TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2

BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES HANDBOOK

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# BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES HANDBOOK

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Note: A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).
1. GENERAL INFORMATION

The information in this handbook is intended for the Case Management for the Blind Children’s Vocational Discovery and Development Program (BCVDDP), Case Management for Children and Pregnant Women (CPW), Early Childhood Intervention (ECI) Targeted Case Management services, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), Mental Health and Mental Retardation Center (MHMR), or psychologist.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.4.1.2, “Reporting Child Abuse or Neglect” and subsection 1.4.1.5, “Training” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information).

Important: All providers are required to read and comply with Section 1, “Provider Enrollment and Responsibilities”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure to deliver, at all times, healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Subsection 8.1, “Medicaid Managed Care” (Vol. 1, General Information).


2. BLIND CHILDREN’S VOCATIONAL DISCOVERY AND DEVELOPMENT PROGRAM (BCVDDP)

2.1 Enrollment

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid provider of case management for children who are 15 years of age or younger and blind or visually impaired. Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in DBS case management activities.

Refer to: Subsection 1.1, “Provider Enrollment” (Vol. 1, General Information) for more information about procedures for enrolling as a Medicaid provider.
2.1.1 Medicaid Managed Care Enrollment
DARS DBS providers do not need to enroll with Medicaid Managed Care. All claims for service provided by DARS DBS are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients.

2.2 Services/Benefits, Limitations, and Prior Authorization
Services eligible for reimbursement are limited to 1 payable contact per month per client, regardless of the number of contacts that are made during the month. DARS DBS providers should bill procedure code G9012.

A contact is defined as “an activity performed by a case manager with the client or with another person or organization on behalf of the client to locate, coordinate, and monitor necessary services.”


2.2.1 Prior Authorization
Prior authorization is not required for BCVDDP case management services.

2.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including BCVDDP services.

BCVDDP services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement
BCVDDP case management services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements. Providers must not submit a claim when or after the client turns 16 years of age.

Any child with a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child’s development and provides blindness-specific services to increase the child’s skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the DARS website at www.dars.state.tx.us.

Case management services for BCVDDP are reimbursed at a fixed rate in accordance with 1 TAC §355.8381. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.
3. CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN (CPW)

3.1 Overview

Case management services are provided to help eligible clients get necessary medical, social, educational, and other services; encourage cost-effective health and health-related care; discourage overutilization or duplication of services; and make appropriate referrals to providers. Case managers assess a client’s need for medical, social, educational, and other services and then develop a service plan to address those needs.

3.1.1 Eligibility

To be eligible for services, a person must:

- Be eligible for Texas Medicaid.
- Be a pregnant woman with a high-risk condition or a child (birth through 20 years of age) with a health condition or health risk.
- Be in need of services to prevent illnesses or medical conditions, to maintain function, or to slow further deterioration.
- Want to receive case management services.

Pregnant women with a high-risk condition are defined as women who are pregnant and have one or more high-risk medical or psychosocial conditions during pregnancy. Children with a health condition are defined as children with a health condition or health risk or children who have or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

3.1.2 Referral Process

To refer a Medicaid client for CPW services, call 1-877-847-8377 or consult the CPW provider list at www.dshs.state.tx.us/caseman/providerRegion.shtm. A referral for CPW services can be received from any source. A case management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.

3.2 Enrollment

Enrollment for CPW providers is a two-step process.

Step 1

Potential providers must submit a Department of State Health Services (DSHS) Case Management for CPW provider application to the DSHS Health Screening and Case Management Unit.
Both registered nurses who have an associate’s, bachelor’s, or advanced degree and social workers who have a bachelor’s or advanced degree are eligible to become case managers if they are currently licensed by their respective Texas licensure boards and the license is not temporary in nature. To be eligible, case managers must also have at least 2 years of cumulative, paid, full-time work experience or 2 years of supervised full-time, educational, internship/practicum experience in the past 10 years. The experience must be with pregnant women or with children who are 20 years of age or younger. The experience must include assessing psychosocial and health needs and making community referrals for these populations.

For more information about provider qualifications and enrollment, contact DSHS at 1-512-458-7111, Ext. 2168, visit the case management website at www.dshs.state.tx.us/caseman/default.shtm, or write to the following address:

Case Management
Health Screening and Case Management Unit
1100 West 49th Street, MC 1938
Austin, TX 78756-3199

Note: Before providing services, each case manager must attend DSHS case manager training. Training is conducted by DSHS regional staff.

