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34 Psychologists

Licensed psychologists are enrolled only for services provided to QMB recipients or to recipients under the age of 21 referred as a result of an EPSDT screening.

The policy provisions for psychologists can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

34.1 Enrollment

HP enrolls Psychology providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychology provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychology-related claims.

NOTE:
All ten digits are required when filing a claim.

Psychology providers are assigned a provider type of 54 (Psychologist). Valid specialties for psychology providers include the following:

- Psychology (112)
- QMB/EPSDT (600)

Enrollment Policy for Psychology Providers

Psychologists must meet the following requirements for participation in Medicaid:

- Possess a doctoral degree in psychology from an accredited school or department of psychology
- Have a current license issued by the Alabama Board of Psychology to practice as a psychologist
- Operate within the scope of practice as established by the Alabama Board of Psychology

Minimum Qualifications for Psychology Providers Professional Staff

Medicaid reimbursement for allied mental health professional staff working for or supervised by Medicaid enrolled psychologists may be billed as follows:

- When services are directly provided by a professional counselor licensed under Alabama law (e.g. LPC, ALC) a modifier **U6** must be appended to the appropriate procedure code.
- When services are directly provided by a marriage and family therapist (LMFT) licensed under Alabama law a modifier **U7** must be appended to the appropriate procedure code.
- When services are directly provided by a certified social worker (LCSW) licensed under Alabama law, a modifier **AJ** must be appended to the appropriate procedure code.
- When services are provided directly by an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, behavioral specialist or other human service field areas and who meets at least one of the following qualifications:

  − has successfully completed a practicum as a part of the requirements for the degree

  − has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience,

  - a modifier **HO** must be appended to the appropriate procedure code.

- When services are provided directly by a licensed psychological technician, only procedure codes 96102 or 96119 may be billed.

NOTE:

Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service description.

Psychologists who delegate work to employees take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. {Please refer to Section 34-26-61 from the **Code of Alabama Governing Psychologists**, Duties – Supervisors, for more information and guidance; excluding #8, 9, and 10 under section (a)}.

For the supervision of licensed psychological technicians please follow the guidelines as set forth in the **Code of Alabama Governing Psychologists,** Section 34-26-62 Duties – Supervisees and Section 34-26-64 Supervision requirements.

Effective with dates of service July 1, 2010 and thereafter, the guidance for allied mental health professionals working under the direction of, or supervised by, a psychologist has been modified. The psychologist does not have to be present in the office when the practitioner is providing the service; however, the psychologist must be readily accessible by phone or pager and able to return to the office if the recipient's condition requires it.

Practitioners must follow the guidelines below for services provided "incident to" the psychologist:

- The psychologist must be able to provide evidence of management of the patient's care through, at a minimum, review of the intake notes and diagnostic impression within 30 days of the initial intake. Evidence of management of care includes:

  1) signing off on the intake notes and diagnostic impression,

  2) signing off on treatment plans,

  3) at least an annual review of the allied mental health professionals' performance, and

  4) signing off on any assessment report.

- The psychologist must employ the allied mental health professional **or** the professional must be employed by the same entity that employs the psychologist.

In addition to the requirements outlined above, effective July 1, 2012, psychologists and the allied mental health professional(s) working for or with them must have an Alabama Medicaid Agency Supervision Contract on file with the Agency.

- The Supervision Contract must be completed for each allied mental health professional billing for services under a psychologist's NPI.
- A fillable or printable version of this form can be downloaded at the following link: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.9.2_Clinical_Psychologists.aspx
- Please submit the completed contract via fax at: (334) 353-2296 or via e-mail at: contracts@medicaid.alabama.gov
- Any claims submitted on or after dates of service July 1, 2012, that do not have a corresponding Supervision Contract on file will be subject to recoupment on post payment review.
- Effective with dates of service October 1, 2013 and thereafter, when submitting the Supervision Contract, please note the following:

    1. The signature dates between the psychologist and the allied mental health professional cannot exceed 7 days or the contract is considered invalid.
    2. Signed contracts (by both the psychologist and allied mental health professional) must be submitted to the Alabama Medicaid Agency within 72 hours of being signed by both parties or the contract will be considered invalid.
    3. The psychologist must sign the contract each time a contract is completed for allied mental health professional supervision; a pre-signed/copied signature page where the date is added or whited out and re-written is not acceptable.
    4. When submitting a supervision contract for non-licensed practitioners, a copy of college diploma, graduate school degree and:

        1. copies of transcripts to demonstrate clinical practicum completion

        <u>or,</u>

        2. letters of supervision from experienced, licensed mental health professional to satisfy clinical supervision requirements

        Must also be submitted or the contract will not be considered complete.

