NEW YORK STATE MEDICAID PROGRAM

CLINICAL PSYCHOLOGY MANUAL

POLICY GUIDELINES

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Section I - Requirements for Participation in Medicaid

Clinical psychological services must be rendered in accordance with the standards of good practice that are outlined in the Rules and Regulations of the New York State Education Department and the Code of Ethics of the New York State Psychological Association. If, after extended psychological care, the recipient's prognosis is not favorable, consideration should be given to curtailing or discontinuing psychological services and/or initiating other means of care.

Only licensed professionals may provide care. License requirements are established by the New York State Department of Education (NYSED), and can be found at

http://www.op.nysed.gov/prof/.

Professionals are required to follow regulations found at http://www.health.ny.gov/regulations/nycrr/title_18/, and by conducting a search for "505.18".

Reporting Requirement

Since psychological services rendered under New York State Medicaid are considered part of a comprehensive approach to health care, a clinical psychologist who treats a Medicaid recipient must send a suitable written report to the referring physician, clinic, or other referral source. If therapy extends for more than five sessions, the source of the referral must be kept informed through additional periodic written reports.

Records to be Maintained

Clinical psychologists must maintain complete legible records in English for each recipient. Records must contain information sufficient to justify the diagnosis and warrant the treatment of each Medicaid recipient served.

Records should include as a minimum, but not be limited to, the following:

- The full name, address and Medicaid identification number (CIN) of each recipient evaluated, tested and/or treated and the date and clock times for each session for which a bill is submitted;

- A copy of the patient’s written referral for psychological services;

- Current diagnosis as contained in the ICD-10-CM, including any diagnostic impressions made for each session;

- A description of the recipient's problems, strengths, conditions, disabilities and needs;

- A statement of the goals and objectives of treatment to address the recipient's problems, disabilities and needs, including an estimate of the duration of the recipient's need for treatment, a description of the proposed treatment and prognosis;

- Progress notes providing a chronological description of the recipient's progress in relation to the goals and objectives of the established plan of treatment;

- Documentation of collaboration with the patient's personal physician or other appropriate medical provider;

- A copy of the written report(s) sent to the patient's referral source; and

- A summary of the recipient's condition and disposition when treatment is completed or terminated.

Recipient clinical records must be retained for six years in accordance with established Medicaid regulations.

Section II - Clinical Psychology Services

Under the New York State Medical Assistance Program (Medicaid), the services of licensed private practicing clinical psychologists are available to eligible individuals as part of their comprehensive health care. Reimbursable services include psychological testing, evaluation and the various therapeutic procedures that are appropriate for the given personality or behavior disorder.

Licensed private practicing clinical psychologists will be reimbursed by Medicaid only for the services they personally provide on a private practitioner basis and will not be reimbursed for services rendered in a facility (e.g. clinic) from which the clinical psychologist receives a salary or other compensation. Licensed private practicing clinical psychologists who receive payment for psychology services under Early Intervention, pre-school, or school-age supportive health service programs will not be reimbursed on a fee-for-service basis by Medicaid for the services they render in that setting.

Individual Psychotherapy

The individual psychotherapy code is to be used to bill for evaluative/therapeutic sessions lasting a minimum of 37 minutes involving the patient alone or a collateral, with or without the patient present. A couple's therapy session, even when both persons involved are Medicaid eligible, is considered a single psychotherapy session.

A one-hour individual psychotherapy session involves approximately 45 to 50 minutes of face-to-face patient contact time (i.e., the "therapeutic hour"). In order to be considered a Medicaid reimbursable service, an individual session must involve a minimum of 37 minutes of patient contact time. A session which lasts less than a "therapeutic hour" due to circumstances beyond the control of the psychologist, or at his/her professional discretion, is not considered to be reimbursable when patient contact is terminated before 37 minutes.

An extended individual psychotherapy session involving a minimum patient contact time of one and one-quarter hours (75 minutes) is reimbursable when medically necessary due to extenuating circumstances, (e.g., a crisis management session). A crisis management session is usually an unscheduled session or an unscheduled extension of a scheduled session. Extended psychotherapy sessions are reimbursable for crisis management when their purpose is the reduction of acute emotional distress which is characterized by the need for immediate attention. Regularly scheduled sessions lasting longer than one-hour for patient convenience are not reimbursable as extended sessions.

Group Psychotherapy

The group psychotherapy code is to be used to bill for therapeutic sessions of one and one-half hours when two or more non-collateral patients are seen in the same setting, at the same time, for a similar therapeutic purpose. The session is to be limited to not more than eight patients.

Psychological Testing

The psychological testing code is to be used to bill for the individual administration of recognized, standardized mental health assessment procedures, including behavior rating and adaptive behavior scales, projective techniques and cognitive/intellectual and personality assessment. Patient interviews (i.e., the taking of a social history or an assessment using similar checklist/questionnaire techniques) are considered evaluative sessions and are not billable as psychological testing.

