Overview

Description: This Worker Guide provides instruction for ordering an Administrative Examination and use of Current Procedure Technology (CPT) billable codes. An Administrative Examination is an evaluation required by the Department of Human Services (DHS) used for eligibility determinations or case planning. A Report Authorization is a request for copies of existing records for a specified date range and is a prior authorization for Oregon Health Authority (OHA) Medicaid provider billing and payment.

Purpose/Rationale: Oregon Administrative Rule (OAR) 410 Division 150 governs the Administrative Examination Services Program. Rules and are posted on the Oregon Secretary of State website (https://secure.sos.state.or.us). The Office of Developmental Disability Services (ODDS) and OHA will only reimburse Oregon Medicaid providers for an Administrative Examination who have an Administrative Examination provider contract and provider number. Providers who do not have an OHA provider number must obtain one through OHA Provider Enrollment, https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx.

The evaluation you receive from the medical professional must be written, contain a diagnosis, prognosis and supporting objective findings, including full
results of all testing and scores. Functional impairments and expected duration should be included.

**Applicability:** This policy applies to Community Developmental Disabilities Programs (CDDP’s); specifically, Eligibility Specialists (ES) and CDDP staff assisting ES’s to complete administrative tasks to determine program eligibility, or to case managers who need to order an evaluation for case planning purposes.

**Timelines**
Collection of records must occur timely, to demonstrate due diligence and evidence the necessity for an admin exam. Best practice includes sending for records that reasonably include developmental history or testing within 10 days of obtaining necessary release of information forms.

An evaluation report should be completed and sent to the ordering program office approximately 15 days following an evaluation. Reasonable extensions to this timeline may occur. If an unreasonable delay in receiving the report occurs, consult with the Diagnoses & Evaluation (D&E) Coordinator.

If an evaluation is received, and results in a completed application as defined in OAR 411-320-0020, a determination notice must be sent within 10 days on the form identified by the Department.

**Procedures**
The Oregon Health Authority (OHA), Health Systems Division Medicaid Programs require the use of the OHA 0729 form for the purpose of prior-authorization of billing and payment for Oregon Medicaid providers. An examination may only be requested by the individual’s ODDS Services Coordinator (SC) or ES. Progress notes, laboratory tests, imaging reports, special test results and copies of other pertinent records or evaluations are documents of justification to include.

**Documentation of Administrative Examination:** All evaluations must have a rationale explaining the necessity for the exam documented in a progress note. An appointment notice should be sent to the individual and/or their representative, along with a copy of the notice kept in the CDDP file with a copy of the OHP 729 authorization form.
Important Case Coding
Refer to AR 11053 for instructions about verifying or adding Medicaid coding to an OHP case or creating a temporary prime number for an Admin Exam.

Medical documentation
Ordering medical documentation is needed to:
- Determine disability, incapacity, or unemployability.
- Aid the eligibility specialist in determining DD program eligibility
- Aid in case planning by the ODDS SC to determine appropriate services.

Administrative examinations are NOT used for additional Mental Health testing (except as listed above), additional school testing for educational planning, information requests from doctors, or other agencies.

Selecting the appropriate examination
- Decide if you are ordering the Admin Exam to make an eligibility disability determination or for ongoing case planning purposes. To order an Admin Exam for case planning, the SC must justify the need for the evaluation to aid in service planning. DO NOT order an exam if it is an external request or if it will not be used for purposes identified in this Worker Guide.
- Identify all procedure codes applicable for eligibility determinations or for "ongoing" case planning. If you need specific testing, such as Autism testing, specific cognitive or adaptive measures, identify that in the provider packet. A provider packet, including relevant records, history, other testing, and your questions of interest should be sent to the provider prior to the evaluation.
- Using the code table, select all appropriate examination procedure codes.
  - If the individual is currently being treated or has been treated or evaluated within the last 12 months for the stated complaint, obtain copies of office records, before ordering testing and identify if available records are sufficient for your purpose.
  - If the individual has been hospitalized, obtain copies of admission and discharge records and any appropriate testing or reports.
Selecting the appropriate provider