Additional Information

All areas of the contract which require additional documentation (including the selection of #14 or #15) must be completed or addressed in order for the contract to be approved.

The contract is not considered valid until received by the Alabama Medicaid Agency. Medicaid billable services by the AMHP are not allowed until a complete valid contract is on file.

For psychologists who already have a supervision contract on file for an unlicensed allied mental health professional, the above information listed in sub-bullet #4 must be submitted by close of business December 31, 2013. If the proof of the above is not received, your contract will no longer be considered valid; and, any claims submitted on or after dates of service January 1, 2014, that does not have the corresponding unlicensed allied mental health professional documentation requirements on file will be subject to recoupment on post payment review.

Supervision

Supervision is defined as the overview, monitoring and directing of the activities of another where all of the following are present: a) Immediate availability by person or phone b) Regular and periodic review of records, work and activities and c) Established procedures (protocols). Supervision is **not** consultation.

For the supervision of allied mental health professionals, please follow the guidelines as set forth below:

The supervisor is the psychologist (*the psychologist will herein be referred to as the supervisor*).

The supervisee is any of the allied mental health professionals listed under the “Minimum Qualification for Psychology Providers Professional Staff” section.

A licensee who has less than 10 years of experience shall meet individually and in person with his or her supervisor for a minimum of 2 hours a month.

A licensee who has 10 or more years of experience shall meet individually and in person with his or her supervisor for a minimum of 1 hour a month.

The supervisor, in most instances, will take full legal responsibility. This means the **supervisor**:

- Is accountable to the authorizing body for the activity (i.e. license board, Alabama Medicaid Agency).
- Has responsibility to the supervisee – providing necessary resources, including training and additional information, and, at time, the setting to do the work.
- Is accountable to the clients served in the context of the supervisory relationship. The supervisor must be easily available for emergencies, meet face to face (with the supervisee) on a regular basis (SKYPE and other telecommunications are not acceptable at this time) and have

access to records and work materials (i.e. computer, phone, fax, reference books etc).

- Has established ***written*** procedures (protocols) for usual, unforeseen or high-risk situations including planned absences such as vacation coverage, maternity leave etc.
- Will be required to document dates and times of supervision, including when record reviews are done, and basic information about the clients discussed or reviewed.

34.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for psychology providers.

Psychology services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

NOTE:

Psychology providers can bill only those procedures listed in Section 34.5.3, Procedure Codes and Modifiers. Only the diagnosis codes within the range of 290-316 are covered for treatment services under this program. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120 even if the resulting diagnosis is mental retardation.

NOTE:

Codes 90832, 90832+90785, 90834, 90834+90785, 90837, 90837+90785, 90846, 90847, 90849, and 90853 may be billed on a weekly basis; although limited to no more than 52 max units per year (combined).

***Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in the group above as per CPT guidelines.**

The Alabama Medicaid Agency will not cover the following therapies:

- Equine assisted psychotherapy
- Biofeedback therapy
- Neurobiofeedback therapy
- Sleep therapy
- Dance therapy
- Music therapy

- Art therapy

Client Intake

An intake evaluation must be performed for each client considered for initial entry into any course of covered services.

The intake evaluation process shall result in a determination of the client's need for psychological services based upon an assessment that must include relevant information from among the following areas:

- Family history
- Educational history
- Medical history
- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam
- Summary of the significant problems the client is experiencing

Treatment Planning

The intake evaluation process shall result in the development of a written treatment plan completed by the fifth client visit.

