CHAPTER 521–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
521.10.1	Psychological Testing 96101	12-05-2005	01-01-2006
521.10.4	Neurobehavioral Status Exam – 96116	12-05-2005	01-01-2006
521.10.5	Neuropsychological Testing Battery 96118	12-05-2005	01-01-2006
521.11.1	Services Requiring Registration – Prior Authorization	12-05-2005	07-01-2004
521.11.2	Registration – Prior Authorization Requirements	12-05-2005	07-01-2004

DECEMBER 05, 2005

Section 521.10.1

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96100
New Policy:	2006 CPT code listed as 96101
Change:	96101 will replace 96100
Directions:	Replace Section 521.9.1

Section 521.10.4

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96115
New Policy:	2006 CPT code listed as 96116
Change:	96116 will replace 96115
Directions:	Replace Section 521.9.4

Section 521.10.5

Introduction:	New CPT codes for Psychologist – Psychological Testing
Old Policy:	CPT code prior to January 1, 2006 was 96117
New Policy:	2006 CPT code listed as 96118
Change:	96118 will replace 96117
Directions:	Replace Section 521.9.5

Section 521.11.1

Introduction:	Update manual to reflect policy change effective 07-01-2004
Old Policy:	Authorizations were process by BMS
New Policy:	Registration and Authorizations are process by BMS' contracted agent
Change:	Addition of Registration – Change in who processes authorizations
Directions:	Replace Section 521.11.1

Section 521.11.2

Introduction:	Update manual to reflect policy change effective 07-01-2004
Old Policy:	Authorizations were process by BMS
New Policy:	Registration and Authorizations are process by BMS' contracted agent
Change:	Reference to Appendix M – which list BMS's contracted agent.
Directions:	Replace Section 521.11.

CHAPTER 521—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

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CHAPTER 521–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PSYCHOLOGICAL SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed, in writing, otherwise by the Bureau for Medical Services.

West Virginia Medicaid covers and reimburses Psychologist services rendered to Medicaid beneficiaries, subject to medical necessity and appropriateness criteria. This chapter sets forth the Bureau for Medical Services requirements for payment of services provided by independently practicing licensed psychologists to eligible West Virginia Medicaid beneficiaries.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Psychological services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

521.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of psychological services described in this chapter.

Event - one episode of contact with the beneficiary regardless of time for which reimbursement is a flat rate for all providers.

Psychological Services - the evaluation and therapy services provided by a Medicaid eligible and enrolled licensed psychologist.

Psychologist - an individual currently licensed under the state in which they are to practice psychology.

Psychologist under supervision for licensure - an individual who:

- Is an unlicensed psychologist with a documented completed degree in psychology at the level of a Ph.D., Psy.D., Ed.D., M.A., M.S. or M. Ed.;
- Has met the requirements of and is formally enrolled in the West Virginia Board of Examiners of Psychologist Supervision process;
- Is working towards licensure under supervision in accordance with the West Virginia Board of Examiners; and,
- Is employed or under contract with the supervision of a psychologist and is working towards licensure in compliance with West Virginia Board of Examiners.

Qualified neuropsychologist - a licensed psychologist with specialized training in neuropsychology and is recognized by the West Virginia Board of Examiners to provide services.

521.2 PROVIDER PARTICIPATION

In order to participate in the West Virginia Medicaid Program and receive payment from the Bureau, psychologists must:

- Meet all applicable State and Federal Laws governing the provision of their services;
- Meet all applicable licensing, accreditation, and certification requirements;
- Meet all Bureau enrollment requirements;
- Have a valid provider enrollment form on file;
- Ensure and maintain documentation that services provided by a psychologist under supervision for licensure meet the requirements of section 521.1 of this Chapter.

521.3 BENEFICIARY ELIGIBILITY

Payment for medically necessary and appropriate psychological services is available on behalf of all eligible West Virginia Medicaid beneficiaries subject to the conditions and limitations that apply to these services.

