TO BE RESCINDED

5101:3-8-05 **Covered psychology services and limitations.**

For dates of service from January 1, 2004 through December 31, 2007, psychology services specified in paragraphs (C) to (F) of this rule were not covered medicaid services for adults twenty-one years of age and older when services were provided by an independent psychologist and independent group psychologist practices.

Psychology services not provided by independent psychologists (for example, services provided in an outpatient hospital facility) continued to be covered medicaid services.

Effective for dates of service from January 1, 2008, psychology services for adults twenty-one years of age and older when provided by an independent psychologist and independent group psychologist practices for adults are covered services subject to the coverage and limitations as specified in this rule.

(A) Definitions:

(1) "Independent psychologist" means a psychologist licensed under Chapter 4732. of the Revised Code who provides services on his/her own, free of administrative and professional control of an employer such as an institution, physician, or agency.

(a) The psychologist treats his/her own patients and has a valid Ohio medicaid provider agreement to bill directly for his/her services. A psychologist practicing in an office located in an institution may be considered an "independently practicing psychologist" when both of the following conditions are met:

(i) The office is in a separately identifiable part of the facility which is used solely as the psychologist's office and is not viewed as extending through the entire institution; and

(ii) The psychologist has a private practice, e.g provides services to consumers outside of the institution as well as to institutionalized .consumers. The private practice is not owned, in part or in total by the institution.

(b) A psychologist seeing nursing home consumers cannot bill medicaid using his/her psychologist provider number. Services to nursing home consumers are covered through the nursing facility's cost report and described in Chapter 5101:3-3 of the Administrative Code.

(2) "Provider-based psychologist" means a psychologist employed by a provider

listed in paragraph (D) of rule 5101:3-8-01 of the Administrative Code.

(3) "Psychological tests" means tests which address personality disorders, intellectual function, behavioral or addictive disorders, or screening tests for organic brain disease.

(4) "Neuropsychological tests" means tests for consumers suffering from cognitive defects due to neurological conditions.

(5) "Direct supervision" is defined in rule 5101:3-4-02 of the Administrative Code.

(6) "Group psychotherapy" means psychological treatment involving two or more consumers participating together in the presence of one or more psychologists who facilitate interactions to effect targeted changes in the behavior of a consumer.

(B) Services must be personally provided by a licensed psychologist meeting the qualifications in section 4732.10 of the Revised Code. Services must be medically necessary for the diagnosis and treatment of an illness or injury to be a covered medicaid service. All services must be within the scope of practice for a licensed psychologist as defined in Chapter 4732. of the Revised Code. To be reimbursed for psychology services:

(1) Services must be billed under the individual psychologist's provider number only when the services are provided by an independently practicing psychologist as defined in paragraph (A) of this rule.

(2) Services must be billed by a psychology group practice only if the psychologist is employed by a group medical practice as defined in rule 5101:3-8-01 of the Administrative Code.

(3) Services must be billed under the hospital's or clinic's medicaid provider number when the psychologist is provider-based as defined in paragraph (A)(2) of this rule.

(4) Effective with services provided on and after October 1, 2003, when billing for any service, the licensed psychologist must bill the appropriate procedure code for the service rendered and modify the code by the "AH" modifier to signify that the service was personally provided by a licensed psychologist.

(5) When services are provided to inpatients in a hospital or to nursing home residents regardless of the billing arrangement, the psychologist cannot

submit a claim as an individual psychologist or as a psychology group medical practice.

(C) Covered psychological testing services:

(1) Psychological and neuropsychological testing are covered when performed to assist in establishing a psychological or neuropsychological disorder. The consumer's medical record must support the medical necessity of the tests performed.

(2) For dates of service beginning on or after January 1, 2006, the department will pay in accordance with rule 5101:3-1-60 of the Administrative Code for procedure codes 96101 through 96118 for medically necessary psychological testing services personally performed by a licensed psychologist.

(D) Covered therapeutic services:

(1) For services provided on or after July 1, 2002, the department will pay eighty-five per cent of the value listed in rule 5101:3-1-60 of the Administrative Code for each procedure code for services performed by a licensed psychologist. The following procedure codes must be billed for therapeutic services:

(a) For individual psychotherapy provided in the office, outpatient clinic, outpatient hospital, or home, bill the following codes:

(i) 90832 Psychotherapy, 30 minutes with patient and/or family member.

(ii) 90834 Psychotherapy, 45 minutes with patient and/or family member.

(iii) 90837 Psychotherapy, 60 minutes with patient and/or family member.

(iv) 90785 Interactive complexity (List separately in addition to the code for primary procedure).

(b) Family psychotherapy is covered only where the primary purpose of such counseling is the treatment of the consumer's condition, not the treatment of the family members. For family or group psychotherapy,

bill the following codes:

(i) 90846 Family psychotherapy (without consumer present).