Step 2
Upon approval by DSHS, potential providers must enroll as a Medicaid provider for CPW and submit a copy of their DSHS approval letter. Facility providers must enroll as a CPW group, and each eligible case manager must enroll as a performing provider for the group. Federally Qualified Health Center (FQHC) facilities that provide CPW services will use their FQHC number and should not apply for an additional provider number for CPW.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about the procedures for enrolling as a Medicaid provider.

3.2.1 Medicaid Managed Care Enrollment
CPW providers are not required to enroll in Medicaid managed care. All claims for services provided by CPW providers are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients. Medicaid managed care health plans are not responsible for reimbursing CPW program services.

3.3 Services/Benefits, Limitations, and Prior Authorization
CPW services are limited to 1 contact per day per client. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

The procedure code to be used for all CPW services is G9012. Modifiers are used to identify which service component is provided.

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<tr>
<th>Service</th>
<th>Contact Code</th>
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<tbody>
<tr>
<td>Comprehensive visit</td>
<td>G9012 with modifier U5 and modifier U2</td>
</tr>
<tr>
<td>Follow-up face-to-face</td>
<td>G9012 with modifier U5 and modifier TS</td>
</tr>
<tr>
<td>Follow-up telephone</td>
<td>G9012 with modifier TS</td>
</tr>
</tbody>
</table>

Providers must adhere to CPW case management program rules, policies, and procedures.

Note: CPW providers are not required to file claims with other health insurance before filing with Medicaid.

Reminder: Billable services are defined in program rule 25 TAC §27.5.

CPW services are not billable when a client is an inpatient at a hospital or other treatment facility.
Reimbursement will be denied for services rendered by providers who have not been approved by the DSHS Health Screening and Case Management Unit.

3.3.1 Prior Authorization

All services must be prior authorized. One comprehensive visit is approved for all eligible clients. Follow-up visits are authorized based on contributing factors. Additional visits can be requested and may be authorized based on a continuing need for services. A prior authorization number is required on all claims for CPW services.

*Note:* Prior authorization is a condition of reimbursement, not a guarantee of payment.

Approved case management providers may request prior authorization from DSHS by fax at 1-512-458-7574 or on the website at www.dshs.state.tx.us/caseman/subpaweb.shtm.

3.4 Technical Assistance

Providers may contact DSHS program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns.

3.4.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure may contact DSHS program staff. Contact names and numbers can be obtained from the case management website at www.dshs.state.tx.us/caseman/default.shtm, or by calling 1-512-458-7111, Ext. 2168.

Regional staff make routine contact with providers to ensure providers are delivering services as required.

3.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CPW services.

CPW services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.6 Claims Filing and Reimbursement

3.6.1 Assistance with Claims Concerns

Providers should review all Medicaid bulletins for any changes to claim filing requirements. Providers that have questions, concerns, or problems about claims should contact the TMHP provider relations representative in their region. Call the TMHP Contact Center at 1-800-925-9126 for more information about provider relations representatives.

3.6.2 Claims Information

CPW services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

CPW providers are reimbursed in accordance with 1 TAC §355.8401. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.
Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement.

4. EARLY CHILDHOOD INTERVENTION (ECI) TARGETED CASE MANAGEMENT SERVICES

4.1 Overview

ECI Targeted Case Management services are provided to Medicaid-eligible children who have been determined to be eligible for ECI services by the ECI program providers. ECI Targeted Case Management services help eligible children and their families get needed medical, social, educational, developmental and other appropriate services. Services include a comprehensive needs assessment, development of a Case Management Care Plan, referral and related activities, and the coordination, monitoring, and follow-up activities that are necessary to meet the needs of the child.

The Texas ECI Program is available statewide to families of children who are birth through 35 months of age and who have disabilities or developmental delays. The state agency responsible for ECI services is DARS. DARS contracts local ECI programs to take referrals, determine clients’ eligibility for ECI, and provide services, including case management services, to ECI-eligible children.

ECI programs use evaluations and assessments to determine eligibility. Children are eligible for ECI if they are birth through 35 months of age and have one or more of the following:

- Developmental delay—A delay in the development of cognitive, motor, communication, social-emotional, or self-help skills.
- Atypical development—Patterns of development that are unusual or different from their peers, including unusual sensory-motor or language patterns, auditory impairments, and visual impairments.
- Medically diagnosed condition that has a high probability of resulting in developmental delay—Diagnoses that have a high probability of resulting in developmental delay include, but are not limited to, Down syndrome and spina bifida.