Psychological testing sessions having a total face-to-face administration time of greater than one hour, (i.e., for initial diagnostic/evaluative test batteries), are reimbursable as multiple units of the testing code. Times for individual tests are additive, with increments of 0.5 hour or greater rounded up to the next whole hour. Only face-to-face patient contact time, is used in the time calculation for testing. Patient contact time is only that time during which the psychologist interacts with the patient, (i.e., explains the test procedure or manipulates or presents objects for patient response) or observes the test taker, where such observation adds significantly to the interpretation of the test results. The psychologist's physical presence at the testing session, without an interactive or observational component as described above, does not count as face-to-face administration time.

Simultaneous testing of more than one individual (i.e., group administration) is reimbursable only when objective and mechanical tests (i.e., self-reporting scales) are administered to more than one person at the same time due to unusual patient-specific circumstances which must be documented in the patients' records. It must also be documented that test conditions allowed the psychologist direct access to, and continuous monitoring of each patient so tested, but did not compromise patient confidentiality, detract from test integrity, compromise test validity, nor adversely impact individual performance. Under no circumstances may more than two individuals be tested simultaneously. Medicaid reimbursement is not available for routine group administration of psychological tests.

Medicare Cross-over

Reimbursement for Medicare cost-sharing expenses (co-insurance and deductible) for dually eligibles may be claimed when the service has been approved by Medicare and meets Medicare's conditions for coverage of psychological services, which may differ from those used in defining reimbursable services under Medicaid. Medicare/Medicaid crossover claims should use the closest comparable coding available in the Procedure Codes and Fee Schedule section of this manual.

Section III - Basis of Payment for Services Provided

Only services which are personally provided by an enrolled licensed private practicing clinical psychologist may be reimbursed by New York State Medicaid.

A psychologist enrolled in the Medicare Program must comply with departmental requirements found in Social Services regulations at 18 NYCRR 505.18. These requirements include:

- Licensure to practice psychology in accordance with Article 153 of the New York State Education Law; and

- Completion of at least three years of training or has at least three years of supervised experience in clinical psychology; and

- Current engagement in professional practice, at least half of which is devoted to providing clinical psychological services

Note: Medicaid reimbursement is not available for either the supervision of, or the services provided by unlicensed psychological interns, trainees or assistants or anyone else who may otherwise legally provide such services.

Under New York State Medicaid, **licensed** private practicing clinical psychologists will be reimbursed on the basis of time in accordance with the fees that are listed in the Procedure Codes and Fee Schedule section of this manual.

The fees include payment for the face-to-face encounter with the patient and/or collateral, the preparation for that encounter and the post-encounter services including analysis or review of records or tests, updating of records and communication with the referent or patient through written reports and telephone contact.

A collateral is a member of the patient's family or household who regularly interacts with the patient and is directly affected by, or has the capability of affecting, the patient's condition. The purpose of collateral services is to assist in the diagnosis, evaluation and therapy of the patient by gathering information to assure appropriate planning of care, to ameliorate those factors of the home environment which interfere with treatment goals and to encourage continuation of a therapeutic environment in the home setting. An occasion of collateral service shall be billed against the primary patient's Medicaid identification number.

Note: The time component in the service descriptions is defined as only that time the psychologist spends face-to-face (i.e., contact time) with the patient and/or collateral. Non face-to-face time, also called pre-and-post encounter time, is not to be included in calculation of the time component of the coding.

Psychological testing services are reimbursable when used for the diagnosis, evaluation or assessment of mental illness, emotional disturbance and personality or behavioral disorders.

For more information on fees, please refer to the Procedure Codes and Fee Schedule Section of this Manual.

Referral Requirement

All recipients who are under the care of a licensed private practicing clinical psychologist must have been referred in writing for such services by either the patient's personal physician or nurse practitioner, a medical director in an industrial concern, an appropriate school official, or an official of a voluntary health or social agency.

Collaboration Requirement

Except for the services of initial diagnostic evaluation and testing, the services of clinical psychologists must be rendered in collaboration with the recipient’s physician or other appropriate practitioners who render medical services to the recipient.

The practitioner may be either the recipient’s personal physician or nurse practitioner or a practitioner who is associated with a clinic that serves that individual. The participation of the recipient’s personal physician and other medical practitioners is considered essential to comprehensive health care.

Section IV - Unacceptable Practices

In addition to the guidelines that appear in the Information for All Providers, General Policy Section of this Manual, private practicing clinical psychologists are specifically prohibited from engaging in practices considered unacceptable, including, but not limited to the following:

- Offering cash payments to physicians, clinics or others who refer recipients for psychological services;
- Billing for services that are available free of charge to the general public;
- Billing for services rendered to recipients who were not properly referred; and
- Billing for services rendered, in part or entirely, by individuals other than the enrolled licensed clinical psychologist.