- Obtain the name of the individual’s current medical provider(s), and copies of records and review prior to scheduling an evaluation to identify if existing records are sufficient for purposes in this guide.
- If treating providers are not the best choice to obtain needed information or if it is a provider type who cannot be paid, choose another provider (e.g., If the individual needs IQ testing, send him/her to a psychologist; if they need neuro-psych testing send them to a neuropsychologist).
- Determine if the chosen provider has a current OHA Medicaid provider number prior to scheduling an evaluation.
- Order services only from authorized providers using the procedure codes.
- Out-of-state providers may be used if necessary, if they have a current OHA Medicaid provider number. These referrals should be staffed with the Diagnosis and Evaluation Coordinators (D&E Coordinators) before testing.

Scheduling appointments and transportation

The eligibility specialist or case manager schedules the evaluation with the provider. Use of Non-Emergent Transportation Brokerages for Oregon Health Plan members (and transportation services) should be used when needed to assure attendance. A copy of the OHP 729 may be sent to the Transportation Brokerage to authorize the transportation payment.

Completion of OHP 729 forms

- The OHP 729 forms are a series of seven forms (links appear at the end of this guide) used to order testing or obtain copies of records from Medicaid providers for determining I/DD eligibility or case planning; the OHP 729 form is required, and the 729a may be used if desired.
- Instructions to complete the OHP 729 are included in the form.
- Send appropriate OHP 729(s) and a release of information (if necessary, to re-disclose authorized records for review) to the provider.
- The OHP 729 is the pre-authorization for payment.

Processing the provider's report

- Determine if the report is what you requested.
- If the report is inadequate, immediately contact the provider to obtain the requested information. Do NOT authorize additional payment or order a new Admin Exam if requested pre-authorized service was not provided.
- Providers should submit the 837P electronic transaction or use the provider web portal for billing and payment. The paper CMS-1500 claim form may be used if necessary.
## Eligibility Determination Commonly Used Procedure Codes

<table>
<thead>
<tr>
<th>Procedural code</th>
<th>Description</th>
<th>Restrictions and instructions</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical records ordering/billing</strong></td>
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<tr>
<td><strong>S9981</strong></td>
<td>Medical records copying fee, administrative. Use for initial and ongoing eligibility when client has been (1) in the hospital or (2) has had a medical history and physical in the last 60 days.</td>
<td>If not completing DMAP 729D (optional), make sure to include on the DMAP 729 under Description of Service, “Include progress notes, laboratory reports, X-ray reports, and special study reports since [include date requesting records from]. Include recent hospital admission records if available.”</td>
<td>Allowable rate¹</td>
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<td><strong>Psychological evaluations – to be completed by licensed psychologists</strong></td>
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| **96130** (IQ evaluation, first hour) AND **96131** (IQ evaluation, each additional hour) | NEW - Psychological testing evaluation services by psychologist, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour.** Each additional hour, beginning at 1 hour, 31 minutes. (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS) | **ALERT:**  
- Replaces 96101, first hour only  
- Must be used with 96131 for each additional hour  
Use for initial or ongoing eligibility to determine intellectual disability or ability to grasp facts and figures.  
Use for ongoing case planning, if appropriate. | Allowable rate¹ |
| **96132** (Neuropsych testing, first hour) | NEW - Neuropsychological testing evaluation services (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test, first hour of the psychologist’s or physician’s time, both face-to-face time | **ALERT:**  
- Replaces 96118, first hour only  
Cannot be requested in combination with 96130 or 96131 | Allowable rate¹ |
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| AND 96133 (Neuropsych testing, each additional hour) | administering tests to the patient and time interpreting these test results and preparing the report.  
- Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients. |  
- **Must** be used with 96133 for each additional hour  
- Must be billed with test administration services.  
May be billed on the same or different days as test administration and scoring services. |        |

**Test Administration Procedure Code Option**

| 96136 | NEW – Effective 1/1/2019  
Test administration and scoring, by a psychologist or neuropsychologist; first 30 minutes | Use for test administration and scoring, may be used in addition to 96130/96131 or 96132/96133 |        |

| AND 96137 | Code 96137 used for each additional 30-minute increment of test administration or scoring. | |        |

