Department of Social and Health Services

Community Services Division

Social Services Manual

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Category:	**Medical Evidence Requirements and Reimbursements**
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Summary

Effective July 1, 2020, reimbursements for medical records to support an ABD or HEN Referral eligibility determination are paid through the ProviderOne system.

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Revised on: ~~March 26, 2018~~July 1, 2020

Clarifying Information

Reimbursements described in this section 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 evaluate medical conditions that are not claimed or unlikely to impair work functions.

If a person meets all of the non-disability/incapacity eligibility requirements listed in WAC 388-400-0060 or WAC 388-400-0070, we reimburse for the costs of obtaining the objective evidence necessary to determine disability/incapacity based on our published fee schedules.

1. Clients must be determined financially eligible before we authorize an evaluation or payment.
2. We r~~R~~equest medical records if available before authorizing new evaluations or services.

3. Payments do not apply to services authorized by the Division of Disability Determination Services (DDDS) or medical examinations or reports required by court order or treatment placement.
4. Payments for medical evidence related to TANF cases are authorized in eJAS as Support Services (WorkFirst Handbook 2.2).
5. See WorkFirst Handbook 3.6.1 for information regarding reimbursement for medical evidence associated with TANF/SFA ineligible parent time limit extensions.

What is "Current" Medical Evidence?

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 disability.
    a. Document your reason for obtaining new medical evidence.
    b. For the purposes of establishing a diagnosis, medical evidence ~~greater~~ older than 90 days ~~old~~ from the date of application is acceptable when it is:
        - A report within the past 5 years that includes a diagnosis of a medically determinable impairment based on an examination by an "acceptable medical source," defined in WAC 388-449-0010 and WAC 388-447-0005;
        - Intelligence testing scores from a Wechsler Adult Intelligence Scale (WAIS - III or IV editions) administered after age 18; or
        - 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 a review decision must be based on an examination or findings from within the past **45 days** for the ABD Program or **90 days** for the HEN Referral Program.
    a. If the client has seen a medical provider within the past 45 days, request a report from records rather than authorizing a new evaluation whenever possible.
    b. If existing available medical records are not sufficient to determine disability, clearly document the reason for obtaining any new testing or evaluations at review.

NOTE: Under the Concurrent Determination process, first attempt to obtain medical evidence (identified in WAC 388-449-0015) necessary to determine eligibility for the ABD program.

Medical Evaluations and Testing

1. **General physical evaluation:** A general physical evaluation should contain all of the following information:
    a. The c~~C~~hief complaint and symptoms reported by the client;

b. Medical history including onset date and treatment history;
c. Physical examination findings including but not limited to: vital signs, observations, a description of any abnormal findings, and range of motion (when appropriate);
d. Results of diagnostic testing and imaging (e.g. labs, X-rays, pulmonary function tests, etc.);
e. A diagnosis and International Classification of Diseases (ICD) code for any impairment that affects work activity and is supported by objective findings;
f. A description of how the medical condition impacts the client's overall ability to perform basic work-related activities;
g. A description of any non-exertional limitations which may include workplace restrictions;
h. A prognosis including an estimate of how long the functional impairment will persist at the current level of severity;
i. Current or past drug or alcohol use;
j. An opinion whether current impairments which limit work activity are primarily the result of alcohol or drug use within the past 60 days;
k. Recommendations for additional testing or consultation;
l. Treatment recommendations;
m. The name, title and signature of the person performing the evaluation;
n. The date of service; and
o. 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. A **Psychological** evaluation is a diagnostic interview, including an MSE (mental status exam) and an assessment of daily living skills conducted by an “acceptable medical source” defined in WAC 388-449-0010.
    b. A **Psychiatric** evaluation is a diagnostic interview, including an MSE (mental status exam) and an assessment of daily living skills conducted by a licensed psychiatrist (MD, DO).
    c. Both evaluation types result in a written report that must include:
        1. The chief complaint or the impairment/symptoms claimed by the client;
        2. Psychosocial history including onset date and treatment history;
        3. Educational and work history;