Families and professionals work together to develop an Individualized Family Service Plan (IFSP) and a Case Management Care Plan for appropriate services that are based on the unique needs of the child and the child’s family.

Other ECI services include physical, occupational, and speech-language therapy; nursing services; vision services; audiology services; developmental services; nutrition services; psychological services; social work; family education and counseling; behavioral intervention; socialization services; health services; transportation; and assistive technology services and devices.

4.2 Enrollment

To be a qualified provider, the provider must be contracted by the DARS ECI Program and must comply with all of the applicable federal and state laws and regulations that govern the ECI program. ECI providers are eligible to enroll as Texas Medicaid Targeted Case Management providers and to render
services to children who are birth through 35 months of age and who have a disability or developmental delay, as defined by ECI criteria. After meeting the case management criteria of the Texas ECI Program, providers must request a Medicaid application from TMHP Provider Enrollment.

To participate in Texas Medicaid, an ECI provider must comply with all applicable federal, state, local laws, and regulations about the services provided. Facilities must be certified by the Texas ECI Program and must submit a copy of the current contract award from the Texas ECI Program.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about the procedures for enrolling as a Medicaid provider.

4.2.1 Medicaid Managed Care Enrollment
ECI Targeted Case Management providers do not need to enroll in Medicaid managed care. Providers must file all claims for ECI Targeted Case Management services to TMHP, including those for Medicaid managed care clients. Medicaid managed care health plans are not responsible for reimbursing ECI Targeted Case Management services.

4.3 Services/Benefits, Limitations, and Prior Authorization
ECI providers are reimbursed for Targeted Case Management services that are rendered to children who are birth through 35 months of age and who have a disability or developmental delay as defined by ECI criteria. Targeted Case Management services can be billed only 1 time per month per eligible child, regardless of the number of contacts during the month. Targeted Case Management services must be stated in the child’s Case Management Care Plan. Providers must submit claims for ECI Targeted Case Management Services using procedure code G9012. Children lose their eligibility for ECI services on their third birthday.

A contact is defined as an activity performed by the assigned service coordinator (case manager) with the client or with another person or organization on behalf of the client to locate, coordinate, and facilitate access to necessary services.

4.3.1 ECI Referral Requirement
All health-care professionals are required by federal and state regulations to refer children who are birth through 35 months of age to the Texas ECI Program within 2 business days of identifying a disability or suspected delay in development.

Referrals can be based on professional judgment or a family’s concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the DARS Inquiries Line at 1-800-628-5115. For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are deaf or hard of hearing can call the TDD/TTY Line at 1-866-581-9328.


4.3.2 Prior Authorization
Prior authorization is not required for ECI services.

4.4 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including ECI services.

ECI services are subject to retrospective review and recoupment if documentation does not support the service billed.
4.5 Claims Filing and Reimbursement

Claims for Targeted Case Management services that have been rendered by an ECI provider must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements.

ECI Targeted Case Management services are reimbursed according to a maximum allowable fee established by HHSC. See the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid reimburses covered ECI services which are mostly provided in the child’s natural environments. Natural environments are defined as settings that individual families identify as natural or normal for their family, including the home, neighborhood, and community settings in which children without disabilities participate. ECI Targeted Case Management services may be provided in the following places of service (POS): office/ facility (POS 1), home (POS 2), and other locations (POS 9). The POS for ECI Targeted Case Management is determined by the service coordinator’s location at the time the service is rendered.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.


Instructions for completing paper claims are provided in subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information).

Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement.

5. LICENSED CLINICAL SOCIAL WORKER (LCSW), LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT), AND LICENSED PROFESSIONAL COUNSELOR (LPC)

5.1 Enrollment

5.1.1 LCSW

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

5.1.2 LMFT

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a multi-speciality group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.
5.1.3 LPC

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about procedures for enrolling as a Medicaid provider.

Section 8, "Managed Care" (Vol. 1, General Information) for more information, or contact the client’s behavioral health organization (BHO).

5.2 Services/Benefits, Limitations, and Prior Authorization

Psychotherapy/counseling services that are provided by LCSWs, LMFTs, and LPCs are benefits of Texas Medicaid for clients of any age who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

Psychotherapy/counseling services can be provided in the office (POS 1), home (POS 2), skilled nursing or intermediate care facility (SNF/ICF) (POS 4), outpatient hospital (POS 5), extended care facility (ECF) (POS 8), or in other locations (POS 9).

