Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 17: Mental Health Services

Effective July 1, 2018

Link: Look for possible updates and corrections to these payment policies at:

www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2018/

Table of contents

Definitions........................................................................................................................................17-2

Payment policies:
All mental health services..............................................................................................................17-3
Case management services ...........................................................................................................17-7
Individual and group insight-oriented psychotherapy ..............................................................17-8
Narcosynthesis and electroconvulsive therapy .............................................................................17-10
Neuropsychological testing ..........................................................................................................17-11
Pharmacological evaluation and management .............................................................................17-13
Mental health consultations and evaluations ...............................................................................17-14

More info:
Related topics..................................................................................................................................17-15

CPT® codes and descriptions only are © 2017 American Medical Association
Definitions

- **Bundled codes**: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.
**Payment policy: All mental health services**

- **Who the policies in this chapter apply to**

  The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

  The policies in this chapter don't apply to crime victims.

  **Links:** For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300. (Also, see Authorization and Reporting Requirements for Mental Health Specialists, below.)

  For information about mental health services’ policies for the Crime Victims’ Compensation Program, see: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/ and WAC 296-31.

- **Who can be an attending provider and who can’t**

  **Can be attending provider: Psychiatrists and psychiatric ARNPs**

  A psychiatrist or psychiatric ARNP can be a worker’s attending provider only when:

  - The insurer has accepted a psychiatric condition, *and*
  - It is the only condition being treated.

  A psychiatrist or psychiatric ARNP may certify a worker’s time loss from work if:

  - A psychiatric condition has been allowed, *and*
  - The psychiatric condition is the only condition still being treated.

  A psychiatrist may also rate mental health permanent partial disability.

  A psychiatric ARNP can’t rate permanent partial disability.
Can’t be attending provider: Psychologists

Psychologists can't be attending providers and can’t certify time loss from work or rate permanent partial disability.

Link: For more information on who can be an attending provider, see WAC 296-20-01002.

Payment rates for specific provider types

Licensed clinical psychologists and psychiatrists

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric ARNPs

Psychiatric ARNPs are paid at 100% of the values listed in L&I’s Professional Services Fee Schedule.


Social workers and other master’s level counselors

Mental health evaluation and treatment services provided by social workers and other master’s level counselors aren’t covered even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO), or
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), or
- Licensed clinical PhD or PsyD psychologist.
Psychological testing

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must:

- Interpret the testing, and
- Prepare the reports.

Services that aren’t covered

These services (CPT® billing codes) aren’t covered:

- 90845,
- 90846,
- 90849, and
- 90863

Psychologists can’t bill the E/M codes for office visits.

Treatment of chronic migraine or chronic tension-type headache with transcranial magnetic stimulation isn’t a covered benefit.

Link: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available at:

Payment limits

These services (CPT® billing codes) are bundled and aren’t payable separately:

- 90885,
- 90887, and
- 90889.

Note: See definition of Bundled in Definitions at the beginning of this chapter.
Psychiatrists and psychiatric ARNPs may only bill the E/M codes for office visits on the same day psychotherapy is provided if it’s medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized.

**Note:** The provider must submit documentation of the event and request a review before payment can be made.

**Link:** For additional information: Authorization and Reporting Requirements for Mental Health Specialists see:


This document provides guidance for mental health specialists on the following:

1. Coverage of Mental Health Conditions
   a. Conditions caused or aggravated by an industrial injury or occupational disease
   b. Pre-existing or unrelated conditions delaying recovery
   c. Services that mental health specialists provide
2. Authorization Requirements
   a. Initial evaluation and treatment
   b. Ongoing treatment
3. Reporting Requirements
   a. Diagnosis of a mental health condition
   b. Return to work considerations
   c. Identification of barriers to recovery from an industrial injury
   d. Documenting a treatment plan with special emphasis on functional recovery
   e. Assessment of functional status during treatment
4. Billing Codes
Payment policy: Case management services

Payment limits

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences, and secure e-mail) when mental health services are authorized.

Link: For more information about payment criteria and documentation requirements for these services, see the payment policy for Case management services in: Chapter 10: Evaluation and Management.
Payment policy: Individual and group insight-oriented psychotherapy

Prior authorization

Group psychotherapy

Group psychotherapy treatment is authorized on a case by case basis only. If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Requirements for billing

Individual psychotherapy services

To report individual psychotherapy:

- Don’t bill more than one unit per day, and
- Use the following timeframes for billing the psychotherapy codes:
  
  o 16-37 minutes for 90832 and 90833.
  o 38-52 minutes for 90834 and 90836.
  o 53 or more minutes for 90837 and 90838.

Note: Coverage of these services is different for psychiatrists and psychiatric ARNPs than it is for clinical psychologists (see below).

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, or
- Drug management, or
- Writing physician orders, or
- Interpreting laboratory or other medical tests.
Psychiatrists and psychiatric ARNPs may bill the following individual insight-oriented psychotherapy CPT® billing codes without an E/M service:

- 90832,
- 90834, and
- 90837.

Psychiatrists and psychiatric ARNPs may bill the following codes when performing an evaluation and management service on the same day:

- 90833,
- 90836, and
- 90838.

