5101:3-8-05 **Psychology services provided by licensed psychologists.**

(A) Scope. This rule sets forth provisions governing payment for psychology services provided by licensed psychologists in non-institutional settings. Provisions governing payment for psychology services as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5160-2;

(2) Nursing facility services, Chapter 5160-3;

(3) Physician services, Chapter 5160-4;

(4) Clinic services rendered by the following providers:

(a) Fee-for-service ambulatory health care clinics, Chapter 5160-13;

(b) Rural health clinics, Chapter 5160-16;

(c) Federally qualified health centers, Chapter 5160-28; or

(d) Outpatient health facilities, Chapter 5160-29;

(5) Medicaid school program services, Chapter 5160-35; and

(6) Intermediate care facility services, Chapter 5123:2-7.

(B) The following definitions apply to this rule:

(1) "Psychologist" is a person who holds a valid license as a psychologist under Chapter 4732. of the Revised Code.

(2) "Independent psychologist" is a psychologist who is not subject to the administrative and professional control of an employer such as an institution, physician, or agency. A psychologist practicing in an office that is located within an entity is considered to be independent when both of the following conditions are met:

(a) The part of the entity constituting the psychologist's office is used solely for that purpose and is separately identifiable from the rest of the facility; and

(b) The psychologist maintains a private practice (i.e., offers services to the general public as well as to the customers, residents, or patients of the entity), and the practice is not owned, either in part or in total, by the entity.

(3) "General supervision" has the same meaning as in rule 5160-4-02 of the

Administrative Code.

(C) Providers.

(1) Independent psychologists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.

(2) Rendering providers. The following eligible providers may render a psychology service:

(a) A psychologist; or

(b) A doctoral-level psychology intern completing a required internship, if the following conditions are met:

(i) The service is provided under the general supervision of the psychologist responsible for the patient's care;

(ii) The psychologist responsible for the patient's care has face-to-face contact with the patient during the initial visit and not less often than once per quarter (or during each visit if visits are scheduled more than three months apart);

(iii) The psychologist responsible for the patient's care keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The psychologist responsible for the patient's care includes in the patient's medical record documentation that appropriate service was provided under general supervision, that the psychologist checked and updated the medical record at least once a week, and that all requirements for payment were met.

(3) Billing ("pay-to") providers. The following eligible providers may receive medicaid payment for submitting a claim for a psychology service on behalf of a rendering provider:

(a) An independent psychologist;

(b) A professional medical group;

(c) A hospital;

(d) A fee-for-service ambulatory health care clinic;

(e) A rural health clinic;

(f) A federally qualified health center; or

(g) An outpatient health facility.

(D) Coverage.

(1) Payment may be made for the following psychology services:

(a) Psychological and neuropsychological testing;

(b) Therapeutic services:

(i) Individual psychotherapy provided in the office, outpatient clinic, outpatient hospital, or home:

(a) Psychotherapy, 30 minutes with patient and/or family member;

(b) Psychotherapy, 45 minutes with patient and/or family member;

(c) Psychotherapy, 60 minutes with patient and/or family member; and

(d) Interactive complexity (reported separately in addition to the primary procedure);

(ii) Family or group psychotherapy for which the primary purpose is the treatment of the patient and not of family members:

(a) Family psychotherapy without patient present;

(b) Family psychotherapy with patient present;

(c) Group psychotherapy;

(d) Multiple-family group psychotherapy; and

(e) Interactive complexity (reported separately in addition to the primary procedure, only when specific communication barriers complicate the delivery of service); and

(c) Diagnostic evaluation, one unit.

(2) The following payment limitations apply to psychology services provided to an individual in a non-hospital setting:

(a) For psychological testing, a maximum of eight hours per twelve-month period;

(b) For diagnostic evaluation, one date of service per twelve-month period, not on the same date of service as a therapeutic visit; and

(c) For therapeutic visits, a maximum of twenty-four dates of service per twelve-month period if a diagnostic evaluation is performed, twenty-five if no diagnostic evaluation is performed.

(3) The following psychology-related items and services are not covered by medicaid:

(a) Services that are not medically necessary in accordance with Chapter 5160-1 of the Administrative Code;

(b) Services rendered by an by unlicensed individual, even if the services are provided under the personal supervision of a psychologist;

(c) Services rendered by licensed psychologist who lacks a current medicaid provider agreement, even if the services are provided under the personal supervision of a psychologist who has a current medicaid provider agreement;

(d) Psychology-related services listed as non-covered in rule 5160-4-29 of the Administrative Code;

(e) Services unrelated to the treatment of a specific medical complaint;

(f) Services determined by a third-party payer not to be medically necessary;

(g) Any psychology service for which payment is denied by medicare;

(h) The outpatient psychiatric exclusion from medicare payments;

(i) Self-administered or self-scored tests of cognitive function; and

(j) Biofeedback therapy.

(E) Documentation of services. The patient's file must substantiate the medical necessity of services performed. Each record should include the signature and professional discipline of the provider. The following items illustrate the types of information to be included:

(1) A description of the patient's symptoms and functional impairment;

(2) Relevant medical and psychiatric diagnoses;

(3) Evidence that the patient has sufficient cognitive capacity to benefit from treatment;

(4) A treatment plan that specifies treatment goals, tracks responses to ongoing treatment; and presents a prognosis;

(5) The type, duration, and frequency of treatment, with dates of service;

(6) Medications taken by or prescribed for the patient;

(7) The amount of time spent by the provider face-to-face with the patient;

(8) The amount of time spent by the provider in interpreting and reporting on procedures represented by Central Nervous System Testing codes;

(9) Test results, if applicable, with interpretation; and

(10) Summaries of and notes on psychotherapy sessions.

(F) Claim payment.

(1) Providers must report appropriate procedure codes and modifiers on claims.

(2) The maximum fee for a psychology service performed by a psychologist is the lesser of the provider's submitted charge or eighty-five per cent of the amount for the service specified in appendix DD to rule 5160-1-60 of the Administrative Code.

(3) A psychology service performed during a hospital stay is treated as a hospital service.

(4) Payment for a psychology service rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem. An independent psychologist who renders a psychology service to a NF resident must seek payment from the NF.

(5) A psychologist may be reported on a claim as the billing provider only if the psychologist is independent. If a psychologist is a member of a professional medical group or is employed by a hospital or clinic, then the medical group, hospital, or clinic must be reported as the billing provider.

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