LCSWs, LMFTs, and LPCs must not bill for services that were provided by people under their supervision, including services provided by students, interns, and licensed professionals. Services may only be billed to Texas Medicaid if they were provided by a licensed LCSW, LMFT, or LPC who is a Medicaid-enrolled practitioner. LCSWs, LMFTs, and LPCs who are employed by or remunerated by another provider may not bill Texas Medicaid directly for counseling services if that billing would result in duplicate payment for the same services.

If more than one type of session is provided on the same date of service (outpatient individual, group, or family psychotherapy/counseling), each session type will be reimbursed individually. The only services that can be reimbursed are those provided to the Medicaid-eligible client per session.

Services that are provided by a psychiatric nurse, mental health worker, psychiatric assistant, or psychological assistant (excluding a Masters-level licensed psychological associate [LPA]) are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Documentation of the face-to-face time with the client must be maintained in the client’s medical record to support the procedure code billed. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider.

Documentation must include the following:

- The times at which the session began and ended
- All of the pertinent information about the client’s condition that is necessary to substantiate the need for services, including, but not limited to, the following:
  - A complete diagnosis, as listed in the DSM-IV-TR
  - Background, symptoms, impression
  - Narrative description of the assessment
Behavioral observations made during the session
Narrative description of the counseling session
Treatment plan and recommendations

All payments are subject to recoupment if the required documentation is not maintained in the client’s medical record.

Family psychotherapy/counseling is reimbursed for only one Medicaid eligible client per session, regardless of the number of family members present during that session. When providing family counseling services, the Texas Medicaid client and a family member must be present during the face-to-face encounter/visit.

According to the definition of “family” provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in the supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
- Foster parent
- Legal guardian

Behavioral health services are limited to a total of 4 hours per client per day, regardless of the provider.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as any/all behavioral health services (such as examinations, therapy, psychological or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes encounters/visits by all behavioral health practitioners.
Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

HHSC and TMHP routinely perform retrospective review of all providers. Retrospective review may include all behavioral health procedure codes included in the 12-hour system limitation.

Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider’s Texas Provider Identifier (TPI) base (the first seven digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

Refer to: Subsection 7.3, “The 12-Hour System Limitation” of this handbook for details about the 12-hours-per-day behavioral health services limitation.

LCSWs, LMFTs, and LPCs must bill therapy/counseling services with procedure code 90804, 90806, 90808, 90847, or 90853.

Note: LMFTs must use modifier U8 when billing these procedure codes.

Psychotherapy/counseling services (procedure codes 90804, 90806, 90808, 90847, and 90853) must be submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>29040</td>
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<td>29189</td>
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<td>31323</td>
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<td>99554</td>
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</tbody>
</table>
5.2.1 Prior Authorization

5.2.1.1 Initial Prior Authorization Request for Encounters/Visits beyond the 30-Encounter/Visit Limit

Each Medicaid client is limited to 30 encounters/visits per calendar year. It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required.

A provider who sees a client regularly and who anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client’s 25th encounter/visit.

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client’s 25th encounter/visit.

After the 30 encounter/visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters/visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter/visit annual limit must be submitted on a completed “Outpatient Psychotherapy/Counseling Form,” which must include the following:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- History of substance abuse
- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters and/or visits that the services will be provided
- Date on which the current treatment is to begin
- Indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services, when appropriate

Refer to: Form BH.1, “Outpatient Psychotherapy/Counseling Form” in Section 11, “Forms” in this handbook.

Note: All areas of the request form must be completed with the information required by the form. If additional room is needed for a particular section of the form, providers may state “see attached,” in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.
A prior authorization request for initial extended encounters/visits must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

Prior authorization requests will be reviewed by HHSC or its designee’s Medical Director. The number of encounters/visits that are prior authorized will depend upon the patient’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional request(s) must include the following new documentation concerning the patient’s current conditions.