The treatment plan shall:

- Identify the clinical issues that will be the focus of treatment
- Specify those services necessary to meet the client's needs
- Include referrals as appropriate for needed services
- Identify expected outcomes toward which the client and therapist will work to have an effect on the specific clinical issues
- Be approved in writing by a psychologist licensed in the state of Alabama
- The (initial) Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the treatment plan to document the recipients participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the treatment plan.

Services must be specified in the treatment plan in order to be paid by Medicaid. Changes to the treatment plan must be approved by the psychologist licensed in the state of Alabama.

The psychologist must review the treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. This review shall be documented in the client's clinical record by

notation on the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued without change.

Treatment plan review is not a face-to-face service, therefore the recipient/ or legally responsible person signature is not required. Only the reviewing psychologist signatures (handwritten or computerized electronic {not typed} signature) or initials and dates are neccessary. A stamped signature is not acceptable.

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested shall include, at a minimum, the following:

- The identification of the specific services rendered
- The date and the amount of time (time started and time ended--- excluding time spent for interpretation of tests) that the services were rendered
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

The list of required documentation described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed.

Additional Information

To further clarify service documentation questions/issues, please note the following:

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.

- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be ***preprinted*** or predated.
- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.
- The Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.
- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Corrections

- White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

Communication

- It is the responsibility of the provider to ensure that the primary care physician has been made aware of treatment plan goals by the fifth recipient visit, annually prior to EPSDT renewal; and, when requesting more than one therapy session per week.

Documentation of communication will be required i.e. treatment note, fax confirmation sheet.

34.3 Prior Authorization and Referral Requirements

Psychology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A completed Referral for Services Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

34.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

* The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

90847, 90849, 90853, 90865, 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

34.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

34.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Psychology to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

34.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

34.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for psychologist services. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes listed in this section are covered under this program. Some codes are covered for QMB recipients only. Check the guidelines following this grid.

CPT Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90791	Psychiatric diagnostic evaluation	1	1	1
90791 +90785	Psychiatric diagnostic evaluation with medical services	1	1	1
90837	Psychotherapy-60 minutes (53+*) with patient and/or family member	2, 3	1	This group of procedure codes may be billed on a weekly basis; although limited to no more than 52 max units per year total (combined)
90837 +90785	Psychotherapy, 60 minutes (53+*) with patient and/or family member with interactive complexity services	2, 3	1	
90832	Psychotherapy, 30 minutes (16-37*) with patient and/or family member	3, 9	1	
90834	Psychotherapy, 45 minutes (38-52*) with patient and/or family member	3, 9	1	
90832 +90785	Individual psychotherapy, 30 minutes (16-37*) with patient and/or family member with interactive complexity services	3, 9	1	
90834 +90785	Psychotherapy, 45 minutes (38-52*) with patient and/or family member with interactive complexity services	3, 9	1	*Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines.
90846	Family psychotherapy (without the patient present)	4, 9		
90847	Family medical psychotherapy (conjoint psychotherapy) with patient present	4, 9	1	

CPT Code	Description	See Note	Daily Max	Annual Max
90849	Multiple-family group psychotherapy	4, 9	1	
90853	Group psychotherapy (other than of a multiple-family group)	5, 9	1	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	6*,7	5*	These procedure codes may be billed separately or in any combination for no more than 5 units total annually as per CPT guidelines.
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAID), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	6*,7	5*	
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report.	6*,7, 8	5*	
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.	7, 10	5	
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per 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.	7*	5*	These procedure codes may be billed separately or in any combination for no more than 5 units total annually as per CPT guidelines.
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	7*	5*	

CPT Code	Description	See Note	Daily Max	Annual Max
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	7*, 8	5*	

Individual psychotherapy codes should be used only when the focus of the treatment encounter involves psychotherapy. Psychotherapy codes should not be used as generic psychiatric service codes.

