

Psychology Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (<http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

eManual Contents

Please send comments to ePubs_updates@jfs.ohio.gov

[Medicaid Handbook Transmittal Letters](#)

[Miscellaneous Medicaid Handbook Transmittal Letters](#)

[Medical Assistance Letters](#)

[Psychology Rules](#)

[Appendices](#)

[Billing Instructions](#)

Medicaid Handbook Transmittal Letters

MHTL 3341-09-01 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3341-09-01

January 8, 2010

TO: All Eligible Psychologists
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

[Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance \(DMA\) Program and the Rescission of Ohio Administrative Code \(OAC\) Rule 5101:3-23-01](#)

MHTL 3341-08-02

Medicaid Handbook Transmittal Letter (MHTL) 3341-08-02

July 31, 2008

TO: All Providers of Independent Psychology Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Medicaid Program fee increases

Change effective July 1, 2008.

Medicaid Reimbursement-OAC 5101:3-1- 60

The Department is pleased to announce that the Medicaid maximums for certain codes will be increased as part of the Governor's biennium budget. An aggregate 3% increase is being implemented for claims with dates of service on and after July 1, 2008 based on the volume of services paid for all CPT codes.

The Medicaid maximums for selected CPT codes have been raised. If the Medicaid maximum was over the Medicare price, the Medicaid maximum was lowered since Ohio Medicaid is prohibited from paying a price that exceeds the Medicare price. For many codes, the Medicaid maximum remains unchanged.

The full text of this rule amendment and the accompanying appendix DD to this rule can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the General Information for Medicaid Providers handbook.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (Medicaid fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1- 60 will affect them. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "Psychology Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3341-07-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3341-07-01

December 27, 2007

TO: All providers of Independent Psychology Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Revision of OAC rule 5101:3-8-05 "Covered psychology services and limitations"

Rule change effective January 1, 2008.

The purpose of this MHTL is to provide notice of revision to the following rule:

Rule 5101:3-8-05 entitled: "Covered psychology services and limitations" was amended in accordance with Am. Sub. House Bill 119 (127th General Assembly) which authorized the restoration of psychology benefits for Medicaid consumers 21 years of age and older when provided by an independent psychologist and independent group psychologist practices.

The coverage and limitations for psychology services remains the same regardless of the age of the consumer.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu. Providers may view current reimbursement rates online by:
 - (1) Selecting the "Legal Services" folder;
 - (2) Selecting "ODJFS Ohio Administrative Code"; and
 - (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3341-06-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3341-06-01

January 23, 2006

TO: All Eligible Providers of Psychology services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Medicaid psychology service rule 5101:3-8-05 and OAC rule 5101:3-1-60

Rules and Program Changes are effective January 1, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of the revision of OAC rules 5101:3-8-05 Covered psychology services and limitations and 5101:3-1-60 Medicaid reimbursement. These rules are to be filed on an emergency basis on December 30, 2005 and are due to be proposed in January 2006 for permanent amendment.

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

This rule was amended to eliminate all language and instructions associated with services rendered prior to July 1, 2002 and to correct minor grammatical and formatting errors contained throughout the rule. In addition, paragraph (C) of this rule was modified to update program codes pertaining to the testing of the cognitive function of the central nervous system due to current procedural terminology (CPT) code changes for psychology services for 2006.

OAC rule 5101:3-1-60 Medicaid reimbursement.

This rule was amended due to changes in the Medicaid psychology program codes for 2006. To remain compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), several covered psychology program codes are being deleted and replaced by new Current Procedural Terminology (CPT) codes as listed below. For psychology services rendered for dates of service prior to January 1, 2006, providers are instructed to use the current covered CPT codes:

96100 Psychological testing

96115 Neurobehavioral status exam

96117 Neuropsychological testing battery

For psychology services rendered to Medicaid consumers for dates of service on or after January 1, 2006, providers are instructed to use the following new CPT codes:

96101 Psychological testing

96116 Neurobehavioral status exam

96118 Neuropsychological testing battery

The Department recommends that providers view the entire text of the Medicaid psychology program rules at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Click the link "Ohio Health Plan Providers" (left column) and then the link "Psychology services" (right column).

