

Topic:	Administrative Examination Procedure Code Guide	
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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) (<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://oregon.gov/oha/HSD/OHP/Pages/Provider-enroll), oregon.gov/oha/HSD/OHP/Pages/Provider-enroll

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 CDDPs; 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

For eligibility determination purposes, due diligence in collecting records that are necessary to justify the necessity for an admin exam must occur in a timely manner.

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 requires the use of the [OHA 0729](#) form to prior-authorize 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 should be included.

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" cases/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).

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

Procedural code	Description	Restrictions and instructions	Amount
Medical records ordering/billing			
S9981	<p>Medical records copying fee, administrative.</p> <p>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.</p>	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."	Allowable rate ¹
Psychological evaluations – to be completed by licensed psychologists			
<p>96130 (IQ evaluation, first hour)</p> <p>AND</p> <p>96131 (IQ evaluation, each additional hour)</p>	<p>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.</p> <p>Each additional hour, beginning at 1 hour, 31 minutes. (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS)</p>	<p><u>ALERT:</u></p> <ul style="list-style-type: none"> • Replaces 96101, first hour only • Must be used with 96131 for each additional hour <p><u>Use for</u> initial or ongoing eligibility to determine intellectual disability or ability to grasp facts and figures.</p> <p><u>Use for</u> ongoing case planning, if appropriate.</p>	Allowable rate ¹
96132 (Neuropsych testing, first hour)	<p>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</p>	<p><u>ALERT:</u></p> <ul style="list-style-type: none"> • Replaces 96118, first hour only <p>Cannot be requested in combination with 96130 or 96131</p>	Allowable rate ¹

Procedural code	Description	Restrictions and instructions	Amount
<p>AND</p> <p>96133 (Neuropsych testing, each additional hour)</p>	<p>administering tests to the patient and time interpreting these test results and preparing the report.</p> <ul style="list-style-type: none"> Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients. 	<ul style="list-style-type: none"> Must be used with 96133 for each additional hour Must be billed with test administration services. <p>May be billed on the same or different days as test administration and scoring services.</p>	
Test Administration Procedure Code Option			
<p>96136</p> <p>AND</p> <p>96137</p>	<p>NEW – Effective 1/1/2019 Test administration and scoring, by a psychologist or neuropsychologist; first 30 minutes</p> <p>Code 96137 used for each additional 30-minute increment of test administration or scoring.</p>	<p>Use for test administration and scoring, may be used in addition to 96130/96131 or 96132/96133</p>	
Procedure Code Option for Developmental (adaptive) Evaluations:			
<p>96111 (Adaptive Behavior)</p> <p>AND</p> <p>96112</p>	<p>Developmental evaluation; may be provided under 96130/96131 or 96132/96133 instead</p> <p><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.</p> <p>Developmental test administration (including assessment of fine and/or gross motor, language,</p>	<p>Use of 96111 for Developmental Disability (DD) clients.</p> <p>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</p> <p>96130 may be requested by same provider, same date of service solely when an intellectual disability determination is</p>	<p>Allowable rate¹</p>

Procedural code	Description	Restrictions and instructions	Amount
<p>AND</p> <p>96113</p>	<p>cognitive level, social, memory, and/or executive functions by standardized developmental instruments) by psychologist or neuropsychologist; first hour.</p> <p>Each additional 30 minutes; list separately to primary procedure code 96111</p>	<p>needed, and adaptive testing is billed separately</p> <p><u>ALERT:</u></p> <ul style="list-style-type: none"> • When completing the 0729 claims form, include both 96130 and 96111 for I/DD evaluations if provider will bill separately 	
<p>96146</p>	<p>NEW – Effective 1/1/2019</p> <p>Automated psychological or neuropsychological instrument administered via electronic platform (e.g. computer) which includes automated results.</p>	<p>Allowable once per session; may not be duplicated if two or more electronic tests are administered in the same session.</p> <p>Use for: computerized testing that is not completed as part of an evaluation</p>	<p>Allowable rate¹</p>
<p>Psychological Procedure Code Optional codes: when service is not provided/billed under psychological or neuropsychological testing and services</p>			
<p>90889 (report preparation).</p>	<p>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.</p> <p><u>Use for</u> requesting a written report of 90791 or 90792 when requested for completing a psychiatric diagnostic interview examination (see notes under 90791/90792)</p> <p><u>Use for</u> eligibility determination or ongoing case planning.</p>	<p>The written report must be in accordance with the recommended outline included in DMAP form 729A, Comprehensive Psychiatric or Psychological Evaluation.</p> <p><u>ALERT</u></p> <ul style="list-style-type: none"> • 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 	<p>Allowable rate¹</p>