**Procedure Code Option for Developmental (adaptive) Evaluations:**

| 96111 (Adaptive Behavior) | Developmental evaluation; may be provided under 96130/96131 or 96132/96133 instead  
Use for eligibility or ongoing case planning to determine if an individual is a person with a development disability which is attributed to an intellectual disability, autism, cerebral palsy or other neurological condition that may be characterized by a concurrent adaptive behavior deficit. | Use of 96111 for Developmental Disability (DD) clients.  
Current test results for both cognitive and adaptive evaluations are needed for diagnosis of intellectual and/or developmental disability. If billed separate from 96130/96131 or 96132/96133, testing time must be billed using 96113  
96130 may be requested by same provider, same date of service solely when an intellectual disability determination is | Allowable rate¹ |

<p>| AND 96112 | Developmental test administration (including assessment of fine and/or gross motor, language, | |        |</p>
<table>
<thead>
<tr>
<th>Procedural code</th>
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<tr>
<td>AND 96113</td>
<td>cognitive level, social, memory, and/or executive functions by standardized developmental instruments) by psychologist or neuropsychologist; first hour. Each additional 30 minutes; list separately to primary procedure code 96111</td>
<td>needed, and adaptive testing is billed separately. <strong>ALERT:</strong> When completing the 0729 claims form, include both 96130 and 96111 for I/DD evaluations if provider will bill separately</td>
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<tr>
<td>96146</td>
<td>NEW – Effective 1/1/2019 Automated psychological or neuropsychological instrument administered via electronic platform (e.g. computer) which includes automated results. Allowable once per session; may not be duplicated if two or more electronic tests are administered in the same session. Use for: computerized testing that is not completed as part of an evaluation</td>
<td>Allowable rate¹</td>
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**Psychological Procedure Code Optional codes: when service is not provided/billed under psychological or neuropsychological testing and services**

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<tr>
<th>Procedural code</th>
<th>Description</th>
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<tr>
<td>90889</td>
<td>Preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers. Use for requesting a written report of 90791 or 90792 when requested for completing a psychiatric diagnostic interview examination (see notes under 90791/90792). Use for eligibility determination or ongoing case planning.</td>
<td>The written report must be in accordance with the recommended outline included in DMAP form 729A, Comprehensive Psychiatric or Psychological Evaluation. <strong>ALERT</strong> Do not authorize 90889 if either 96111 or 96130 is requested in conjunction with 90791/90792. National Correct Coding Initiative (NCCI) edit will deny 90889 as a component procedure to 90791/90792, and not separately reimbursable when 90889 and</td>
<td>Allowable rate¹</td>
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<tr>
<td>Procedural code</td>
<td>Description</td>
<td>Restrictions and instructions</td>
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| **90791 or 90792**<br>(Effective 1/1/2013) | **90791**: Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.  
**90792**: Is as described above for 90791 and includes medical services. Use when a medical assessment is required, including other physical examination elements as indicted and recommendations. **Is restricted to use by a physician.**  
**Use for**: Use for initial or ongoing eligibility for client with mental health condition. Use for ongoing case planning, if appropriate.  
**OR**  
**ONLY** for Child Welfare, OYA and DD services clients may be used to request a psychosocial evaluation including assessment of history and degree of offending behavior, cognitive distortions, empathy, hostility, compulsivity and impulsivity.  
Reimbursement includes up to 1 hour of medical record review. Refer to 90885 for medical review beyond 1 hour.  
Cannot be reported on the same day as an evaluation and management service (e.g. a 99201-99215) performed by the same individual.  
The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. **These services should be reported with add-on code 90785 used in conjunction with 90791, 90792.**  
When requesting 90791/90792 for a psychiatric diagnostic interview examination, **90889** *(narrative report)* must be billed on a different date of service in accordance with the recommended outline included in DMAP form 729A, Comprehensive Psychiatric or Psychological Evaluation.  
**OR**  
**ONLY** for Child Welfare, OYA and DD services clients, when requesting 90791/90792 for a psychosocial evaluation, also request **99080** for a Mental | Allowable rate¹ |
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<th>Amount</th>
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<td>Residual Function Capacity Report (DMAP 729F) and/or Rating of Impairment Severity Report (DMAP 729G).</td>
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<td><strong>Alert</strong></td>
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<td>• National Correct Coding Initiative (NCCI) edit will deny 90889 as a component procedure to 90791/90792, and not separately reimbursable when 90889 and 90791/90792 are billed by the same provider, on the same date of service.”</td>
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<tr>
<td>90785</td>
<td>Interactive Complexity (List separately in addition to the code for primary procedure 90791, 90792)</td>
<td>Use for: Can be used when specific communication factors are present that complicate the delivery of a psychiatric procedure (90791, 90792). Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.</td>
<td>Allowable rate¹</td>
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<tr>
<td>90885</td>
<td>Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, each 30-minute increment.</td>
<td>When requested with 90791 or 90792, this code can be used for time spent reviewing client medical records beyond the 1 hour included in 90791 or 90792, and not to exceed 3 hours.</td>
<td>Allowable rate¹</td>
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<tr>
<td>Procedural code</td>
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<td>and perceptual abnormalities. Not to be used for clients with a sole primary physical health condition.</td>
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**Service Coordination and Case Planning Commonly Used Procedure Codes**