5.2.1.1.1 Client Condition Requirements
The following documentation requirements indicating the client conditions must be submitted when requesting the prior authorization of initial outpatient services beyond the 30-encounter/visit annual limitation:

- A description of why treatment is being sought at the present time
- A mental status examination that verifies that a diagnosis is listed in the DSM-IV-TR
- A description of any existing psychosocial and/or environmental problems
- A description of the current level of social and occupational/educational functioning

5.2.1.1.2 Initial Assessment Requirements
There must be a pertinent history containing the following assessment requirements:

- A chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment
- A social and family history
- An educational and occupational history

5.2.1.1.3 Active Treatment Plan Requirements
The treatment plan must contain the following:

- A description of the primary focus of the treatment
- Clearly defined discharge goals that indicate that treatment can be successfully concluded
- The expected number of sessions it will take to reach the discharge goals, which must be based on the standards of practice for the client’s diagnosis
- Family therapy services are appropriately planned unless there are valid clinical contraindications

5.2.1.1.4 Discharge Plan Requirements
Discharge planning must reflect the following:

- A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
- An identification of the client’s aftercare needs that includes a plan of transition

5.2.1.2 Subsequent Prior Authorization Request for Encounters/Visits after the Initial Prior Authorized Encounters

5.2.1.2.1 Client Condition Requirements
The following documentation requirements indicating the client conditions must be submitted when requesting prior authorization for subsequent encounters/visits.
All of the requirements for the initial authorized treatment sessions must be met in addition to an assessment of the client’s response to treatment, which indicates one of the following:

- The client has not achieved the discharge goal necessary to conclude treatment, but the description of the client’s progress indicated that treatment can be concluded within a short period of time.
- The client’s psychiatric condition has not responded to a trial of short term outpatient therapy and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).
- The client’s condition is one that includes long-standing, pervasive symptoms and/or patterns of maladaptive behavior.

5.2.1.2.2 Active Treatment Plan Requirements

There must be an assessment that explains why the client was unable to achieve the expected treatment objectives that were previously set. The assessment must address the following:

- Factors that interfered or are interfering with the client’s ability to make progress as expected
- The continued appropriateness of the treatment goals
- The continued appropriateness of the type of therapy being utilized
- The need for obtaining consultation
- The current diagnosis and the need for revisions and/or additional assessments
- The ongoing treatment plan must reflect the initial treatment plan requirements and the additional information must include:
  - Changes in primary treatment focus or discharge goals have been identified and are consistent with the client’s current condition
  - The expected progress toward the discharge goals is described within the extended time frame
  - Appropriate adjustments have been made in the medication regimen based on the client’s therapeutic response
  - No contraindications to the use of the prescribed medications are present

5.2.1.2.3 Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
- An identification of the client’s aftercare needs that includes a plan of transition

5.2.1.2.4 Prior Authorization for Court-Ordered and Department of Family and Protective Services (DFPS)-Directed Services

A request for prior authorization of court-ordered or DFPS-directed services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services for outpatient behavioral health services may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for outpatient behavioral health services may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from or go beyond the DFPS direction, the additional services will be reviewed for medical necessity.
Court-ordered or DFPS-directed services will be prior authorized with modifier H9.

Mail or fax prior authorization request to:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-B Riata Trace Parkway, Suite 150  
Austin, TX 78727  
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: Subsection 5.3.1, “Prior Authorization Requests Through the TMHP Website” in section 5, Prior Authorization (Vol. 1, General Information) for additional information, including mandatory documentation and retention requirements.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including behavioral health services.

Behavioral health services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.4 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid’s responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client’s Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. Medicaid is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: Subsection 2.6.2, “Part B” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information)  
Subsection 4.9.2, “Medicare Part B Crossovers” in Section 4, Client Eligibility (Vol. 1, General Information)

LCSW, LMFT, and LPC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, “TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.  
Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Under 1 TAC §355.8261, an FQHC is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.
Refer to: Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement Subsection 7.3, “The 12-Hour System Limitation” in this handbook for details about the 12-hours-per-day behavioral health services limitation.

6. MENTAL HEALTH REHABILITATION, MENTAL HEALTH CASE MANAGEMENT, AND MENTAL RETARDATION SERVICE COORDINATION

6.1 Enrollment

To enroll in Texas Medicaid, MH providers must contact the DSHS at 1-512-206-5810. Entities that provide services to clients with MR must contact the Texas Department of Aging and Disability Services (DADS) at 1-512-438-3011 to be approved.

Local MR providers are eligible to enroll for MR service coordination with the approval of DADS. Local MH providers are eligible to enroll for MH rehabilitative services with the approval of DSHS.

A community mental health centers (CMHC) can enroll in Texas Medicaid without the approval of DSHS, but must be enrolled in Medicare.

6.1.1 Medicaid Managed Care Enrollment

MR service coordination, MH case management, and MH rehabilitative services providers are not required to enroll with Medicaid Managed Care. Claims for MR and MH services are submitted to TMHP for all Medicaid clients including Medicaid Managed Care clients.

Exception: MH providers in the Dallas service area must join the NorthSTAR BHOs to provide services to NorthSTAR clients.