Procedural code	Description	Restrictions and instructions	Amount
		90791/90792 are billed by the same provider, on the same date of service.	
90791 or 90792 (Effective 1/1/2013)	<p>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.</p> <p>90792: Is as described above for 90791 and includes medical services. Use when a medical assessment is required, including other physical examination elements as indicated and recommendations. Is restricted to use by a physician.</p> <p>Use for: Use for initial or ongoing eligibility for client with mental health condition. Use for ongoing case planning, if appropriate.</p> <p>OR</p> <p>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.</p>	<p>Reimbursement includes up to 1 hour of medical record review. Refer to 90885 for medical review beyond 1 hour.</p> <p>Cannot be reported on the same day as an evaluation and management service (e.g. a 99201-99215) performed by the same individual.</p> <p>The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. <i>These services should be reported with add-on code 90785 used in conjunction with 90791, 90792.</i></p> <p>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.</p> <p>OR</p> <p>ONLY for Child Welfare, OYA and DD services clients, when requesting 90791/90792 for a psychosocial evaluation, also request 99080 for a Mental</p>	Allowable rate ¹

Procedural code	Description	Restrictions and instructions	Amount
		Residual Function Capacity Report (DMAP 729F) and/or Rating of Impairment Severity Report (DMAP 729G). <u>ALERT</u> <ul style="list-style-type: none"> 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) 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.	90785 is an add-on code for interactive complexity to be reported in conjunction solely with 90791 or 90792. Refer to CPT guidebook for complete guidelines for use.	Allowable rate ¹
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-minute increment. <u>Use for</u> clients with a presumed severe psychiatric disorder. Psychiatric disorders are mental disorders including various affective, behavioral, cognitive	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.	Allowable rate ¹

Procedural code	Description	Restrictions and instructions	Amount
	and perceptual abnormalities. Not to be used for clients with a sole primary physical health condition.		

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: <ul style="list-style-type: none"> • 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: <ol style="list-style-type: none"> (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: <ol style="list-style-type: none"> (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 rate ¹

	(3) Presenting problem(s) are of <u>moderate severity</u> , and (4) Physicians typically spend 30 minutes face-to-face with the patient and/or family.	(DD may use)	
99204 (new patient)	Differs from 99201-99203 by the following: (1) A <u>comprehensive</u> history and examination; (2) Medical decision making of <u>moderate complexity</u> (3) Presenting problem(s) are of <u>moderate to high severity</u> , 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 <u>comprehensive</u> history and examination; (2) Medical decision making of <u>high complexity</u> (3) Presenting problem(s) are of <u>moderate to high severity</u> , 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 <u>established</u> 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 <u>established</u> patient, which requires at least 2 of these 3 key components: <ul style="list-style-type: none"> • A <u>problem focused</u> history; • A <u>problem focused</u> examination; • <u>Straightforward</u> 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 <u>self limited</u> DD will still need to determine whether there are significant impairments with adaptive behavior. <u>or minor</u> . Physicians typically spend 10 minutes face-	DD will still need to determine whether there are significant impairments with adaptive behavior.	Allowable rate ¹

	DD will still need to determine whether there are significant impairments with adaptive behavior.to-face with the patient and/or family.		
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: 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 an psychologist recommends that a neuropsych do 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.

Definitions

References

New transmittal

[AR 11053](#)

[OHA Provider Enrollment](#)

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.

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