**Medical authorizations – can be used by physicians (34) [and as applicable, psychologists (53)]**

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<thead>
<tr>
<th>Procedural code</th>
<th>Description</th>
<th>Restrictions and instructions</th>
<th>Amount</th>
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</table>
| **99201 (new patient)** | Office or other outpatient visit for the evaluation and management of a **new** patient, which requires these 3 key components:  
- A **problem focused** history;  
- A **problem focused** examination;  
- **Straightforward** medical decision making  
Counseling and/or coordinated care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) are **self limited or minor**. Physicians typically spend **10** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior.  
(DD would most likely not use) | Allowable rate¹ |
| **99202 (new patient)** | Differs from 99201 by the following:  
(1) An **expanded** problem focused history and examination;  
(2) Presenting problem(s) are of **low to moderate severity**, and  
(3) Physicians typically spend **20** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior.  
(DD would most likely not use) | Allowable rate¹ |
| **99203 (new patient)** | Differs from 99201-99202 by the following:  
(1) A **detailed** history and examination;  
(2) Medical decision making of **low complexity**. | DD will still need to determine whether there are significant impairments with adaptive behavior. | Allowable rate¹ |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Complexity</th>
<th>Severity</th>
<th>Time</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>New patient visit</td>
<td>Moderate complexity</td>
<td>Moderate severity</td>
<td>30 minutes</td>
<td>Physician will determine significant impairments with adaptive behavior.</td>
</tr>
<tr>
<td>99205</td>
<td>New patient visit</td>
<td>High complexity</td>
<td>Moderate to high severity</td>
<td>45 minutes</td>
<td>Physician will determine significant impairments with adaptive behavior.</td>
</tr>
<tr>
<td>99211</td>
<td>Established patient visit</td>
<td></td>
<td>Self limited</td>
<td>10 minutes</td>
<td>Physician will determine significant impairments with adaptive behavior.</td>
</tr>
<tr>
<td>99212</td>
<td>Established patient visit</td>
<td></td>
<td>Self limited</td>
<td>10 minutes</td>
<td>Physician will determine significant impairments with adaptive behavior.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Example</td>
<td>Allowable Rate</td>
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<td>99213</td>
<td>(established patient) Differs from 99212 by the following:</td>
<td>- An expanded problem focused history and examination;</td>
<td>Allowable rate¹</td>
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<td>(2) Medical decision making of low complexity,</td>
<td>(3) Presenting problem(s) are of low to moderate severity,</td>
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<td>(4) Physicians typically spend 15 minutes face-to-face with the patient and/or family.</td>
<td>DD will still need to determine whether there are significant impairments with adaptive behavior.</td>
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<tr>
<td>99214</td>
<td>(established patient) Differs from 99212-99213 by the following:</td>
<td>- A detailed history and examination;</td>
<td>Allowable rate¹</td>
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<td></td>
<td>(2) Medical decision making of moderate complexity,</td>
<td>(3) Presenting problem(s) are of moderate to high severity,</td>
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<td>(4) Physicians typically spend 25 minutes face-to-face with the patient and/or family.</td>
<td>DD will still need to determine whether there are significant impairments with adaptive behavior.</td>
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<tr>
<td>99215</td>
<td>(established patient) Differs from 99212-99214 by the following:</td>
<td>- A comprehensive history and examination;</td>
<td>Allowable rate¹</td>
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<tr>
<td></td>
<td>(2) Medical decision making of high complexity,</td>
<td>(3) Presenting problem(s) are of moderate to high severity,</td>
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<td></td>
<td>(4) Physicians typically spend 40 minutes face-to-face with the patient and/or family.</td>
<td>DD will still need to determine whether there are significant impairments with adaptive behavior.</td>
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Frequently asked questions