(ii) 90847 Family psychotherapy (with consumer present).

(iii) 90849 Multiple-family group psychotherapy.

(iv) 90853 Group psychotherapy as defined in paragraph (A)(6) of this rule (other than of a multiple-family group).

(c) Interactive complexity is covered only where specific communication factors complicate the delivery of a psychotherapy service listed in (D)(1)(a)(i) to (D)(1)(a)(iii) of this rule. For interactive complexity, bill the following code:

(i) 90785 Interactive complexity (List separately in addition to the code for primary procedure).

(E) Diagnostic evaluation

(1) For dates of service on and after October 1, 2003, a diagnostic evaluation will be a covered service.

(2) To be reimbursed, bill code 90791. This code is not time-based and can be billed only as one unit of service.

(3) The department will pay eighty-five per cent of the medicaid maximum for an evaluation personally performed by a licensed psychologist.

(F) Services provided by clinical psychology doctoral level interns completing required internships.

For services provided by clinical psychology doctoral level interns completing required internships to be reimbursed to a psychologist, the following conditions must be met:

(1) The psychologist billing medicaid must have a letter on file covering the dates of services of the doctoral level internship from the doctoral level program;

(2) The graduate doctoral level intern must be under the direct supervision of the

licensed psychologist responsible for the consumer's care;

(3) The licensed psychologist responsible for the consumer's care must have face-to-face contact with the consumer during the consumer's visit and must confirm that the service provided by the doctoral level intern was appropriate; and

(4) The consumer's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the consumer's care reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the consumer's care.

(G) Non-covered psychological services:

The following psychologists' services are not covered by the Ohio medicaid program:

(1) All services listed in paragraph (F) of rule 5101:3-4-29 of the Administrative Code describing mental and emotional disorders;

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

(3) Services provided by a school psychologist in facilities regulated by the state board of education;

(4) Biofeedback therapy;

(5) Services which are not personally performed by a psychologist with whom the department has a provider agreement and who is licensed under Chapter 4732. of the Revised Code;

(a) With the exception of the provisions stated in paragraph (F) of this rule, services provided by licensed individuals with whom the department does not have an individual provider agreement are not reimbursable even though the covered services are provided under the personal supervision of licensed psychologist with whom the department does have a provider agreement.

(b) Services provided by unlicensed individuals under the personal supervision of a licensed psychologist are not reimbursable.

(6) Services provided to nursing home residents are reimbursable through the nursing facility's cost report and shall not be billed directly by the psychologist as specified in Chapter 5101:3-3 of the Administrative Code;

(7) Services provided to consumers in an inpatient or outpatient hospital setting are not covered in this rule but are covered in Chapter 5101:3-2 of the Administrative Code;

(8) Services unrelated to the treatment of a specific medical complaint or services which are not medically necessary as defined in Chapter 5101:3-1 of the Administrative Code;

(9) Services determined by another third-party payer (especially medicare Title XVIII) as not medically necessary are not covered;

(a) All psychological services denied by medicare; and

(b) The thirty-seven point five per cent outpatient psychiatric payment limitation subtracted from medicare claims.

(H) Limitations:

(1) Psychological testing is limited to a maximum of eight hours per twelve-month period per consumer in a non-hospital setting.

(2) Therapeutic visits and diagnostic interview examinations in excess of a combined twenty-five dates of service per consumer in a twelve-month period in an non-hospital setting are not covered.

(3) Diagnostic interview examinations will be limited to one per consumer per twelve month period and may not be billed on the same date of service as a therapeutic visit.

(I) Documentation:

The consumer's medical record must support the medical necessity of the tests and/or therapies performed. The records should contain the following documentation at a minimum:

(1) The date the service was provided;

(2) The type of tests and/or type of therapies performed, including test results;

(3) The face-to-face time spent with the consumer on testing or therapy;

(4) Time spent interpreting and reporting for testing codes specified in rule 5101:3-1-60 of the Administrative Code under the title "Central Nervous System (CNS) Test";

(5) A written interpretation by a psychologist of the tests and/or psychotherapy sessions should be in the consumer's record;

(6) The discipline and signature of the professional providing the service; and

(7) All documentation provisions for therapeutic services outlined in paragraph (H) of rule 5101:3-4-29 of the Administrative Code shall apply to therapeutic services provided by a psychologist with the exception that a psychologist does not need to have the treatment plan signed and dated by a physician prior to initiating therapy.

Effective: 01/01/2014

R.C. 119.032 review dates: 10/15/2013

CERTIFIED ELECTRONICALLY

Certification

12/20/2013

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5162.20, 5164.02, 5164.70
Prior Effective Dates:	07/01/2002, 08/17/2003, 01/01/2004, 12/30/2005 (Emer), 03/27/2006, 01/01/2008, 12/31/2012 (Emer), 03/28/2013