# DD Procedural Codes for Administrative Examinations

**To be used solely by DD staff**

Updated -1/1/2014

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## Overview

An Administrative Examination is an evaluation required by the Department of Human Services (DHS) to help determine eligibility and case planning. An examination can only be requested by the individual's DHS service coordinator or eligibility specialist.

The evaluation you receive from the medical professional must be written and must contain a diagnosis, prognosis and supporting objective findings. Functional impairments and expected duration should also be included.

An Administrative Medical Report is a request for copies of existing records from a specified date. Progress notes, laboratory tests, X-ray reports, special test results and copies of other pertinent records should be included.

Oregon Administrative Rule (OAR) 410 Division 150 govern the Administrative Examination Services Program, rules are posted at http://www.dhs.state.or.us/policy/healthplan/guides/adminexam/main.html .

DMAP will only reimburse those provider types noted in the Tables contained in this worker guide who have the Administrative Examination provider contract.

## Important Coding

Refer to AR 11053 for instructions about verifying appropriate coding or request a individual's case to be coded for the Admin Exam.

## Medical documentation

Medical documentation is needed to:

- Determine disability, incapacity, or unemployability.
- Aid in casework planning by the DHS service coordinator or eligibility specialist and to determine appropriate services.

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

## Selecting the appropriate examination

- Decide if you are ordering the Admin Exam in order to make an initial eligibility determination or if you're doing ongoing case planning. (i.e., You as a worker need the information. DO NOT order an exam because a medical provider asks for it.)
- Look for proper codes to use for "initial" determinations and those used in "ongoing" cases.
- Using the code table, match the type of health problem with the appropriate examination procedure code. Find the proper examination or report and the appropriate type of provider that can be paid for that service.
    - If the individual is currently being treated or has been treated within the last 12 months for the stated complaint, obtain copies of office records, or
    - If the individual has been hospitalized, obtain copies of admission and discharge records.

## Selecting a provider

- Obtain the name of the individual's current medical provider.
- If this provider is 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).
- Determine if the chosen provider is enrolled with DMAP (Medicaid)
- Order services only from authorized providers using the procedural codes.
- Do not use an out-of-state provider unless they have a DMAP provider number. It is recommended that you staff these providers with the Diagnosis and Evaluation Coordinators (D&E Coordinators).

## Scheduling appointments

The eligibility specialist or service coordinator schedules the evaluation with the provider.

## Completion of DMAP 729 forms

- The DMAP 729 forms are a series of seven forms (links appear at the end of this guide) used to order medical procedures. For DD eligibility determination cases, only the main DMAP 729 form is needed.
- Instructions to complete the DMAP 729 are on the back of each form.
- Send appropriate DMAP 729(s) and a release of information to the provider (release if necessary).
- The DMAP 729 is the authorization for payment.

## Processing the provider's report

- Determine if the report is what you requested.
- If the report is inadequate, request more information from the provider, but do NOT authorize additional payment or order a new Admin Exam.
- When submitting claim forms, providers can submit the paper CMS-1500 claim form, the 837P electronic transaction or use the provider web portal.

| Procedural code | Description | Restrictions and instructions | Amount |
|---|---|---|---|
| **Medical records** | | | |
| **S9981** | Medical records copying fee, administrative.<br><br>Use for initial and ongoing eligibility when client has been (1) in the hospital or (2) has had a history and physical in the last 60 days. | 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." | $19.30 |
| | | | |
| **Psychological evaluations – to be completed by licensed psychologists (53)** | | | |
| **96101**<br>(IQ testing) | Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.<br><br><u>Use for</u> initial or ongoing eligibility to determine intellectual disability or ability to grasp facts and figures.<br><br><u>Use for</u> ongoing case planning, if appropriate. | ***<u>ALERT:</u>***<br>• When 96101 and 96111 are billed same date of service, a National Correct Coding Initiative (NCCI) edit will deny one service as similar services, and not separately reimbursable.<br><br>• When completing the 0729 claims form, you must include direction (or instruction) to provider that if both 96101 and 96111 provided on the same date of service, provider must include modifier 59 on CPT 96101 on the billing claim form* to ensure reimbursement" | $53.98 per unit<br><br>Max= 6 units<br><br>(If provider requests additional hours, <u>must</u> consult with D&E Coordinator for approval, prior to authorization of additional hours) |
| **96111** | Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive | **Use of 96111 is restricted for Developmental Disability (DD)** | $104.05 |