Q: Can I retract an admin exam request if I find out I don’t need one?
A: Yes, however if you have already sent the 729 to the provider you will also need to contact Provider Services to let them know you have cancelled the request.

Q: What do I do if the evaluator is taking too long to get a report back to me? Is there a timeline for when the evaluator must get me a report?
A: Contact the evaluator in writing (email or fax) to relay the report is expected (usually in your provider packet) within approx. 15 days from the date of the evaluation; follow up with the provider around day 20 if report isn’t received; follow up in another 10 days in writing and by phone. If the report has not been received within 30 days of the evaluation, identify if there is good cause for a delay (additional testing, interviews, leave of absence, etc.) and if none, relay the report must be received within a week. If a report continues to be delayed with no good cause, contact the D&E Coordinator to consult on next steps.

Q: What do I do if a psychologist recommends that a neuropsych perform an additional exam? Can I submit a request for payment for both evaluators?
A: The ES should identify if a neuro-psychological evaluation is needed prior to ordering an admin exam, and schedule with a Neuro-Psychologist initially. Individuals who have had an insult to the brain prior to age 22, such as a hemorrhage (stroke), brain injury, tumor, etc., should always have neuropsychological testing completed to identify if a NeuroDevelopmental Disorder due to that condition exists. If co-occurring conditions exist obtaining the clinical opinion on if the NeuroDevelopmental Disorder is primary to adaptive behavior functioning obtained through a neuropsychological evaluation is best practice. If unknown conditions are identified and a referral is made for Neuropsych testing then in most cases that should be obtained before a determination is made.

Q: Does the ES have to schedule the appointment and send a notice? Is verbal or email notification okay? What if we have a good system in place with a psychologist, and address issues individually?
A: Written notification should be provided to the individual and/or their representative. If you have a specific process already in place with a psychologist, and there is no delay for individuals getting appointments scheduled and attending those processes are fine. OAR 411-320-0080(1)
indicates the department will assist the individual in obtaining a completed application; the expectation is that if an individual or their representative have limitations the CDDP should be assisting in scheduling an appointment, providing advanced written notification of the appointment and assuring transportation is not a barrier to attending the appointment required for eligibility determination purposes.

Q: Can a provider bill for a service and not see the patient?  
A: The American Psychological Association advises against this; it is possible a service may not be billable if a patient was not seen by the psychologist.

Q: Do psychologist need to bill by the end of December for all evaluations that were administered in 2018?  
A: OHA and MMIS will allow for billing and payment for services provided prior to 1/1/2019 after 1/1/2019 as long as the date of service is clearly before 1/1 and the procedure codes are the 2018 codes.

Q: A psychologist must administer 2 or more tests in order to bill for 96136/96137. Since an adaptive assessment is coded separately, does it count as the 2nd test?  
A: The provider can/should bill for the adaptive assessment as the 2nd test; this will require them to administer a first test, such as an intelligence assessment, or Autism assessment, etc.