Refer to: Section 8, ”Managed Care” (Vol. 1, General Information)

6.2 Services/Benefits, Limitations, and Prior Authorization

6.2.1 Service Coordination and Case Management

Texas Medicaid provides the following service coordination and case management services:

- Service coordination for people with MR or a related condition (adult or child) per consumer, per month. Persons with a related condition are eligible only if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an intermediate care facility for persons with mental retardation (ICF-MR) facility.

- Case management for people with serious emotional disturbance (child, 3 to 17 years of age)

- Case management for people with severe and persistent mental illness (adult, 18 years of age or older)

Providers must use the following procedure code and applicable modifiers for MR targeted case management:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service coordination for people with MR or a related condition (adult or child)</td>
<td>G9012</td>
<td>N/A</td>
<td>Once per calendar month</td>
</tr>
</tbody>
</table>
An MR service coordination reimbursable contact is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual who is eligible for service coordination. To bill and be paid for 1 unit of service coordination per month, at least 1 face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

Providers must use the following procedure code and applicable modifiers for MH targeted case management:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine mental health targeted case management (adult)</td>
<td>T1017</td>
<td>TF and HZ</td>
<td>32 units (8 hours) per calendar day for people 18 years of age or older</td>
</tr>
<tr>
<td>Routine case management (child and adolescent)</td>
<td>T1017</td>
<td>TF, HA, and HZ</td>
<td>32 units (8 hours) per calendar day for people 18 years of age or younger</td>
</tr>
<tr>
<td>Intensive case management (child and adolescent)</td>
<td>T1017</td>
<td>TF, HA, and HZ</td>
<td></td>
</tr>
</tbody>
</table>

An MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual who is authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Service coordination and case management services are not reimbursable when they are provided to a client who is eligible for Medicaid and who receives services through the HCS waiver. These services are included in the waiver. Claims submitted to TMHP for people who receive services under the HCS waiver are identified quarterly by DADS and payments are recouped.

Texas Medicaid must not be billed for service coordination or case management services provided to people who are residents or inpatients of:

- Nursing facilities (for people not mandated by the Omnibus Budget Reconciliation Act [OBRA] of 1987).
- An ICF-MR.
- State-supported living centers.
- State MH facilities.
- Title XIX participating hospitals, including general medical hospitals.
- Private psychiatric hospitals.
- A Texas Medicaid-certified residence not already specified.
- An institution for mental diseases, such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing the diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services.
- A jail or public institution.

Note: A contact by the service coordinator to assist in the discharge planning of some of the above may be reimbursed, if it is provided within 180 days before discharge. Service coordination services provided to people who are on predischARGE furlough to the community from a nursing facility, intermediate care facility, or state-supported living centers may be
reimbursed. Service coordination services provided to people who are on trial placement from a state MR facility to the community may be reimbursed if the person remains eligible for Texas Medicaid upon release from the facility and receives regular Texas Medicaid coverage.

Texas Medicaid must not be billed for MH case management services provided before the establishment of a diagnosis of mental illness and the authorization of services.

Refer to: Subsection 8.1, “Medicaid Managed Care” in Section 8, “Managed Care” (Vol. 1, General Information) for more information or contact the client’s BHO. Do not bill TMHP for MH case management services rendered to NorthSTAR clients.

Note: For more information about billing for MH Case Management, providers should refer to 25 TAC, Part 1, Chapter 412-Subchapter I and the Mental Health Case Management Billing Guidelines available through the Department of State Health Services, Mental Health, and Substance Abuse Program Services Division.

