Iowa Department of Human Services

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PSYCHOLOGY SERVICES MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***PSYCHOLOGY SERVICES MANUAL***, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; and pages 1 through 6, revised.

Summary

The ***PSYCHOLOGY SERVICES MANUAL*** is revised to:

- Align with current IA Health Link policies, procedures, and terminology.
- Update links due to the Department's new website.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the ***PSYCHOLOGIST SERVICES MANUAL***:

Page	Date
Chapter III	
Contents (page 1)	April 1, 2014
1-8	April 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at: http://dhs.iowa.gov/sites/default/files/Psych.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PSYCHOLOGISTS ELIGIBLE TO PARTICIPATE

All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

Psychologists who are not listed in the National Register but who feel they meet those qualifications should present their credentials to Iowa Medicaid Enterprise (IME). A questionnaire must be completed to establish that National Register standards are met.

Psychologists must be independently practicing and not employed by a physician, hospital, community mental health center, or other entity.

Psychologist interns: To qualify, psychological internships must meet current criteria required by the American Psychological Association.

B. COVERAGE OF PSYCHOLOGIST SERVICES

Payment will be approved for services as authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing, or residential care facility.

Payment shall be made only for time spent in face-to-face consultation with the member. No payment will be made for services rendered by employees of the psychologist or for services not rendered personally by the psychologist.

1. Covered Services

Coverage is generally limited to psychotherapy and psychological examinations in the office setting. However, payment will be made for covered procedures necessary to maintain continuing treatment during periods of hospitalization or convalescence for a physical illness.

Payment will also be made for procedures provided within a hospital, day hospital, nursing facility or residential care facility as part of an approved plan of treatment when a psychologist is not employed by the facility.

a. Mileage

Payment will be approved for mileage when the following conditions are met:

- It is necessary for the psychologist to travel outside of the home community, and
- There is no qualified mental health professional more immediately available in the community, and
- The member has a medical condition which prohibits travel.

b. Psychological Examinations

Payment will be approved for psychological examination and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress not to exceed eight hours in any 12-month period.

Medicaid members and applicants entering nursing homes (ICF and SNF) are screened by the IME to determine if the person has a need related to mental illness, intellectual disability, or a related condition (developmental disability). This is a Level I screening.

If the person has such needs, the IME requires a further evaluation before Medicaid will pay the nursing home care. This Level II evaluation shall specifically identify the needs of the member, so the facility can develop a plan to meet the member's needs. This examination is payable even if the member has already received eight hours of examination and testing.

These procedures are part of the Centers for Medicare and Medicaid Services (CMS) Preadmission Screening and Annual Resident Review (PASARR) requirements.

c. Psychotherapy

Payment will be approved for the following:

- Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period; or
- Couple, marital, family or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period; or
- A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

2. Exclusions

Payment will not be made for the following:

- Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
- Psychological examinations covered under Part B of Medicare, for individuals with primary coverage under Medicare, except for the Part B Medicare coinsurance and deductibles.
- Psychological examinations employing unusual or experimental instrumentation, methods, techniques or practices.
- Individual or group psychotherapy without specification of condition, symptom, or complaint.
- Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress, such as job dissatisfaction or general unhappiness.

3. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code (IAC) Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

4. Service Reviews

The Department maintains a process of review of service through the IME. The following services are subject to review:

- Protracted therapy, beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and may be reviewed periodically thereafter.
- Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

C. BASIS OF PAYMENT

Psychologists are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Click here to view the fee schedule for Psychologists.

D. PROCEDURE CODES AND NOMENCLATURE

Enter the procedure code, description of service, and total length of time spent with the member in field 24D of the claim form. Claims submitted without a procedure code and an ICD-CM or DSM IV diagnosis code will be denied.

When a combination of the group, family, and individual therapy is provided, the limit is that the cost shall not exceed the allowance for 40 hours of individual therapy per year.

Modifier	Description
Z1	Modifier used after the procedure code when services are a result of an Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) physical
Z3	Modifier used after the procedure code when service is provided in an inpatient hospital setting
U4	Modifier used to designate intellectual disability (e.g., ID testing)

Service will be reimbursed on the basis of time. Enter the number of units in 24F, with one unit equal to the time as shown in the description for the procedure code. (If a charge is made for mileage, enter the number of miles in 24F.)

Payment for group therapy is based on the actual number of persons who comprise the group, but not less than six. For example, if eight persons comprise the group, payment will be based on this number. However, if the group consists of four persons, payment will nevertheless be based on six persons. The number of people in the group should be entered in 24C (description of service).

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for psychology providers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf