Topic:	Administrative Examination Procedure Code Guide	
	Date Issued/Updated:	Revised March 2019

Contents

Overview 1
Timelines 2
Procedures 2
Frequently asked questions 11
References 13
Applicable forms 13
Relevant Oregon Administrative Rules 13
Contacts 13

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 Enrollment9, 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), CDDP staff assisting ES's to complete administrative tasks to determine program eligibility, *and* Case Managers (CM) 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 case manager or ES. Progress notes, laboratory tests, imaging reports, special test results and copies of other pertinent records or evaluations are documents which may be obtained with a 729, and provide justification for an exam.

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 case manager 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. A rationale for ordering an Admin Exam must be documented in progress notes. 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 assessment, specific cognitive or adaptive measures, identify that in progress notes and in the provider referral. A provider packet, including relevant records, history, other testing, the 0729 form and your questions of interest must 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 36 months for related complaints, obtain copies of 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.
    - All reasonable attempts must be made to obtain documentation of any developmental history in school, medical and/or mental health records and to identify what is missing in existing records and necessary for your purpose.

Selecting the appropriate provider

- Providers who have training, education and experience in intellectual and developmental disabilities should be utilized.
- Obtain releases and records from the individual's current medical provider(s), and copies of records and review prior to scheduling an evaluation and identify if existing records or treating providers information is sufficient for eligibility or case planning.
- If treating providers information does not meet the need, or if it is a provider type who cannot be paid, refer to a specialized 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 provider has a current OHA provider number, type 53, prior to scheduling an evaluation.
- Order services only from authorized providers using procedure codes listed.
- 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 is responsible for scheduling the evaluation with the provider and the individual or their representative. 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 forms used to order testing or obtain copies of records from Medicaid providers for determining eligibility or case planning; the OHP 729 form is required, and the 729a may be used.
- Instructions to complete the OHP 729 are imbedded in the form and below.
- Send appropriate OHP 729(s) and a release of information (if necessary, to re-disclose authorized records for review) to the provider.

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 the prior-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 – Provider Type 53

Procedural code	Description	Restrictions and instructions	Amount
Medical records ordering/billing			
S9981	Medical records copying fee, administrative. **Max 1 unit**	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			
90785	**Interactive Complexity –** Used for common complex factors exist: difficult communication with family, young verbally undeveloped or impaired patient, third parties such as parents, guardians, case workers, or when interpreters, language translators, agencies, court officers, or schools are involved in care.	***Add-on code:*** to be used solely with 90791 or 90792. Refer to CPT guidebook for complete guidelines on use.	$10.59
90791	**Psychiatric diagnostic evaluation –** integrated biopsychosocial assessment, including history, mental status, and recommendations. May include communication with family or other sources and review/ordering of diagnostic studies. **Max unit 1.**	***Includes:*** 1 hour of medical record review. May be used with 96130/96131 For Child Welfare, OYA and DD; eligibility and case planning.	$222.60
90792	**Medical evaluation –** Used by a physician when physical examination elements are required.	Includes 1 hour of medical record review. Request 99080 for completion of Rating of Impairment Severity Report (OHP 729g). For Child Welfare, OYA and DD; eligibility and case planning	$222.60
90880	**Special Reports –** more than the standard reporting form, such as insurance forms.	Do not request with 90889. Max units 2. Use for 729E – G series. DD use with 90791	$33.45

Procedural code	Description	Restrictions and instructions	Amount
90885	**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.** 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.**	$35.34
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.** **Use for requesting a written report when only 90791 or 90792 are requested for completing a psychiatric diagnostic interview examination (see notes under 90791/90792)** **Use for eligibility determination or ongoing case planning.**	Use for requesting a written report of 90791 or 90792 when requested for completing a psychiatric diagnostic interview examination (see notes under 90791/90792) Do not use if 96130/131, or 96132/133 are authorized; report prep is included in those codes. Use for eligibility determination or ongoing case planning.	$53.61
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. Max 1 unit** **Each additional hour,** beginning at 1 hour, 31 minutes. (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), **Max 7 units**	***ALERT:*** • **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.	$105.00

Procedural code	Description	Restrictions and instructions	Amount
96132 (Neuropsych testing, first hour **AND** **96133** (Neuropsych testing, each additional 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 administering tests to the patient and time interpreting these test results and preparing the report. Max 1 unit. • Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients. Additional time **after 1st hour. Max 7 units**	***ALERT:*** • First hour only Cannot be requested in combination with 96130 or 96131 • **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.	$119.61
Test Administration Procedure Codes			
96136 **AND** **96137**	**NEW** – Effective 1/1/2019 Test administration and scoring, by a psychologist or neuropsychologist; **first 30 minutes** Code 96137 used for each additional 30-minute increment of test administration or scoring.	Use for test administration and scoring, when more than one test is administered. May be used in addition to 96130/96131 or 96132/96133	$56.73
Procedure Code for Developmental (adaptive) Evaluations:			
96112 (adaptive behavior) **AND** **96113**	**Developmental testing**; Including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments) by psychologist or neuropsychologist; **first hour. Max 1 unit** **Each additional 30 minutes**; list separately to primary procedure code 96112. **Max 7 units**	**Use for DD clients:** 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 with concurrent adaptive behavior deficit. Required for diagnoses of ID/DD. Use with 96130/131 or 96132/133 for I/DD evaluations when adaptive assessments are required.	$114.52 $57.26