### 6.2.2 MH Rehabilitative Services

The following rehabilitative services may be provided to individuals who satisfy the criteria of the MH priority population and who are determined to need rehabilitative services. These services may be provided to a person with a single severe mental disorder (excluding MR, pervasive developmental disorder, or substance abuse) or a combination of severe mental disorders as defined in the DSM-IV-TR:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Limitations</th>
</tr>
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<tbody>
<tr>
<td>Day program for acute needs</td>
<td>G0177</td>
<td>HZ</td>
<td>6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older</td>
</tr>
<tr>
<td>Medication training and support, adult, individual</td>
<td>H0034</td>
<td>HZ</td>
<td>8 units (2 hours) per calendar day in any combination</td>
</tr>
<tr>
<td>Medication training and support, adult, group</td>
<td>H0034</td>
<td>HQ and HZ</td>
<td></td>
</tr>
<tr>
<td>Medication training and support, child and adolescent, individual</td>
<td>H0034</td>
<td>HA and HZ</td>
<td>8 units (2 hours) per calendar day in any combination, for people 18 years of age or younger</td>
</tr>
<tr>
<td>Medication training and support, child and adolescent with other individual</td>
<td>H0034</td>
<td>HA and HZ</td>
<td></td>
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<tr>
<td>Medication training and support, child and adolescent, group</td>
<td>H0034</td>
<td>HA and HQ</td>
<td></td>
</tr>
<tr>
<td>Medication training and support, child and adolescent with other group</td>
<td>H0034</td>
<td>HA, HQ, and HZ</td>
<td></td>
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<tr>
<td>Crisis intervention services, adult</td>
<td>H2011</td>
<td>HZ</td>
<td>96 units (24 hours) per calendar day in any combination</td>
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<tr>
<td>Crisis intervention services, child and adolescent</td>
<td>H2011</td>
<td>HA and HZ</td>
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<tr>
<td>Skills training and development, adult, individual</td>
<td>H2014</td>
<td>HZ</td>
<td>16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older</td>
</tr>
<tr>
<td>Skills training and development, adult, group</td>
<td>H2014</td>
<td>HQ and HZ</td>
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</table>
6.2.2.1 Rehabilitative Services Limitations

Texas Medicaid must not be billed for the following:

- Rehabilitative services provided:
  - Before the establishment of a diagnosis of mental illness and authorization of services.
  - Rehabilitative services provided to individuals who reside in an institution for mental diseases.
  - Rehabilitative services provided to general acute care hospital inpatients.
- Vocational services
- Educational services
- Nursing facility residents who are not mandated to need services by OBRA of 1987
- Services provided to individuals in jail or a public institution

Refer to: 25 TAC, Part I, Chapter 419, Subchapter L and the Medicaid MH rehabilitative billing guidelines, which are available through the Texas Department of State Health Services Mental Health and Substance Abuse Division, for more information.

6.2.2.2 Billing Units

All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary caregiver/legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are individual, group (15 continuous minutes), and day programs (45 to 60 continuous minutes).

6.2.3 Prior Authorization

Prior authorization is not required for MHMR services.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including MH and MR services.
MH and MR services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.4 Claims Filing and Reimbursement

MR coordination services and MH case management and rehabilitative services must be submitted to TMHP in an approved electronic claims format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

MHMR are cost reimbursed in accordance with 1 TAC §§355.743, 355.746, and 355.781. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Section 3, “TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement and the federal matching percentage.

7. PHYSICIAN, PSYCHOLOGIST, AND LICENSED PSYCHOLOGICAL ASSOCIATE (LPA) PROVIDERS

7.1 Enrollment

7.1.1 Physicians

To enroll in Texas Medicaid to provide medical services, physicians (doctor of medicine [MD] or doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], and doctor of podiatric medicine) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.
7.1.2 Psychologists

To enroll in Texas Medicaid, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists (TSBEP). Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric based psychologist is enrolling as part of a Medicare enrolled group, then the psychologist must also be enrolled in Medicare. Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. Texas Medicaid accepts temporary licenses for psychologists.

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about procedures for enrolling as a Medicaid provider.

Section 8, "Managed Care" (Vol. 1, General Information) for more information, or contact the client’s BHO.

7.1.3 Licensed Psychological Associate (LPA)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scopes and standards of practice. Services performed by an LPA are a Medicaid covered benefit when the following conditions are met:

- The services must be performed under the direct supervision of a licensed, Medicaid-enrolled psychologist.
- The supervising psychologist must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- The LPA performing the behavioral health service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

The TSBEP requires an LPA to work under the direct supervision of a licensed psychologist and does not allow an LPA to engage in independent practice. Therefore, an LPA will not be independently enrolled in the Medicaid program and must provide services under the delegating psychologist’s provider identifier.

LPAs may perform the same outpatient behavioral health services that are Medicaid benefits when performed by licensed psychologists. These services include psychiatric diagnostic interviews, psychological and neuropsychological testing, and psychotherapy/counseling (including individual, group, or family counseling.) A modifier must be used to identify whether the psychologist or the LPA performed the service.

Psychological services provided by a psychologist or LPA must be billed with a modifier. Any claim submitted without a modifier will be denied.

Modifiers to be used with procedure codes for licensed psychologist services:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Identifies services provided by a clinical psychologist</td>
</tr>
<tr>
<td>UC</td>
<td>Identifies services provided by an LPA</td>
</tr>
</tbody>
</table>

Psychological services provided by an LPA must be billed under the supervising psychologist's Medicaid identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.

