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 Nevada Medicaid 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.

Provider type 26 providers may enroll with the following specialties:

- 926: Psychologist
- 826: Psychologist Group
- 071: Neuropsychology
- 160: Adolescent Psychology
- 161: Child Psychology
- 162: Clinical Psychology
- 246: Psychological Assistant
- 247: Psychological Intern
- 248: Psychological Trainee
- 400: Ordering, Prescribing, Referring (OPR)

Smoking/Tobacco Cessation Counseling

Effective on claims with dates of service on or after December 1, 2021, Current Procedural Terminology (CPT) codes 99406 (Smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes) may be used to bill smoking cessation counseling for all Nevada Medicaid recipients. Procedure codes 99406 and 99407 are no longer restricted to counseling for pregnant women only. The limitation for both codes is a maximum of 24 encounters per year. These limitations can be exceeded if determined medically necessary by Nevada Medicaid.

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.

- Neuropsychological, Psychological and Developmental Testing:

  Prior authorization is required for all of the following services: Developmental testing (CPT codes 96112 and 96113); Psychological testing administration and scoring (CPT codes 96136, 96137, 96138 and 96139) and Psychological testing evaluation services (CPT codes 96130 and 96131); Neuropsychological testing administration and scoring (CPT codes 96136, 96137, 96138 and 96139) and Neuropsychological testing evaluation services (CPT codes 96132 and 96133); and Automated Testing and Result (96146). Prior authorization must indicate medical necessity and the number of units requested should not exceed the reasonable time necessary to address the treating provider's referral question with identified measures.

  Prior authorization requests for Psychological testing must include one (1) unit of testing evaluation services (CPT code 96130) and one (1) unit of testing administration and scoring services (CPT code 96136 or CPT code 96138).

Prior authorization requests for Neuropsychological testing must include one (1) unit of testing evaluation services (CPT code 96132) and one (1) unit of testing administration and scoring services (CPT code 96136 or CPT code 96138).

- Neurotherapy (CPT codes 90875 and 90876) and Biofeedback Training (CPT code 90901). Neurotherapy is inclusive of a psychotherapy component incorporating a biofeedback component delivered by a certified Biofeedback Technician. Both components must be delivered by a qualified provider or providers enrolled under Nevada Medicaid. Neurotherapy is allowed for up to 18 units for adults and 26 units for children annually. Biofeedback is allowed for up to 6 units per a 4-week period. If additional services are medically necessary, providers may submit a request for prior authorization. Documentation of the service must include both components, completed appropriately by the provider of the component.
- Psychoanalysis (CPT code 90845) requires prior authorization to exceed the service limitations based on the Intensity of Needs determination.

Health and behavior assessment and re-assessment (CPT code 96156) needs prior authorization only to exceed units (one unit equals face-to-face with patient assessment/reassessment) per calendar year. Health and Behavior Interventions do not require prior authorization.

HCPCS code T1016 (Case management): Prior authorization demonstrating medical necessity is required if the service will exceed limitation. Limitation is 10 hours for the first calendar month (40 units), and five hours for the following three consecutive calendar months (20 units per month). The four months must be consecutive. The limit is based on per recipient, per calendar month.

It is important to verify that an approved prior authorization is in place before providing services. This can be verified online through the Provider Web Portal (PWP). Instructions to verify PA are in the PWP User Manual Chapter 4 Prior Authorization under Checking Prior Authorization Status.

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.

Request timelines

- **Initial request for Outpatient Mental Health (OMH)**: Submit no more than 15 *business* days *before* and no more than 15 *calendar* days *after* the start date of service.
- **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.
- **Unscheduled revisions**: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of requested units should be appropriate for the remaining time in the existing authorization period.
- **Retrospective request**: Submit no later than 90 days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively.
- **Emergency request for Crisis Intervention only**: Submit within five (5) business days of the delivery of additional services, including the first date of service of the first occurrence.

Prior Authorization Forms

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

- Use form FA-10C to request authorization for **developmental testing.**
- Use form FA-10D to request authorization for **automated 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.

Billing instructions

Follow the instructions specified in the Transaction 837P – Professional Health Care Claim and Encounter EDI Companion Guide, which is available on the Electronic Claims/EDI webpage, and PWP Chapter 3 Claims, which is available on the PWP User Manual webpage.

HCPCS Code T1016: Providers must bill using the U1 modifier to determine the first starting month, U2 for the second month, U3 for the third month and U4 for the fourth month. If the claim is outside the four consecutive months, do not bill with modifiers U1 to U4.

National Correct Coding Initiative (NCCI) Edits and Service Limitations

The objective of the National Correct Coding Initiative (NCCI) is to promote correct coding methodologies. The Centers for Medicare & Medicaid Services (CMS) is responsible for the development and administration of the NCCI Edits: *"The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices."*

Nevada's Medicaid Management Information System (MMIS) uses NCCI Edits in the processing of Nevada Medicaid claims. Nevada Medicaid receives quarterly and annual NCCI Edit updates that are added to the MMIS. Providers can find the most current Annual Code report and the quarterly Medically Unlikely Edits (MUE), Procedure to Procedure (PTP) and Add-On Code reports on the following website:

https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

It is not possible to provide the most current quarterly or annual changes in this billing guide; for the most current information please reference the website link provided above.

Providers are reminded to bill procedures with the correct modifier combinations, units of service provided and correct code combinations.

Note: It is the responsibility of providers to ensure the use of current CPT codes, service limitations and MUEs are applied when billing claims.