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| (Adaptive Behavior) | functioning by standardized developmental instruments (with interpretation and report).<br><br><u>Use for</u> 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. | **clients.**<br>Current test results for both 96101 (cognitive) and 96111 (adaptive) are needed for diagnosis of intellectual disability. One or the other may have been completed by school, psychiatric hospital, or other provider of residential services. Request records.<br><br>Therefore, 96101 may be requested by same provider, same date of service solely when an intellectual disability determination is needed, and only when approved by the worker's supervisor or program policies.<br><br>***<u>ALERT:</u>***<br>• When 96101 and 96111 are billed same date of service, a National Correct Coding Initiative (NCCI) edit will deny one service as similar services, and not separately reimbursable.<br><br>• When completing the 0729 claims form, you must include direction (or instruction) to provider that if both 96101 and 96111 provided on the same date of service, provider must include modifier 59 on CPT 96101 on the billing claim form* to ensure reimbursement"<br><br>  • 96118 will deny due to NCCI edit when billed same day as 96111<br><br>*Providers can in fact submit either the paper CMS-1500 claim form, the 837P electronic transaction or use the provider web portal. | Max = 1 unit<br><br>(effective May 1 2012, max unit is revised to ensure compliance with 2005 CPT guideline revisions which removed hourly increments.) |

| Procedural code | Description | Restrictions and instructions | Amount |
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| **96118** (Neuropsych testing) | Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test, per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.<br><br>Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients. | If required, can be requested in combination with 90791 or 90792, and 90889, psychiatric diagnostic interview examination.<br><br>(Cannot be requested in combination with 90791 or 90792, and 8, psychosocial evaluation.)<br><br>ALERT:<br>• 96118 will deny due to NCCI edit when billed same day as 96111. If you are requesting 96118 AND 96111 you should instruct the provider to complete 96118 on a separate date of service. | $53.98 per unit<br><br>Max= 3 units |
| **90801** | **DELETED** – See 90791/90792 | | |
| **90791 or 90792 (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.<br><br>**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.**<br><br>Use for: Use for initial or ongoing eligibility for client with mental health condition. Use for ongoing case planning, if appropriate. | Reimbursement includes up to 1 hour of medical record review. Refer to 90885 for medical review beyond 1 hour.<br><br>Cannot be reported on the same day as an evaluation and management service (e.g. a 99201-99215) performed by the same individual.<br><br>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.*<br><br>When requesting 90791/90792 for a | $222.60<br><br>Max = 1 unit |

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| | **OR**<br><br>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. | 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.<br><br>**OR**<br><br>ONLY for Child Welfare, OYA and DD services clients, when requesting 90791/90792 for a psychosocial evaluation, also request **99080** for a Mental Residual Function Capacity Report (DMAP 729F) and/or Rating of Impairment Severity Report (DMAP 729G).<br><br>***ALERT***<br><br>• 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." | |
| **90785** | Interactive Complexity (List separately in addition to the code for primary procedure 90791, 90792)<br><br>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 | 90785 is an add-on code for interactive complexity to be reported in conjunction solely with 90791 or 90792.<br><br>Refer to CPT guidebook for complete guidelines for use. | DMAP rate<br><br>Max = 1 unit |

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| | 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. | | |
| **90885** **Effective 1/1/2014** | Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, **each 30 minutes**<br><br>Use for clients with a presumed severe psychiatric disorder. Psychiatric disorders are mental disorders including various affective, behavioral, cognitive and perceptual abnormalities. Not to be used for clients with a sole primary physical health condition. | 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. | $34.72 per unit<br><br>Max = 6 units at 30 minutes per unit |
| **Additional codes to be used with psychological evaluations by licensed psychologists (53)** | | | |
| **90889** (report preparation). | 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.<br><br>Use for requesting a written report of 90791 or 90792 when requested for completing a psychiatric diagnostic interview examination (see notes under 90791/90792)<br><br>Use for eligibility determination or ongoing case planning. | The written report must be in accordance with the recommended outline included in DMAP form 729A, Comprehensive Psychiatric or Psychological Evaluation.<br><br>***ALERT***<br><br>• Do not authorize if either 96111 or 96101 is requested in conjunction with 90791/90792.<br>• 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. | $53.61 per unit.<br><br>Max= 1 unit |
| **Medical authorizations – can be used by physicians (34) [and as applicable, psychologists (53)]** | | | |

