Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services

Health Care Financing Administration

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CHANGE REQUEST 710

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2150 - 2152 (Cont.)	2-86.3 - 2-86.6 (4 pp.)	2-86.3 - 2-86.6 (4 pp.)

REVISED MATERIAL--EFFECTIVE DATE: June 30, 1998
IMPLEMENTATION DATE: July 1, 2000

Section 2150, Clinical Psychologists Services, is revised to reflect the provisions of §6113 of the Omnibus Budget Reconciliation Act of 1989, §4157 of the Omnibus Budget Reconciliation of 1990, and §147(b) of the Social Security Act of 1994.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Allied Health Professionals/Nonphysician Practitioners

2150. CLINICAL PSYCHOLOGIST SERVICES

Section 6113(a) of OBRA 1989 (P. L. 101-239) eliminates the restriction on clinical psychologist (CP) services imposed by prior law, which required that, to be paid for directly, the services be furnished at community mental health centers (CMHCs) or offsite at a CMHC for those who are institutionalized or are physically or mentally impaired.

A CMHC is an institution that provides the mental health services required by §1916(c)(4) of the PHS Act and is certified by the appropriate State authorities as meeting such requirements.

Services furnished by a CP and services furnished incident to the services of a CP to hospital patients during the period July 1, 1990, through December 31, 1990, were bundled. Therefore, Medicare made payment to the hospital for these services. However, as a result of the enactment of §4157 of OBRA 1990, effective January 1, 1991, professional CP services furnished to hospital patients are no longer bundled under 42 CFR 411.15(m). Section 4157 amended §1862(a)(14) of the Act to permit direct payment to CPs under Medicare Part B for such services. However, services furnished incident to the professional services of CPs to hospital patients remain bundled. Therefore, payment must continue to be made to the hospital for such "incident to" services.

The diagnostic services of psychologists who are not clinical psychologists, and who are practicing independently, are discussed in §2070.2.

A. Clinical Psychologist Defined.--To qualify as a CP, a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology;

- Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

B. Qualified Clinical Psychologist Services Defined.--Effective July 1, 1990, the diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished.

C. Types of Clinical Psychologist Services That May Be Covered.--CPs may provide the following services:

- Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and/or regulation. Pay all qualified CPs based on the fee schedule for their diagnostic and therapeutic services. Also, pay those practitioners who do not meet the requirements for a CP on the basis of the physician fee schedule for the provision of diagnostic services under §2070.2.

o Services and supplies furnished incident to a CP's services are covered if the requirements that apply to services incident to a physician's services, as described in §2050.1 are met. These services must be:

- Mental health services that are commonly furnished in CPs' offices;
- An integral, although incidental, part of professional services performed by the CP;

- Performed under the direct personal supervision of the CP, i.e., the CP must be physically present and immediately available; and

- Furnished without charge or included in the CP's bill.

Any person involved in performing the service must be an employee of the CP (or an employee of the legal entity that employs the supervising CP) under the common law control test of the Act, as set forth in 20 CFR 404.1007 and §RS 2101.020 of the Retirement and Survivors Insurance part of the Social Security Program Operations Manual System.

Be familiar with appropriate State laws and/or regulations governing a CP's scope of practice. The development of lists of appropriate services may prove useful.

D. Noncovered Services.--The services of CPs are not covered if they are otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. For example, §1862(a)(1)(A) of the Act excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though the services are authorized by State law, the services of a CP that are determined to be not reasonable and necessary are not covered. Additionally, any therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are not covered.

E. Requirement for Consultation.--When applying for a Medicare provider number, a CP must submit to the carrier a signed Medicare provider/supplier enrollment form that indicates an agreement to the effect that, contingent upon the patient's consent, he or she will attempt to consult with the patient's attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality.

If the patient assents to the consultation, the CP must attempt to consult with the patient's physician within a reasonable time after receiving the consent. If the CP's attempts to consult directly with the physician are not successful, the CP must notify the physician within a reasonable time that he or she is furnishing services to the patient. Additionally, the CP must document, in the patient's medical record, the date the patient consented or declined consent to consultations, the date of consultation, or, if attempts to consult did not succeed, that date and manner of notification to the physician.

The only exception to the consultation requirement for CPs is in cases where the patient's primary care or attending physician refers the patient to the CP. Also, neither a CP nor a primary care or attending physician may bill Medicare or the patient for this required consultation.

See H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 789 (1989).

F. Payment Methodology Limitation.--Payment for the services of CPs is made on the basis of a fee schedule or the actual charge, whichever is less, and only on the basis of assignment.

G. Outpatient Mental Health Services Limitation.--All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health services limitation in §2470ff (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services. (See §2472.4.C.)

H. Assignment Requirement.--Make all claims for covered services rendered by CPs on an assignment basis.

2152. CLINICAL SOCIAL WORKER SERVICES

Medical and other health services include the services provided by a clinical social worker (CSW). Payment is made only under assignment. The amount payable cannot exceed 80 percent of the lesser of the actual charge for the services or 75 percent of the amount paid to a psychologist for the same service. See §5112 for the payment guidelines and subsection F for application of the mental health payment limitation.

A. Clinical Social Worker Defined.--Section 1861(hh) of the Act defines a "clinical social worker" as an individual who:

- Possesses a master's or doctor's degree in social work;
- Has performed at least 2 years of supervised clinical social work; and
- Either;
  - Is licensed or certified as a clinical social worker by the State in which the services are performed; or
  - In the case of an individual in a State that does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic.

B. Clinical Social Worker Services Defined.--Section 1861(hh)(2) of the Act defines "clinical social worker services" as those services that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a SNF that the SNF is required to provide as a requirement for participation are not included. The services that are covered are those that are otherwise covered if furnished by a physician or as an incident to a physician's professional service.

C. Covered Services.--Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a CSW may be covered under Part B if they are:

- The type of services that are otherwise covered if furnished by a physician, or as incident to a physician's service. (See §2020 for a description of physicians' services and §2020.2 for the definition of a physician.);

- Performed by a person who meets the definition of a CSW (see subsection A); and

- Not otherwise excluded from coverage.

Become familiar with the State law or regulatory mechanism governing a CSW's scope of practice in your service area. The development of a list of services within the scope of practice may prove useful.

D. Noncovered Services.--Services of a CSW are not covered when furnished to inpatients of a hospital or to inpatients of a SNF if the services furnished in the SNF are those that the SNF is required to furnish as a condition of participation in Medicare. In addition, CSW services are not covered if they are otherwise excluded from Medicare coverage even though a CSW is authorized by State law to perform them. For example, the Medicare law excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

F. Outpatient Mental Health Services Limitation.--All covered therapeutic services furnished by qualified CSWs are subject to the outpatient psychiatric services limitation in §2470ff (i.e., only 62 1/2 percent of expenses for these services are considered incurred expenses for Medicare purposes). The limitation does not apply to diagnostic services. (See §2476.5.)