Psychiatrists and psychiatric ARNPs bill these codes in addition to the code for evaluation and management services.

**Clinical psychologists**

Clinical psychologists may bill only the individual insight-oriented psychotherapy codes without an E/M component 90832, 90834, and 90837. They can’t bill psychotherapy codes 90833, 90836, or 90838 in conjunction with an E/M component because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist’s license in Washington.

**Prolonged Services**

Use the appropriate prolonged services code (99354, 99355, 99356, 99357) with 90837 for psychotherapy services of 90 minutes or longer, face to face with the patient, not performed with E/M service.

**Group psychotherapy services**

If group psychotherapy is authorized and performed on the same day as individual insight-oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

**Note:** The insurer doesn’t pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.
Payment policy: Narcosynthesis and electroconvulsive therapy

- Prior authorization
  Narcosynthesis and electroconvulsive therapy require prior authorization.

- Who must perform these services to qualify for payment
  Authorized services are payable only to psychiatrists.

- Services that can be billed
  Use CPT® codes 90865 (narcosynthesis) and 90870 (electroconvulsive therapy).

Link: More information about electroconvulsive therapy is available online at:
www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/NonPharmTreatments.asp
Payment policy: Neuropsychological testing

What’s included in neuropsychological testing

Test data includes:

- The injured worker's test results,
- Raw test data,
- Records,
- Written/computer-generated reports,
- Global scores or individual's scale scores, and
- Test materials such as:
  - Test protocols,
  - Manuals,
  - Test items,
  - Scoring keys or algorithms, and
  - Any other materials considered secure by the test developer or publisher.

The term test data also refers to:

- Raw and scaled scores,
- Patient responses to test questions or stimuli, and
- Psychologists' notes and recordings concerning patient statements and behavior during an examination.

Note: The psychologist is responsible for releasing test data to the insurer.
Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

<table>
<thead>
<tr>
<th>If the CPT® code is…</th>
<th>Then it may be billed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791 or 90792</td>
<td>Once every 6 months per patient per provider.</td>
</tr>
<tr>
<td>96101 or 96102</td>
<td>Up to a combined 4 hour maximum. In addition to CPT® codes 96118 and 96119.</td>
</tr>
<tr>
<td>96118 or 96119</td>
<td>Per hour, up to a combined 12 hour maximum.</td>
</tr>
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Note: Reviewing records and/or writing/submitting a report is included in these codes and can't be billed separately.
Payment policy: Pharmacological evaluation and management

- Who must perform these services to qualify for payment

  Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

- Requirements for billing

  Services conducted on the same day

  When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP:

  - Can bill one of the add on psychotherapy codes 90833, 90836, or 90838 and
  - Can bill a separate code for E/M services (CPT® codes 99201-99215) at the same time.

  Note: Also see Requirements for billing, above (in this same payment policy) as well as Requirements for billing under the payment policy for Individual and group insight-oriented psychotherapy earlier in this chapter.

  Services not conducted on the same day

  When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.
Payment policy: Mental health consultations and evaluations

**Links:** For more information on consultations and consultation requirements, see [WAC 296-20-045](#) and [WAC 296-20-051](#).

- **Prior authorization**
  
  Prior authorization is required for all mental health care referrals. This requirement includes referrals for mental health consultations and evaluations.

- **Services that can be billed**
  
  When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the:
  
  - Psychiatric diagnostic evaluation code **90791**, or
  
  - Psychiatric diagnostic evaluation with medical services code **90792**.

  When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code **90791** (Psychiatric diagnostic evaluation).

  Telehealth psychology services are covered. For more information see link below.

  **Links:** For more information, see the payment policy for Teleconsultation and other telehealth services in: [Chapter 10 Evaluation and Management (E/M) Services](#).

- **Payment limits**
  
  CPT® codes **90791** or **90792** are limited to one occurrence every six months, per patient, per provider.
# Links: Related topics

<table>
<thead>
<tr>
<th>If you’re looking for more information about…</th>
<th>Then go here:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Becoming an L&amp;I provider</strong></td>
<td>L&amp;I’s website: <a href="http://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/">www.Lni.wa.gov/ClaimsIns/Providers/Becoming/</a></td>
</tr>
<tr>
<td><strong>Billing</strong> instructions and forms</td>
<td>Chapter 2: <a href="#">Information for All Providers</a></td>
</tr>
<tr>
<td><strong>Fee schedules</strong> for all healthcare facility services (including ASCs)</td>
<td>L&amp;I’s website: <a href="http://feeschedules.Lni.wa.gov">http://feeschedules.Lni.wa.gov</a></td>
</tr>
<tr>
<td><strong>Mental health services website</strong></td>
<td>L&amp;I’s website: <a href="http://www.Lni.wa.gov/mentalhealth">www.Lni.wa.gov/mentalhealth</a></td>
</tr>
<tr>
<td><strong>Payment policies for case management services</strong></td>
<td>Chapter 10: <a href="#">Evaluation and Management (E/M) Services</a></td>
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<tr>
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- **Need more help?** Call L&I’s Provider Hotline at **1-800-848-0811**