| Procedural code | Description | Restrictions and instructions | Amount |
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| **99201** (new patient) | Office or other outpatient visit for the evaluation and management of a **new** patient, which requires these 3 key components:<br>• A **problem focused** history;<br>• A **problem focused** examination;<br>• **Straightforward** medical decision making<br>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.<br>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.<br><br>(DD would most likely not use) | $[3] |
| **99202** (new patient) | Differs from 99201 by the following:<br>(1) An **expanded** problem focused history and examination;<br>(2) Presenting problem(s) are of **low to moderate severity**, and<br>(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.<br><br>(DD would most likely not use) | $[3] |
| **99203** (new patient) | Differs from 99201-99202 by the following:<br>(1) An **detailed** history and examination;<br>(2) Medical decision making of **low complexity**,<br>(3) Presenting problem(s) are of **moderate severity**, and<br>(4) Physicians typically spend **30** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior.<br><br>(DD may use) | $[3] |
| **99204** (new patient) | Differs from 99201-99203 by the following:<br>(1) A **comprehensive** history and examination;<br>(2) Medical decision making of **moderate complexity**<br>(3) Presenting problem(s) are of **moderate to high severity**, and<br>(4) Physicians typically spend **45** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior.<br><br>(DD may use) | $[3] |

| Procedural code | Description | Restrictions and instructions | Amount |
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| **99205** (new patient) | Differs from 99201-99204 by the following:<br>(1) A **comprehensive** history and examination;<br>(2) Medical decision making of **high complexity**<br>(3) Presenting problem(s) are of **moderate to high severity**, and<br>(4) Physicians typically spend **60** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior.<br><br>(DD may use) | $[3] |
| **99211** (established patient) | Office or other outpatient visit for the evaluation and management of an **established** patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | DD will still need to determine whether there are significant impairments with adaptive behavior. | $[3] |
| **99212** (established patient) | Office or other outpatient visit for the evaluation and management of a **established** patient, which requires at least 2 of these 3 key components:<br>• A **problem focused** history;<br>• A **problem focused** examination;<br>• **Straightforward** medical decision making<br>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.<br>Usually the presenting problem(s) are **self limited** DD will still need to determine whether there are significant impairments with adaptive behavior.**or minor**. Physicians typically spend **10** minutes face-DD will still need to determine whether there are significant impairments with adaptive behavior.to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior. | $[3] |
| **99213** (established patient) | Differs from 99212 by the following:<br>(1) An **expanded** problem focused history and examination;<br>(2) Medical decision making of **low complexity**,<br>(3) Presenting problem(s) are of **low to moderate severity**, and<br>(4) Physicians typically spend **15** minutes face-to- | DD will still need to determine whether there are significant impairments with adaptive behavior. | $[3] |

| Procedural code | Description | Restrictions and instructions | Amount |
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| | face with the patient and/or family. | | |
| **99214** (established patient) | Differs from 99212-99213 by the following:<br>(1) An **detailed** history and examination;<br>(2) Medical decision making of **moderate complexity**,<br>(3) Presenting problem(s) are of **moderate to high severity**, and<br>(4) Physicians typically spend **25** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior. | $[3] |
| **99215** (established patient) | Differs from 99212-99214 by the following:<br>(1) An **comprehensive** history and examination;<br>(2) Medical decision making of **high complexity**,<br>(3) Presenting problem(s) are of **moderate to high severity**, and<br>(4) Physicians typically spend **40** minutes face-to-face with the patient and/or family. | DD will still need to determine whether there are significant impairments with adaptive behavior. | $[3] |

[2]Policy I-D.6.2, http://www.dhs.state.or.us/policy/childwelfare/manual_1/i-d62.pdf

[3]Maximum allowable rates are in accordance with the Division of Medical Assistance Programs (Division) physician fee schedule. Please refer to the fee schedule in effect for the date the service will be requested, at: http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml#fee_schedule

To note, there may be two rates for a 99xxx Evaluation and Management CPT code; the higher rate coded with a "P." The maximum allowable under the Administrative Examination Services Program will be the lower of the two rates.

[4]Effective January 1, 2011, the Division of Medical Assistance Programs (DMAP) no longer honors Evaluation and Management (E/M) codes 99241-99255 [under the OHP benefit packages (e.g. BMM, BMD, BMH, KIT)] and does not reimburse when these codes are used to bill for consultations. See announcement at: http://www.dhs.state.or.us/policy/healthplan/guides/adminexam/table2.pdf Providers were directed to bill consultations using appropriate E/M codes, depending on location of service: Office setting: 99201-99215