Guidelines for Covered Procedure Codes:

1. Codes 90791 and -90791+90785 have a combined annual max limitation of 1.
2. Please note 90837 / 90837+90785 are now the codes to be used to reflect 60 minutes of face-to-face time, and is included in the 52 unit annual max limitation.
3. Medicaid will not accept psychiatric therapy procedure codes 90832-90837 being billed on the same date of service as an E&M service by the same physician or mental health professional group.
4. Procedure codes 90847 and 90849 are used to describe family participation in the treatment process of the client. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members in treatment. Group therapy must be led by a clinical psychologist licensed in the state of Alabama.
5. Procedure code 90853 is used when psychotherapy is administered in a group setting with a trained group leader in charge of several clients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group therapy must be led by a clinical psychologist licensed in the state of Alabama.
6. Procedure code 96101-96103 includes the administration, interpretation, and scoring of the tests mentioned in the CPT description and other medically accepted tests for evaluation of intellectual strengths, psychopathology, mental health risks, and other factors influencing treatment and prognosis. The clinical record must indicate the presence of mental illness or signs of mental illness for which psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended---excluding time spent for interpretation of tests). The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). Billing should reflect the **total** time for face-to-face administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes. Procedure codes 96101 and 96102 can be billed separately or in combination with code 96103 for **no more than** five hours per year (as per CPT guidelines). The units of measure for testing codes 96101 – 96103 has been

changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes).

Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary.

7. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120), even if the resulting diagnosis is mental retardation. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended---excluding time spent for interpretation of tests). The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing at this time. Billing should document the **total** time for face-to-face administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes. Procedure codes 96118 and 96119 can be billed separately or in combination with code 96120 for **no more than** five hours per year (as per CPT guidelines). The units of measure for testing codes 96118 – 96120 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes)

   Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary.

8. Codes 96103 and 96120 describe psychological/neuropsychological testing by a computer; **including** time for the qualified healthcare professional's interpretation and reporting. These codes are billed only once as one service regardless of the number of tests taken or time spent by the recipient completing the test. The computer code is used only when the recipient is taking a computer-based test unassisted, but the provider who interprets the report must be available during the time the recipient is taking the test. These codes cannot be billed if the computer is used only to score tests.

NOTE:

When **testing** is administered by a computer, the time that the qualified healthcare professional spends interpreting and reporting the results of each individual **test** is already included in each of these codes, scoring and/or test interpretation is not a separately billable service. For paper-and-pencil tests, the psychologist should bill appropriately for any other service provided.

9. These procedure codes may be used in any combination for no more than 52 units total annually. Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines. For exceptional circumstances where more than 52 units will be needed, consideration for request must be submitted.
10. Procedure Code 96116 is intended to describe the performance of gathering information to provide an important first analysis of brain dysfunction and progression and changes in the symptoms over time. This exam must include screening for impairments in acquired knowledge, attention, language, learning, memory, problem solving, and visual-spatial abilities.

For consideration of lifting the maximum cap on weekly unit limitations, submit a cover letter, documentation of medical necessity **and** the exceptional circumstance (i.e. how the recipient is an eminent danger to self or others and/or is at risk for hospitalization or decompensation) along with the claim, related progress note(s) and cover letter to the following address:

Institutional Services
Mental Health Program Director
P.O. Box 5624
Montgomery, AL 36103-5624

A sample Psychologist Override Request form (that can be used in lieu of a cover letter) can be found at:
http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.9_Mental_Health_Services/4.4.9.2_Clinical_Psychologists/4.4.9.2_Psychology_Override_Request_Template.pdf

Use of Modifiers

When one of the following disciplines is the performing provider, please append the following modifiers:

Modifier	***Allied Mental Health Professional***
U6	Licensed Professional Counselor (LPC) or Associate Licensed Counselor (ALC)
U7	Licensed Marriage and Family Therapist (LMFT)
AJ	Licensed Certified Social Worker
HO	An individual with a masters degree or above, not yet licensed but has successfully completed a practicum as a part of the requirements for the degree or has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience.

Codes billed with the above modifiers will be reimbursed at 75% of the allowable amount.

Services performed by an allied mental health professional but not billed with the modifier will be subject to recoupment on post payment review.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible psychologist (and/or allied professional mental health staff) staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.-This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible psychologist (and/or allied professional mental health staff) staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (*http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be performed or billed by psychologists.

34.5.4 Place of Service Codes

The following place of service codes apply when filing claims for psychology services:

POS Code	*Description*
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Clinic
99	Other Unlisted Facility

34.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

34.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N