# Psychologist

Outpatient mental health services rendered by a psychologist may be provided to individuals who have an identifiable, clinical psychiatric disorder for which treatment can reasonably be expected to assist the individual in achieving optimal levels of functioning.

Nevada Medicaid covers procedure codes listed on the Provider Type 26 Reimbursement Rates document available on the Division of Health Care Financing and Policy (DHCFP) website.

Medicaid Services Manual (MSM) Chapter 400 provides complete coverage and limitations for each covered service.

Current Procedural Terminology (CPT) code **90791** (psychiatric diagnostic evaluation) is covered twice per calendar year for each episode of care. Additional services require prior authorization.

## Smoking Cessation Counseling for Pregnant Women

As of October 13, 2011, CPT codes 99406 and 99407 are used to bill smoking cessation counseling for pregnant women only. For all other recipients, these services are billed using the appropriate Evaluation and Management (E&M) office visit code.

## Prior Authorization Requirements

A recipient may receive an initial psychiatric diagnostic evaluation (i.e., code 90791) and a combination of 26 sessions of group, individual and/or family therapy in one year without prior authorization. A psychologist is responsible for requesting any subsequent authorizations for treatment.

- Prior authorization is required for all of the following services: Psychological testing (CPT codes 96101-96103), developmental testing (CPT code 96111) and neuropsychological testing (CPT codes 96118-96120). Prior authorization may be granted for up to 4 hours for codes 96101-96102 with one unit of 96103, and for up to 6 hours for codes 96118-96119 with one unit of 96120.
- Biofeedback training (CPT codes 90875, 90876, 90901 and 90911)
- Psychoanalysis (CPT code 90845)

Health and behavior assessment (CPT code 96150) and re-assessment (CPT code 96151), 15-minute units, need prior authorization only when they exceed 2 (for adults) or 4 (for adolescents) sessions per calendar year.

HCPCS code T1016 (Case management): Prior authorization is required for provider type 26 if service will exceed 30 hours (120 units) per recipient, per calendar month.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

**Continued service requests:** Submit 5-15 business days prior to the last date of the current authorized period. MSM Chapter 400, Section 403.6B.7, recommends the continued service request be submitted fifteen (15) days prior to the end date of the existing service period to avoid an interruption in services for the recipient.

## Prior Authorization Forms

- Use form FA-10A to request authorization for **psychological testing.**
- Use form FA-10B to request authorization for **neuropsychological testing.**

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- Use form FA-10C to request authorization for **developmental testing.**
- Use form FA-11 to submit an **initial request** for outpatient mental health services that require prior authorization, or for **concurrent authorization**, **unscheduled revision**, **reconsideration** or **retrospective authorization** via the Provider Web Portal.