    d. Facts in addition to objective evidence to support the medical provider's opinion that you are unable to be gainfully employed, such as proof of hospitalization.
4. When making an incapacity decision, we do not use your report of symptoms as evidence unless

objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

5. We don't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining incapacity.
6. We consider diagnoses that are independent of addiction or chemical dependency when determining incapacity.
7. We determine you have a diagnosis that is independent of addiction or chemical dependency if the impairment will persist at least ninety days after you stop using drugs or alcohol.
8. If you can't obtain medical evidence of an impairment that prevents you from working 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 fee schedules.
9. We decide incapacity based solely on the objective information we receive. We are not obligated to accept a decision that you are incapacitated or unemployable made by another agency or person.
10. We can't use a statement from a medical professional to determine that you are incapacitated unless the statement is supported by objective medical evidence.

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

CLARIFYING INFORMATION

WAC 388-448-0030 (4) If you cannot obtain 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 chapter are solely to pay the fees to obtain objective medical evidence of an impairment that limits work activity. The medical evidence obtained may indicate there is no incapacity, or may be used to support SSI facilitation, but we do not pay for medical evidence to rule out medical conditions that are not incapacitating.

1. Clients must appear to be financially eligible for Disability Lifeline before we authorize payment.
2. These payments do not apply to services authorized by DDDS (Division of Disability Determination

Services) or to medical examinations or reports requested in relation to placement in treatment or court orders.
3. Payments for medical evidence for TANF cases are completed in EJAS as support services.
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.
6. When requesting examinations or other diagnostic services attach a copy of the Statement of Health, Education and Employment (DSHS 14-050).

HOW TO DECIDE WHAT MEDICAL EVIDENCE IS NEEDED

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

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 14-150, 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 must 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 (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, 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
MSE (mental status exam)	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 or WAIS-IV: Weschler Adult Intelligence Scale
      - WMS-III: Weschler Memory Scale
      - TOMM Test of Memory Malingering
      - 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~~

Request subtest scores, statistical scores, and the narrative summary of all tests that you request. 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".

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.

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:**

We don't routinely authorize and reimburse for evaluations when a client is in the SSI application process. We need clear, objective medical evidence to determine eligibility at application and to support an Expedited Medicaid referral. When 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 **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 headquarters staff. If approved, payment would be authorized with SSPS code 96224.

EXAMPLE

A DL-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 DL-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.

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 laboratory work (examples include, urinalysis, blood chemistry tests), radiology, spirometry, strength testing and 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. Pay no more than $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.

Hospital Services for Diagnostic Procedures: For outpatient diagnostic procedures performed 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 Percentage as the allowable maximum.

1. **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**.
2. When you decide a client is eligible for DL either initially or at review, complete the DSHS 14-332 (Disability Assessment) **before** paying for medical evidence. If a DL-X / 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 approval, by the appropriate authority, to do so in the case record. To exceed the allowable maximum 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).	• Approved by state office; *or* • Directed by an ALJ (Administrative Law Judge) 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* • Directed by an ALJ as the result of an Administrative Hearing.
6222	Additional medical evidence to determine eligibility for DL-X when	• Requested by the DL-X contractor; and

		requested by the contracted physician.	• Approved by state office.
6224		Obtaining records to support an SSI claim at the SSI initial claim, reconsideration, or 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 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 copies of client records	$60.00
H	Psychological evaluation, including MSE, and assessment of daily living skills. Clinical interview and ~~correlation~~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 • PAI-II • TOMM • WAIS-III or IV • WMS-III • Rey • ~~BDI-2~~ • ~~Hamilton~~ • Trailmaking	• $50.00 • $50.00 • $30.00 • $120.00 • $120.00 • $10.00 • ~~$10.00~~ • ~~$10.00~~ • $10.00
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*
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.	• $30.00 • $40.00
M	Special report for SSI administrative hearing purposes, **when approved by headquarters.**	• $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

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.

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