If you do not have internet access, you may request a paper copy of this MHTL and rule 5101:3-08-05 by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3341-04-01

Medicaid Handbook Transmittal Letter (MHTL) 3341-04-01

February 20, 2004

TO: All Eligible Providers of Psychological Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Psychology Services Handbook Update

The Department wishes to announce that the Medicaid handbook for psychological services has a new look. Providers accessing the program policies on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid> will no longer see a handbook style format, e.g. PSY.1100 Coverage and Limitations. The policies are now linked to the Ohio Administrative Code (OAC) rules that are the legal basis for those policies. For example, the policy governing "Covered Psychology Services and Limitations" is a direct link to OAC 5101:3-8-05, and the policy governing "Services Provided For the Diagnosis and Treatment of Mental and Emotional Disorders" is linked to OAC 5101:3-4-29. We encourage providers to navigate the new rule-based handbook and become familiar with the organization and location of the rules and other policy information.

ODJFS would like to stress that these are not new rules or policy. All of this information was in our psychology handbook previously but was in a different format. All rules referenced by the primary psychology rules will also be directly linked so that they are easily accessible. Any information that is not in a rule will be located in the appendix called Billing Instructions.

Additionally, please note that the rules are no longer located at the Dynaweb address. The new location of the rules is <http://emanuals.odjfs.state.oh.us/emanuals>. Please update your bookmarks accordingly.

The new psychology book will be divided into the following sections:

Medicaid Handbook Transmittal Letters: An archive of provider communications like this one

Medical Assistance Letters: An archive of provider communications referring to policy changes

Handbook and Appendices in PDF: An easily printable version of the whole handbook in Adobe Acrobat PDF. Adobe Acrobat Reader is free and can be downloaded from <http://www.adobe.com/products/acrobat/readermain.html>

Psychology Rules: The primary psychology rules

Appendices: Rules reference by the primary psychology rules

Billing Instructions: A link to the instructions for billing Medicaid

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form and either mail or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

**Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516**

MHTL 3341-03-01

Medicaid Handbook Transmittal Letter (MHTL) 3341-03-01

August 4, 2003

TO: All Providers of Psychology Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Psychology Handbook Update: Policy/Code Changes

CODE AND POLICY CHANGES

EFFECTIVE OCTOBER 1, 2003

- Discontinuation of adult services provided by individual psychologist
- Update for psychological services
- Update for HIPAA compliant modifier

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to provide notice of modifier and policy changes relating to the policy areas listed above. The rules relating to these policies are in a proposed status but are scheduled to be effective for services provided on and after October 1, 2003.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A. changes in ODJFS, please check the following web site address: <http://www.state.oh.us/odjfs/ohp/hipaa.stm>. The department has posted a code crosswalk for psychology services that shows the local level code(s) (X-Z codes) used by the department, the new H.I.P.P.A. compliant code and its effective date, and the rule number that contains more detailed information about the change. The web address for this crosswalk document is <http://www.state.oh.us/odjfs/ohp/hipaa.stm>. The psychology handbook located on the department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> contains the detailed information about the code changes also.

Psychology Services Handbook Update

I. Discontinuation of adult services provided by individual psychologists

For services provided on and after January 1, 2004, the Ohio Medicaid program will no longer reimburse services provided by independent psychologists to adult (21 years of age and over) Medicaid recipients in accordance with the state budget bill (House Bill 95, 125th General Assembly).

II. Update for Psychology Services

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

Code 90801 for the diagnostic interview examination will be a covered service for licensed psychologists for dates of service on and after October 1, 2003.

- This code is not time-based and can be billed only as one unit of service.
- The department will pay the psychologist's charged amount or 85% of the Medicaid maximum, whichever is less, for an examination personally performed by a licensed psychologist.
- Limitations
 - Therapeutic visits and diagnostic interview examinations in excess of a combined 25 dates of service per recipient in a twelve month rolling period in a non-hospital setting are not covered by the department.

- Diagnostic interview examinations will be limited to one per recipient per twelve month rolling period and may not be billed on the same date of service as a therapeutic visit.
- Documentation
 - For a licensed psychologist, all documentation provisions for therapeutic services outlined in paragraph (H) of rule 5101:3-4-29 or the Administrative code shall apply to therapeutic services provided by a psychologist with the exception that a licensed psychologist does not need to have the treatment plan signed and dated by a physician prior to initiating therapy.