4. Any past or present drug or alcohol use, including treatment history;
5. A description of the client's activities of daily living;
6. A list of all mental health symptoms that impact the client's ability to work, including a description of the severity and frequency of those symptoms;
7. A diagnosis; from the current Diagnostic and Statistical Manual of Mental Disorders (DSM), or lack thereof, of any impairment that impacts work activity and is supported by objective findings;
8. A description of how the medical condition impacts the client's overall ability to perform basic work-related activities;
9. An opinion whether any current limitations on work activity are primarily the result of a substance use disorder;
10. A prognosis including an estimate of how long any functional impairment will persist at the current level of severity;
11. An opinion of the client's capacity to manage funds;
12. Treatment recommendations;
13. The name, title, and signature of the person performing the evaluation; and
14. The date of service.

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

    a. Evaluation of personality disorders:
        1. MMPI-II: Minnesota Multiphasic Personality Inventory
        2. PAI-II: Personality Assessment Inventory
    b. Evaluation of depression:
        1. BDI-II: Beck Depression Inventory
        2. HAM-D: Hamilton Rating Scale for Depression
    c. Evaluation of anxiety:
        1. BAI: Beck Anxiety Inventory
        2. HAM-A: Hamilton Rating Scale for Anxiety
    d. Evaluation of a potential cognitive disorder:
        1. WAIS-III or WAIS IV: Wechsler Adult Intelligence Scale
        2. WMS-III: Wechsler Memory Scale
        3. TONI-4: Test of Nonverbal Intelligence, Fourth Edition
        4. Trails: Trail Making Test Parts A and B
    e. Evaluation of potential memory malingering:
        1. REY 15-Item Memory Test
        2. TOMM: Test of Memory Malingering
    f. Evaluation of potential psychiatric illness malingering
        1. M-FAST: Miller Forensic Assessment of Symptoms Test
        2. SIRS: Structured Interview of Reported Symptoms

Sub-test scores, statistical scores, and a narrative summary of all tests must be included. Please see Mental Incapacity Evaluation Services: Fee Schedule, for limitations on testing reimbursements and additional details.

NOTE: The examining "acceptable medical source" determines which of the listed tests are clinically appropriate and must clearly document in the evaluation report why each test is performed.

Psychological Evaluations from Providers who are not an ABD "Acceptable Medical Source"

1. Psychological evaluations or reports from the following sources may only be used for purposes of determining incapacity for the HEN Referral program per WAC 388-447-0005:
    1. Clinical social worker;
    2. Mental health professional (MHP); or
    3. Physician treating the individual for a mental impairment
2. No reimbursement, other than copy fees, shall be authorized for psychological evaluations or reports authored by the sources listed above.

NOTE: Under the Concurrent Determination process, first attempt to obtain medical evidence (identified in WAC 388-449-0015) necessary to determine eligibility for the ABD program.

ProviderOne and the Social Service Payment System (SSPS)

1. Providers and Medical Record Companies must be enrolled with ProviderOne to claim and receive payment for i~~I~~ncapacity e~~E~~valuation services and medical records.~~,~~
    1. Only use~~Continue to use~~ SSPS to reimburse for Medical Records ~~(copies)~~(billed with a date of service **prior to July 1, 2020**) and ~~,~~SSI Medical Evidence Transportation costs~~,~~ ~~and Medical Evidence to Support SSI Applications (approved through the Barcode ETR process). Most services are paid using SSPS Service Code 6220.~~ Refer to the SSPS Medical Records Desk Aid and SSPS Manual Appendix H for details regarding available Service Codes and how to use them.
2. Pay either the provider's usual and customary fee or the maximum payment, whichever is less. Refer to the Medical Evidence Fee Schedules section for maximum payment amounts.

ABD/HEN Referral Payment Review Request

The Payment Review Request (PRR) tool in ICMS can be used to identify and report psychological and physical functional evaluations that lack elements required by ABD/HEN Referral program rules, and are in need of further review. Please visit the ABD/HEN Referral Payment Review Request section of the CSD Procedure Handbook for additional information.

NOTE: Social Service staff must first attempt to obtain missing information by contacting the medical provider by phone, FAX, or by mail **before** initiating the PRR tool. Be sure to document the attempt in ICMS case notes.