521.4 SERVICE EXCLUSION/PAYMENT LIMITATIONS

In addition to the exclusions listed in Chapter 100 General Information in the Provider Manual, the Bureau will not pay for the following:

- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of dementia which has progressed to a severe cognitive deficit.
- Individual and Group Psychotherapy services for beneficiaries with a diagnosis of severe and profound mental retardation.
- Group Psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, and motion therapy.
- Services provided by a psychologist under supervision for licensure in a “satellite” office, which is not the primary site of the practice and the licensed, enrolled supervising psychologist is not available for direct face-to-face supervision.
- Telephone consultations.
- Failed appointments, including but not limited to, canceled appointments and appointments not kept.
- A copy of the psychological report when the Bureau paid for the original service.

- Experimental services or drugs.

- Services rendered outside the scope of a provider's license.

- Services completed by an employee other than a licensed psychologist or a psychologist under supervision for licensure.

- If facility is reimbursed for psychological services, the psychologist cannot be reimbursed separately.

- Services provided by a "psychologist under supervision for licensure" is limited to the extent that billing for these services is restricted to four(4) individual supervised psychologists per Medicaid enrolled licensed psychologist.

- Family Psychotherapy services when the service constitutes taking a history or documenting evaluation and management services.

- Unlisted Psychiatric/Psychological Services is subject to review and pricing. The completed reports must be attached to the claim form and submitted for consideration to the Bureau.

- Developmental Testing (extended assessment) when Psychological Testing has been billed.

- Neurobehavioral Status Exam when Psychological Testing, Developmental Testing (limited or extended) and Neuropsychological Testing Battery have been billed.

521.5 MEDICAL NECESSITY

All psychological services covered in this chapter are subject to a determination of medical necessity. Medically necessary also means that services are directly related to the diagnostic, preventative, curative treatment of the beneficiary.

Psychologists must document medical necessity to support any services provided and billed to Medicaid. When taking a beneficiary's history, the following factors must be included in the determination of medical necessity and documented in the beneficiary's medical record:

- Chief complaint or presenting problem (s);
- Symptoms;
- Current functioning (GAF-global assessment of functioning);
- Mental status observations;
- Past psychiatric/treatment history;
- Family psychiatric history;
- Pertinent medical history;
- Current medications including over the counter items;
- Diagnostic impressions;
- Current treatment strategy/plan.

521.6 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements and Chapter 800 General Administration of the Provider Manual. In addition, psychologists must comply with the following documentation requirements:

- Psychologists must maintain a specific record for all services provided to each WV Medicaid eligible beneficiary and reimbursed by the Bureau, including at a minimum: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the supervising enrolled psychologist and the psychologist under supervision, if applicable, documentation of services provided, and the dates the services were provided.

- Documentation must justify that the services being provided meet the definition for the service and the criteria for medical necessity.

- All required documentation must be maintained for at least five years in the provider's file and is subject to review by authorized Bureau personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or three years, whichever is greater.

- Failure to maintain all required documentation may result in the disallowance and recovery by the Bureau of any amounts paid to the provider for which the required documentation is not maintained and not provided to the Bureau upon request.

521.7 THERAPEUTIC SERVICES

Services designed to alleviate emotional disturbances, reverse, or change maladaptive patterns of behavior, and to encourage personality growth and development. These services include individual psychotherapy, family psychotherapy and group psychotherapy.

521.7.1 INDIVIDUAL PSYCHOTHERAPY

521.7.1a **Procedure Code:** **90806**

Service Unit: **1 Session**

Service Limit: **10 sessions per year/ per client with registration**

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual Psychotherapy services are face-to face interventions with a beneficiary for approximately forty-five (45) minutes to one hour, depending on the service and the appropriate procedure. Individual psychotherapy is insight-oriented, behavior-modifying and/or supportive services that may be provided in an office or outpatient facility, in an inpatient hospital, partial hospital or residential care setting.

521.7.1b Procedure Code: 90818

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting 45 to 50 minutes face to face with patient.