Paper copies of the handbook updates will not be automatically sent out to providers per the ODJFS Paper Transmittal Reduction initiative. Handbook updates will be available online at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>. Paper copies may be requested from ODJFS by filling out the attached ODJFS 03400 paper request form and sending it to the appropriate address or fax number given on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3341-02-01

Medicaid Handbook Transmittal Letter (MHTL) 3341-02-01

June 13, 2002

TO: All Providers of Psychology Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Psychology Services Handbook Issuance

ELIGIBLE PSYCHOLOGY PROVIDERS AND COVERAGE REVISIONS

EFFECTIVE JULY 1, 2002

- New Psychology Ohio Medicaid Provider Handbook, Chapter 3341
- Billing new psychology codes
- Reimbursement
- Limitations

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the issuance of a new, consolidated Ohio Medicaid Provider Handbook, Chapter 3341 for providers of psychology services. The rules relating to the policies contained in this handbook are in a proposed status but are scheduled to be effective for services provided on and after July 1, 2002. Should there be any change in the effective date, the Department will notify you via a remittance advice message appearing on your weekly remittance from the Department.

The psychology handbook and this MHTL will be available on the Department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>.

Handbook and Policy Update:

Policy updates and changes are contained in this handbook. The handbook addresses eligibility, covered services and limitations, reimbursement requirements, billing code changes, coverage for services provided by psychology graduate students under the direct supervision of a psychologist, documentation requirements and non-covered services for providers of psychology services. All sections of this handbook feature important policy changes and should be read carefully.

Billing new psychology codes

Of particular note is handbook section PSY.1103.1 entitled "Covered psychological testing services" and handbook section PSY.1103.2 entitled "Covered psychological therapeutic services".

Effective for dates of service July 1, 2002 and after, in preparation for H.I.P.A.A., the Department will convert to the use of standard CPT codes for psychology services. To ease the transition, providers can choose to begin using the CPT effective for dates of service July 1, 2002 and after, or if you prefer, you will be able to continue the use of the Z psychology codes until October 1, 2002.

Please contact your billing agency and advise them to use the appropriate CPT codes:

- For psychological testing, use the appropriate CPT code in the range of 96100 through 96117.
- For outpatient psychotherapy, use the appropriate CPT code in the range of 90804 through 90814. For outpatient group therapy, use the appropriate CPT code in the range of 90846 through 90853.

Reimbursement

- Please note that as stated in section PSY.1102 of this handbook, the Department will pay the lesser of the provider's billed charge or the Medicaid maximum for the CPT codes for covered psychology

services. For covered psychotherapy codes, the Department will pay the lesser of the provider's billed charge or 85% of the Medicaid maximum for these codes.

Limitations

- Also, please review handbook section PSY.1105 entitled "Limitations". As stated in this section, psychological testing is limited to a maximum of eight hours per 12-month period per recipient in an outpatient setting. Therapeutic visits are limited to 24 dates of service per recipient in a 12-month period.

Additional Handbook Information

Included in the new handbook, Chapter 3341, is the ODJFS Medicaid Telephone Directory, a listing of ODJFS forms, the Top 15 Commonly Asked Questions and billing instructions.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A., there has been a web site created by Ohio's statewide H.I.P.P.A. committee. Please check the following web site address for educational materials including an awareness brochure:
<http://www.state.oh.us/hipaa/educationalmaterials.htm>

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-13-04

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-13-04](#) is maintained in the General Information e-book.

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-10-02](#) is maintained in the General Information e-book.

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-09-02](#) is maintained in the General Information e-book.

Medical Assistance Letters

MAL 527

Medical Assistance Letter No 527 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 527, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 526

Medical Assistance Letter No 526 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 526, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 453

Medical Assistance Letter (MAL) No. 453

November 18, 2003

TO: Independent Practicing Psychologists and Group Psychologist Practices
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Changes to Psychology Services provided to adults 21 years of age and older

COVERAGE CHANGE EFFECTIVE JANUARY 1, 2004

The purpose of this Medical Assistance Letter (MAL) is to announce the elimination of the coverage of psychology services provided to adults by independent (individual and group) psychology practices.

