

# Health and Recovery Services Administration (HRSA)



## Psychologist Billing Instructions

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## About this publication

**This publication supersedes all previous Psychology Billing Instructions and Numbered Memorandum 02-31 MAA, 03-33 MAA, 03-91 MAA, 03-100 MAA, 04-51 MAA, 05-64 MAA, 05-113 MAA, 06-05, 06-60.**

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# Important Contacts

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A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

**Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?**

Call the toll-free line:  
(866) 545-0544

**Where do I send my HCFA-1500 claims?**

Division of Program Support  
PO Box 9245  
Olympia WA 98507-9245

**For information on electronic billing, go to:**

<https://wamedweb.acs-inc.com/wa/general/home.do>

**Who do I contact if I have questions on...**

**Payments, denials, general questions regarding claims processing, Healthy Options?**

Medical Assistance Customer Service Center (800) 562-6188

**Private insurance or third party liability, other than Healthy Options?**

Division of Client Support  
Coordination of Benefits Section  
PO Box 45565  
Olympia, WA 98504-5565  
(800) 562-6136

**How do I obtain copies of billing instructions or numbered memoranda?**

Check out MAA's web site at:  
<http://maa.dshs.wa.gov>, Provider Publications/Fee Schedules link.

# Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

**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. Medical ID Card will have a “W”.

**Authorization Requirement** – A condition of coverage and reimbursement for specific services or equipment, when required by Washing Administrative Code (WAC) or billing instructions. See WAC 388-501-0165 for the authorization process.

**Client** – An individual who has been determined eligible to receive medical or health care services under any HRSA program.

**Code of Federal Regulations (CFR)** – Rules adopted by the federal government. [WAC 388-500-0005]

**Community Services Office (CSO)** - An office of the department’s Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

**Core Provider Agreement** - The basic contract between HRSA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

**Department** - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

**Explanation of Benefits (EOB)** – A coded message on the medical assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

[WAC 388-500-0005]

## Health and Recovery Services

**Administration (HRSA)** - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

**Managed Care** - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.

[WAC 388-538-050]

**Maximum Allowable** - The maximum dollar amount HRSA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

**Medicaid** - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program (CNP) or medically needy program (MNP).

[WAC 388-500-0005]

**Medically Necessary** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

**Medicare** - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).

- Alpha or numeric character (tiebreaker).

**Provider** - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

**Provider Number** – An identification number issued to providers who have signed contract(s) with HRSA. [WAC 388-500-0005]

**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]

**Remittance And Status Report (RA)** - A report produced by MMIS, HRSA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. [WAC 388-500-0005]

**Revised Code of Washington (RCW)** - Washington State laws.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

**Title XIX** - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.[WAC 388-500-0005]

**Usual & Customary Fee** – The fee that the provider typically charges the general public for the product or service. [WAC 388-500-0005]

**Washington Administrative Code (WAC)** - Codified rules of the State of Washington.

# Client Eligibility

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## Who is eligible?

Clients presenting Medical ID Cards with the following identifiers **are eligible** for psychological evaluations:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP CHIP	Categorically Needy Program - Children's Health Insurance Program
LCP-MNP	Limited Casualty Program-Medically Needy Program

## Who is not eligible?

Clients presenting Medical ID Cards with the following identifier **are not eligible** for psychological evaluations:

Medical Program Identifier	Medical Program
Family Planning Only	Family Planning Only

**Note:** Clients whose Medical ID Cards list the "GAU" medical identifier must go their local community mental health center for mental health services.

## What about clients who are enrolled in an HRSA managed care plan?

Clients whose Medical ID Cards bear an identifier in the HMO column are enrolled in an HRSA managed health care plan. Clients with identifiers in the HMO must be referred by their primary care provider in their managed care plan. Call the HMO telephone number located on the client's Medical ID Card. If the HMO refers the client to you for services, the HMO is responsible for reimbursing you for the services.

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# Coverage

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## What is covered?

The Health and Recovery Services Administration (HRSA) reimburses licensed psychologists for:

- Psychological evaluations;
- Developmental testing; and
- Neuropsychological testing.

## 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 96100** when billing for psychological evaluations.
- Up to two (2) units of CPT™ code 96100 are allowed **without prior authorization** per client, per lifetime.
- If additional testing is necessary, psychologists **must** request additional units of CPT code 96100 through the prior authorization process.

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## Developmental Testing

HRSA 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 HRSA.

## Neuropsychological Testing

HRSA reimburses for neuropsychological testing (CPT codes 96115 and 96117) only when:

- The provider is a neuropsychologist; **and**
- The provider has obtained written/fax prior authorization from HRSA.

**Note:** HRSA 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.

## Obtaining Prior Authorization

**Send or fax your request for prior authorization to:**

HRSA – Division of Medical Management  
Attn: Medical Request Coordinator  
PO Box 45506  
Olympia, WA 98504-5506  
FAX: (360) 586-1471

## What is not covered?

HRSA will *not* reimburse for:

- Psychotherapy provided by a psychologist or an ARNP; or
- Continuing care provided by psychologist or by staff employed by the psychologist.