521.7.1c Procedure Code: 90804

Service Unit: One Session

Service Limit: 10 Sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or out patient facility, 20 to 30 minutes face-to-face with the patient.

521.7.1d Procedure Code: 90816

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes face to face with the patient.

521.7.1e DOCUMENTATION OF INDIVIDUAL PSYCHOTHERAPY SERVICES

Documentation of psychotherapy should include the following:

- Date, name, age, length of session
- Reason for the encounter and pertinent interval history
- Pertinent themes discussed
- Appropriate high risk factors
- Interventions used including: cognitive therapy, behavioral therapy, reality therapy, etc
- Patient assessment (progress or regression)
- Changes in treatment plan, diagnosis, and medication when appropriate
- Expected treatment outcomes on a periodic basis

Codes 90806, 90818, 90804, and 90816 are time specific codes. The face-to-face time spent with the patient during psychotherapy must be documented in the medical record along with the documentation criteria outlined above.

521.7.2 FAMILY PSYCHOTHERAPY

Family Psychotherapy services are face-to-face interventions for the purpose of treating the beneficiary's condition. These services may be provided with the beneficiary present when there is a need to observe and correct, through psychotherapeutic techniques, the beneficiary's interaction with family members. These services may be provided without the beneficiary present where there is a need to assess the conflicts or impediments within the family, and/or assist, the family members in the management of the beneficiary.

521.7.2a Procedure Code: 90847

Service Unit: One Session

Service Limit: 10 sessions per year/ per client (10 sessions is a combined l limit for 90846 and 90847) with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Family psychotherapy (conjoint psychotherapy) (with patient present)

521.7.2b Procedure Code: 90846

Service Unit: One Session

Service Limit: 10 sessions per year/ per client (10 sessions is a combined limit for 90846 and 90847)

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Family Psychotherapy (without patient present)

521.7.2c DOCUMENTATION FOR FAMILY PSYCHOTHERAPY

At a minimum, psychologists must include in the beneficiary's medical record the following documentation:

- Statement regarding the beneficiary's condition relative to the need for family psychotherapy sessions with or without the beneficiary present;
- Justification that the primary purpose of such psychotherapy is the treatment of the beneficiary's condition. Justification includes, but is not limited to. documentation of the clinical need, such as:

  (1) To observe and correct the beneficiary's interaction with family members.

  (2) To assess the conflicts or impediments within the family, and assist the family members in the management of the beneficiary.

521.7.3 GROUP PSYCHOTHERAPY

Group Psychotherapy services are face-to-face interventions where personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group Psychotherapy services are administered in a group

setting (other than a multiple-family group) by a trained leader. Group Psychotherapy services do not include activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, and motion therapy.

521.7.3a Procedure Code: 90853

Service Unit: One Session

Service Limit: 10 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.7.3b DOCUMENTATION OF GROUP PSYCHOTHERAPY SERVICES

The medical record must indicate that all applicable criteria are met. Group therapy, since it involves psychotherapy, must be led by a person who is authorized by state statute to perform this service.

521.8 PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION

Psychiatric Diagnostic Interview Examination Services are face-to-face services with the beneficiary that include the elicitation of a medical (including past, family, social) and psychiatric history, mental status, establishment of a tentative diagnosis, and an evaluation of the beneficiary's ability and willingness to participate in the therapeutic process. Additional information may be obtained from the beneficiary, the beneficiary's physicians, other psychologists, family or other sources.