Ohio's biennial budget did not include funding to retain independent psychology or independent group psychology services as part of Ohio's Medicaid benefit package for adults age 21 and over. As a result, Medicaid will no longer pay for these services for dates of service on or after January 1, 2004 for adults age 21 and older.

Independent (individual and group) psychology practices may continue to provide and bill for psychotherapy services and psychological testing services provided to children (i.e., individuals under the age of 21 years) covered under the Ohio Medicaid program.

Your practice might be able to provide services to adults enrolled in a Medicaid Managed Care Plan (MCP), if the individual's MCP elects to continue the coverage of adult psychology services provided by your practice. Because coverage may vary from plan to plan, it is important that providers check with the plan to confirm that the services are still covered by the plan.

Independent individual and group psychology practices may continue to provide services for consumers in a nursing facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF-MR). Please note that reimbursement for these psychology services in a long term care setting will continue to be paid as part of the per diem payment made to the long term care facility and the psychologist must be compensated by the facility.

For adults who are dually eligible for Medicare and Medicaid and for adults who are qualified Medicare beneficiaries (QMBs), Medicaid will continue to pay the deductible and coinsurance payments for psychology services covered by Medicare.

If an adult consumer elects to receive services from an independent psychologist for dates of service on or after January 1, 2004, the provider may not bill the recipient unless the provider informs the consumer, prior to rendering the service, that: the service is not covered by Medicaid and the consumer agrees in writing to pay for the non-covered service.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MAL 431

Medical Assistance Letter (MAL) No. 431

May 24, 2002

TO: All Psychology Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Proposed Psychology Policies

SCHEDULED TO BE EFFECTIVE JULY 1, 2002

New Billing Codes

The purpose of this Medical Assistance Letter (MAL) is to announce the implementation of new rules pertaining to psychology services. Please note that these rules have been proposed and are pending approval by the Joint Committee on Agency Rule Review (JCARR) in early June. They are scheduled to be effective for services provided on and after July 1, 2002. Should there be a change in the effective date, we will notify all affected providers via a message on a Remittance Advice.

The proposed new rules will be available on the Department's policy web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> by the end of May. Once these rules have been approved, the Department will be finalizing a psychology handbook for and will be forwarding the handbook to you at a later time.

Please note that **all** psychology policies are new and should be reviewed carefully. However, of particular importance is that the Department is converting to CPT codes for psychology services in preparation for H.I.P.A.A. which requires that the Department discontinue the use of all local level codes (including the Z codes for psychology). To ease this transition, providers can choose to begin using the CPT effective for dates of service July 1, 2002 and after, or if you prefer, you will be able to continue the use of the Z psychology codes until October 1, 2002.

Please contact your billing agency and advise them to use the appropriate CPT codes:

- For psychological testing, use the appropriate CPT code in the range of 96100 through 96117.
- For outpatient psychotherapy, use the appropriate CPT code in the range of 90804 through 90814. For outpatient group therapy, use the appropriate CPT code in the range of 90846 through 90853.

Note: The Department will be installing an edit which will reject claims should a provider bill both a Z code for psychology testing or psychotherapy and also bill a CPT code for the same service.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-6108
Out-of-state telephone number 1-614-728-3288

Psychology Rules

MHTL 3334-13-11

Effective Date: January 1, 2014

Most Current Prior Effective Date: March 28, 2013

(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.

Replaces: 5160-8-05

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02

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

Appendices

5101:3-1-01 Medicaid: Medical Necessity

OAC 5101:3-1-01 is maintained in the [ODJFS OAC](#).

5101:3-3-19 Relationship of Other Covered Medicaid Services to Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Services

OAC 5101:3-3-19 is maintained in the [Long Term Care manual](#).

5101:3-4-02 Scope of Coverage

OAC 5101:3-4-02 is maintained in the [Physician Services manual](#).

5101:3-8-01 Eligible Providers of Limited Practitioner Services

OAC 5101:3-8-01 is maintained in the [ODJFS OAC](#).

Billing Instructions

Click [here](#) to view the Billing instructions eManual.

Notice

A Psychology Services provider handbook is currently not available.

Below please find Ohio Administrative Code (OAC) rules regarding Psychology Services and links to the OAC (found in the Legal Services collection) regarding all limited practitioners.