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# Psychologist Coverage Table

CPT Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
<p><b>Note:</b> Due to its licensing agreement with the American Medical Association (AMA), HRSA publishes only the official, brief CPT<sup>®</sup> procedure code descriptions. To view the entire descriptions, please refer to your current CPT book</p>				
96101		Psycho testing by psych/phys		
96102		Psycho testing by technician		
96103		Psycho testing admin by comp		
96105		Assessment of aphasia		
96110		Developmental test, lim	PA	
96111		Developmental test, extend	PA	
96116		Neurobehavioral status exam	PA	
96118		Neuropsych tst by psych/phys	PA	
96119		Neuropsych testing by tech	PA	
96120		Neuropsych tst admin w/comp		

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# Billing

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## What is the time limit for billing? [Refer to WAC 388-502-0150]

- HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.
- The provider must submit claims as described in HRSA's billing instructions.
- HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:
  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders HRSA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed<sup>1</sup> certification criteria.
- HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ✓ DSHS certification of a client for a retroactive<sup>2</sup> period; or
  - ✓ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

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<sup>1</sup> **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

**Eligibility Established After Date of Service but Within the Same Month** - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

<sup>2</sup> **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

**Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The time-periods do not apply to overpayments that the provider must refund to DSHS. After the time-periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ HRSA does not pay the claim.

## What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

**Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

## How do I bill for clients who are eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid (otherwise known as “dual- eligible”), **you must first submit a claim to Medicare and accept assignment within Medicare’s time limitations.** HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA’s initial 365-day requirement for initial claim.
- Codes billed to HRSA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

## Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your HRSA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill HRSA directly.

- If Medicare has made payment, and there is a balance due from HRSA, you must submit a 1500 Claim Form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.
- If Medicare denies services, but HRSA covers them, you must bill on a 1500 Claim Form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.
- If Medicare denies a service that requires prior authorization by HRSA, HRSA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

**Note:**

- ✓ Medicare/Medicaid billing claims must be received by HRSA within six (6) months of the Medicare EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

## Payment Methodology – Medicare Part B

- MMIS compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to HRSA's maximum allowable.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider **accepts** assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

## Third-Party Liability

The Health and Recovery Services Administration (HRSA) is required by federal regulation to determine the liability of third-party resources that are available to HRSA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, HRSA may make payment on the balance if the third-party payment is less than the allowed amount.

To be eligible for HRSA programs, a client must assign his/her insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill HRSA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the client's DSHS Medical ID card; or
- There is a possible casualty claim; or
- You believe insurance is available.

If you would like assistance in identifying an insurance carrier, call the Third-Party Resource Program at 800.562.6136, or refer to the TPL Carrier Code List on HRSA's web site at <http://maa.dshs.wa.gov>.

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**Exception:**

Due to federal requirements, the following services will **not** be denied for third-party coverage **unless** the TPL code is **HM, HI, or HO**:

- ✓ Outpatient preventative pediatric care;
- ✓ Outpatient maternity-related services; and
- ✓ Accident related claims, if the third party benefits are not available to pay the claims at the time they are filed, per 42 CFR 433.139(c).

Indicate all available insurance information on the claim form. HRSA pays the claim and pursue the third-party insurance.

You must pursue collection from the subscriber when the client is not the subscriber and the insurance company makes a benefit payment to the subscriber. Under these circumstances, the client is under no obligation to pay unless he/she is the insurance subscriber.

**Although the billing time limit for HRSA is 365 days, an insurance carrier's time limit on billing allowances may be different. It is your responsibility to meet the insurance carrier's requirement relating to billing time limits prior to any payment by HRSA.**

**Note:** If you receive payment from HRSA in excess of the amount due, you may refund the excess to the Office of Financial Recovery, or you may submit an adjustment request to HRSA to withhold money from future checks. A copy of the appropriate HRSA Remittance and Status Report showing the original payment and copy of the insurance EOB, if available, should be attached to either the check or the adjustment request, whenever possible.

**Mail refund checks to:**

**Office of Financial Recovery - MED  
PO Box 45862  
Olympia, WA 98504-5862**

## What records must be kept?

### General for all providers [Refer to WAC 388-502-0020]

#### Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.
  
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
  
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

**A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.  
(Refer to WAC 388-502-0020[2])**

## Fee Schedule

You may view HRSA's **Psychologist Fee Schedule** on-line at

<http://maa.dshs.wa.gov/RBRVS/Index.html>

For a paper copy of the fee schedule:

- **Go to:** <http://www.prt.wa.gov/> (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby** → **Search by Agency** → **Department of Social and Health Services** → **Health and Recovery Services Administration** → desired document; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/  
telephone 360.586.6360. (Faxed or telephoned orders may take up to 2 weeks to fill.)

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# Completing the 1500 Claim Form

**Attention! HRSA now accepts the new 1500 Claim Form.**

- **On November 1, 2006**, HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

**Note: HRSA encourages providers to make use of electronic billing options.**

For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: <http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html> or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **Psychologist Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:  
**800.562.3022**

## 1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
19.	Reserved for Local Use		When Medicare allows services, enter <i>XO</i> to indicate this is a crossover claim.

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