521.8.1 Procedure Code: 90801

Service Unit: 1 Examination

Service Limit: 1 per provider per year/ per client (Maximum 2) with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.9 DOCUMENTATION OF PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATINATION SERVICES

At a minimum, psychologists must include in the beneficiary's medical record the following documentation at an initial examination:

- Beneficiary's name, age, gender, date of birth (DOB), date of service (DOS), chief complaint (these items are registration items needed in chart but not in notes for the service;
- Pertinent history of present illness (including current medications);
- Pertinent past psychiatric history;
- Pertinent medical history;
- Pertinent mental status examination and symptoms (might include ADL, posture/gate, eye-contact, motor activity (increased/decreased), affect, memory, rate/volume of speech, mood, associations, general knowledge, concentration, orientation, abstraction, paranoid ideation, hallucinations, ideas of reference, appetite, sleep disturbance, etc.)
  Appropriate high-risk factors, such as suicidal or homicidal ideation
  Diagnosis including :

Axis I – Clinical Disorders
Axis II - Personality Disorders, Mental Retardation
Axis III - General Medical Conditions
Axis IV - Psychosocial and Environmental Problems
Axis V - Global Assessment of Functioning

- Initial treatment plan (including diagnostic test results, medications)
- Where psychotherapy is planned and there is a diagnosis of dementia, confusion, or any type of impaired cognition, the documentation should indicate that the client consents to and is able to participate in and benefit from the psychotherapy.
- Long term goals and prognosis when possible
- Anticipated treatment duration (interval) where applicable.

521.10 TESTING SERVICES

Services provided during psychodiagnostic testing of the cognitive function of the central nervous system. Testing services must include administration of psychodiagnostic tests, the interpretation of the results generated by the tests, and a report based on the results of the tests.

521.10.1 Procedure Code: 96101

Service Unit: 1 hour Session

Service Limit: 4 hours per consumer/per provider/per year with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Psychological Testing (includes psychodiagnostic assessment of personality, psychopathology; emotionality, intellectual abilities, academic achievement (e.g. Wechsler Scales, Rorschach, MMPI, Woodcock/Johnson Tests of Achievement) with interpretation and report per hour.

521.10.2 Procedure Code: 96110- Developmental Testing – Limited

Service Unit: 1 event

Service Limit: 4 hours/per consumer/per year/per provider with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Developmental Testing: Limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.

521.10.3 Procedure Code: 96111 – Developmental Test - Extended

Service Unit: 1 hour Session

Service Limit: 4 hours per year/ per provider/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Extended (includes assessment of motor, language, social adaptive, and/or cognitive functions by standardized developmental instruments, e.g. Bayley Scales of Infant Developmental) with interpretation and report, per hour.

Cannot be billed in addition to 96100.

521.10.4 Procedure Code: 96116 – Neurobehavioral Status Exam

Service Unit: 1 hour session

Service Limit: 2 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Neurobehavioral Status Exam (clinical assessment of thinking, reasoning, and judgment e.g. acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report per hour.

Cannot be billed in conjunction with 96100 and 96118.

521.10.5 Procedure Code: 96118

Service Unit: 1 hour Session

Service Limit: 12 sessions per year/ per client with registration

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

Definition: Neuropsychological Testing Battery (e.g. Halstead-Reitan, Luria, WAIS-R) with interpretation and report per hour.

Cannot be billed on same day as 96116. Cannot be billed in addition to 96100 and 96111.

521.10.6 DOCUMENTATION FOR TESTING SERVICES

At a minimum, psychologist must include in the beneficiary's medical record the follow documentation:

(1) Results of tests performed;
(2) Interpretation of the results;
(3) Copy of the written report.

521.11 UNLISTED PSYCHIATRIC/PSYCHOLOGICAL SERVICES

This procedure code can be used to cover evaluations and assessments not otherwise described in this manual. An example could be a juvenile sexual offender assessments or substance abuse assessments, etc. This service must be prior authorized for payment.

521.11.1 Procedure Code: 90899

Service Unit: Event

Prior Authorization: Refer to the ASO's Utilization Management Guidelines

521.12 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Rehabilitation Services described in this chapter.

521.12.1 SERVICES REQUIRING REGISTRATION - PRIOR AUTHORIZATION

The Bureau for Medical Services requires that providers register and/or prior authorize all services described in this manual with BMS' contracted agent. Registration and prior authorization must be obtained from BMS' contracted agent.

521.12.2 REGISTRATION - PRIOR AUTHORIZATION REQUIREMENTS

General information on registration requirements, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' contracted agent