Service Coordination and Case Planning Commonly Used Procedure Codes

Medical authorizations – can be used by physicians (34) [and as applicable, psychologists (53)]			
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 rate[1]
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 rate[1]
99203 (new patient)	Differs from 99201-99202 by the following: (1) A **detailed** history and examination; (2) Medical decision making of **low complexity**, (3) Presenting problem(s) are of **moderate severity**, and (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. (DD may use)	Allowable rate[1]

99204 (new patient)	Differs from 99201-99203 by the following: (1) A **comprehensive** history and examination; (2) Medical decision making of **moderate complexity** (3) Presenting problem(s) are of **moderate to high severity**, and (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. (DD may use)	Allowable rate[1]
99205 (new patient)	Differs from 99201-99204 by the following: (1) A **comprehensive** history and examination; (2) Medical decision making of **high complexity** (3) Presenting problem(s) are of **moderate to high severity**, and (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. (DD may use)	Allowable rate[1]
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.	Allowable rate[1]
99212 (established patient)	Office or other outpatient visit for the evaluation and management of an **established** patient, which requires at least 2 of 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** 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.	Allowable rate[1]

99213 (established patient)	Differs from 99212 by the following: (1) An **expanded** problem focused history and examination; (2) Medical decision making of **low complexity**, (3) Presenting problem(s) are of **low to moderate severity**, and (4) Physicians typically spend **15** minutes face-to-face with the patient and/or family.	DD will still need to determine whether there are significant impairments with adaptive behavior.	Allowable rate[1]
99214 (established patient)	Differs from 99212-99213 by the following: (1) A **detailed** history and examination; (2) Medical decision making of **moderate complexity**, (3) Presenting problem(s) are of **moderate to high severity**, and (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.	Allowable rate[1]
99215 (established patient)	Differs from 99212-99214 by the following: (1) A **comprehensive** history and examination; (2) Medical decision making of **high complexity**, (3) Presenting problem(s) are of **moderate to high severity**, and (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.	Allowable rate[1]

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: If an evaluation has not been received within 30 days of the evaluation, contact the evaluator to inquire on the report status and relay the 729 indicates a 15 day timeline; follow up with the provider again if the report has not been received within another 30 days. Contact the provider again to identify if there is good cause for a delay in the report (additional testing, interviews, leave of absence, etc.) and if none, request the report to be sent within a week. If a report continues to be delayed with no good cause, contact the D&E Coordinator to consult on next steps if it is longer than 90 days from the date of the evaluation.

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 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 in this worker guide 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: This is not recommended. 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. Rare exceptions may exist and should be staffed with ODDS.

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 submitting an general fund exception request before scheduling these forensic evaluations.

Q: Can we authorize medical exam codes for eligibility evaluations?
A: No; the "service coordination" codes are to be used for case management, when the case management entity requires a physician visit as part of the case plan. If a physical evaluation is being considered for eligibility, contact the D&E Coordinator for guidance.

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

OHA Provider Services:
Phone: 800-336-6016 (complex billing Option 5, then 2)
Email: dmap.providerservices@state.or.us
Online: OHP Provider Tools
https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx

Health Systems Division
Medicaid Programs

A Release of Information is enclosed for:	
Patient's name	**Insured ID (Prime Number)**
SSN	**Date of birth**

Agency Use Only – Complete fully before routing			
Program	**Branch**	**Case Number**	**Case Name**

Administrative Medical Examination/Report Authorization (Medical Records Request)

Provider Name
Provider Address
City, State ZIP

Date of request:
Provider number:

DHS/OHA/OYA STAFF: Please complete all fields. ***For specific instructions, point at the field you need help with.***

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 From Date to To Date
☐ Other written report*:*

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.

DHS/OHA/OYA office name and address	Worker name	Worker ID
	Email address	
	Phone number	Fax number

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

Procedure code	**Description of service**	**Authorized fee**	**Procedure code**	**Description of service**	**Authorized fee**
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

When billing OHP:

- **Use diagnosis code Z02.89.** 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, 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.

Health Systems Division
Medicaid Programs

A Release of Information is enclosed for:			
Patient's name		**Insured ID (Prime Number)**	
SSN		**Date of birth**	
Agency Use Only – Complete fully before routing			
Program	**Branch**	**Case Number**	**Case Name**

Administrative Medical Examination/Report Authorization (Medical Records Request)

Date of request:
Provider number:

DHS/OHA/OYA STAFF: Please complete all fields. ***For specific instructions, point at the field you need help with.***

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 to
- ☐ Other written report:

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.

DHS/OHA/OYA office name and address	Worker name		Worker ID
	Email address		
	Phone number	Fax number	

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

Procedure code	Description of service	Authorized fee	Procedure code	Description of service	Authorized fee
1. 90785	Interactive Complexity	$ 10.59	6. 96113	Dev Eval ea ad 30mins	$ 57.26
2. 90791	Diagnostic Eval/Intvw,	$ 222.60	7.		
3. 96130	Eval Services, 1st hr	$ 105.00	8.		
4. 96131	Eval Services, ea adtl hr	$ 105.00	9.		
5. 96112	Develop.Eval, 1st hr	$ 114.52	10.		

When billing OHP:

- **Use diagnosis code Z02.89.** 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, 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.