Q: Can we use this process for psycho-sexual evaluations for case planning?  
A: Common practice is to order these forensic style evaluations following submitting a general fund exception request.
Definitions
CDDP; CMS; Completed Application; Developmental Disability; Intellectual Disability; Eligibility Specialist; History;

References
APD-AR-18-065
AR11053
OHA Provider Enrollment
Non-Emergent Transportation Brokerages for Oregon Health Plan members

Applicable forms
OHA 0729

Relevant Oregon Administrative Rules
Application & Eligibility
OAR 411-320-0020. Definitions related to eligibility
OAR 461-120-0010. DHS residency rule
OAR 411-320-0080. Application & Eligibility

CDDP responsibilities
OAR 411-320-0080(10). CDDP eligibility determination.

Contacts
Name: Mike Harmon; Phone: ; Email: michael.a.harmon@state.or.us
Name: Becky Smallwood; Phone: 503-957-9016; Email: rebecca.smallwood@state.or.us
**Administrative Medical Examination/Report Authorization (Medical Records Request)**

Dr. Psychologist  
His street  
His town, Oregon  

Date of request:  
Provider number:

**DHS/OHA/OYA STAFF: Please complete all fields.**

This form is used by the local Department of Human Services (DHS), Oregon Health Authority (OHA) or Oregon Youth Authority (OYA) branch to request consultative evaluations, reports and/or records from providers who:

- Are enrolled as an Oregon Health Plan (OHP) provider with a current Admin Exam provider contract;  
- Have met the provider qualifications of the requesting DHS/OHA/OYA program; and  
- Have a current contract with the requesting DHS/OHA/OYA office to complete Admin Exam requests.

For current authorized fees, please refer to the Administrative Exams section of the MAP Worker Guide. Additionally, Developmental Disabilities staff should refer to the Developmental Disabilities Worker Guide.

**PROVIDER: Please help us by completing the following report(s) for the patient listed above.**

All reports must be written and must contain a diagnosis, prognosis, and supporting objective findings. Functional impairments (changes in physical/mental functioning as a result of illness, injury, medication or surgery) and expected duration should also be included. **Please retain a copy of this form and the completed report(s) for 7 years.**

- Comprehensive Psychiatric or Psychological Evaluation — OHP 729A  
- Report on Eye Examination — OHP 729C  
- Medical Record Checklist — OHP 729D  
- Mental Residual Function Capacity Report — OHP 729F  
- Physical Residual Function Capacity Report — OHP 729E  
- Rating of Impairment Severity Report — OHP 729G  
- Copies of medical records for dates of service  

Please return completed reports and a copy of this form within 15 days to the office listed below. When possible, please submit HIPAA-compliant electronic records via secure email to the email address listed below.

**You may bill OHP using the codes(s) listed below.** The fee authorized for each code is also listed.

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Description of service</th>
<th>Authorized fee</th>
<th>Procedure code</th>
<th>Description of service</th>
<th>Authorized fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Psychological evaluation services, 1st hr</td>
<td>96130</td>
<td>6.</td>
<td>Developmental testing/Adaptive, 1st hr</td>
<td>96112</td>
</tr>
<tr>
<td>2.</td>
<td>Psychological evaluation services, 1hr 31 mins</td>
<td>96131</td>
<td>7.</td>
<td>Developmental testing/Adaptive, ea. adtl 30 mins</td>
<td>96113</td>
</tr>
<tr>
<td>3.</td>
<td>Test administration &amp; scoring, 1st 30 mins</td>
<td>96136</td>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Test administration &amp; scoring, Adtl 30 min increments</td>
<td>96137</td>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Developmental evaluation, 1st hr</td>
<td>96111</td>
<td>10.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When billing OHP:

- **Use diagnosis code V68.89** (for dates of service on or before 9/30/2015) or Z02.89 (for dates on or after 10/1/2015). Relay this code to Medicaid-enrolled ancillary providers if additional Division-covered outpatient diagnostic services (e.g., lab, X-ray, special studies) are needed.
- **Use the Provider Web Portal** at [https://www.or-medicaid.gov](https://www.or-medicaid.gov), or current, commercially available paper forms.
- **For paper claims:** Mail the CMS-1500 or UB-04 claim form to OHP, PO Box 14955, Salem OR 97309.