Services performed by an LPA and billed with modifier UC must include the LPA license number. Any claim submitted with modifier UC indicating services provided by an LPA and billed without a license number will be denied.
Retrospective review may be performed to validate that services performed on the same client are not billed for the same time and date of service, and that modifiers billed match the provider performing the services.

Services performed by the LPA will be reduced to 70 percent of the psychologist reimbursement fee schedule rate.

### 7.2 Services/Benefits, Limitations, and Prior Authorization

#### 7.2.1 Physicians

Behavioral health services, including diagnostic interviews, psychotherapy/counseling (including individual, group, or family counseling), psychological and neuropsychological testing, pharmacological regimen oversight, pharmacological management, and chemical dependency treatment in chemical dependency treatment facilities (CDTF), are benefits of Texas Medicaid when these services are provided to clients who are experiencing a significant behavioral health issue that is causing distress, dysfunction, and/or maladaptive functioning as a result of a confirmed or suspected psychiatric condition, as defined in the current edition of the DSM-IV-TR.

#### 7.2.2 Psychologists and LPAs

Psychologists who are licensed by the TSBEP and enrolled as Medicaid providers and LPAs who are under the direct supervision of a psychologist are authorized to perform counseling and testing for mental illness/debility. Treatment does not include the practice of medicine.

The services provided by a licensed chemical dependency counselor (LCDC), social worker, psychiatric nurse, or mental health worker are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Psychologists must not bill for services performed by students, interns, or licensed professionals under their supervision except for services provided by licensed LPAs. For mental health services, only the licensed psychologist and Medicaid enrolled provider actually performing the service may bill Texas Medicaid. The services provided by an LCSW, LPC, or LMFT are reimbursable directly to the LCSW, LPC, or LMFT.

### 7.3 The 12-Hour System Limitation

The following provider types are limited in the Medicaid claims processing system to reimburse for a maximum combined total of 12 hour per day per provider system limitation for inpatient and outpatient behavioral health services:

- Clinical Nurse Specialist (CNS)
- LCSW
- LMFT
- LPC
- Nurse Practitioner (NP)
- Physician assistant (PA)
- Psychologist

Because MDs and doctors of osteopathy DOs can delegate and may submit claims in excess of 12 hour per day, they are not subject to the 12-hour system limitation.

Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed.
Because a psychologist can delegate to multiple LPAs and may submit claims for LPA services in excess of 12 hours per day, LPAs are not subject to the 12-hour system limitation.

All providers, including MDs and DOs and each provider to whom they delegate, are subject to retrospective review as outlined below, including the following:

- MDs and DOs and each provider to whom they delegate
- LPAs performing services under the direct supervision of a psychologist.

Court-ordered services are not subject to the 12-hour system limitation per provider per day when billed with modifier H9.

### 7.3.1 Retrospective Review of Behavioral Health Services Billed in Excess of 12 hours per Day

HHSC and TMHP routinely perform retrospective review of all providers. In addition, all provider types including MDs and DOs and each provider to whom they delegate are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day.

Retrospective review of any behavioral health provider may include:

- All behavioral health procedure codes included in the 12-hour system limitation
- All evaluation and management (E/M) procedure codes, including those listed in the E/M section of the *Current Procedural Terminology* (CPT), billed with a psychiatric diagnosis
- All remaining behavioral health procedure codes not included in the 12-hour system limitation such as group therapy and pharmacological management

Documentation requirements for all services billed are listed for each individual specialty in this handbook. If inappropriate payments are identified on retrospective review for any provider type, the reimbursement will be recouped.

Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider’s TPI base (the first seven digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

### 7.3.2 Procedure Codes included in the 12-hour System Limitation

The table below lists the inpatient and outpatient behavioral health procedure codes included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>NA</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90802</td>
<td>NA</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90804</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90805</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90806</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90807</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90808</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90809</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90810</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to 1 decimal point or rounded down to 1 decimal point following standard rounding procedures (as shown in the following example):

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>90811</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90812</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90813</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90814</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90815</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90816</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90817</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90818</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90819</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90821</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90822</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90823</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90824</td>
<td>20-30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90826</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90827</td>
<td>45-50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>90828</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90829</td>
<td>70-80 minutes</td>
<td>80 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>N/A</td>
<td>50 minutes</td>
</tr>
<tr>
<td>96101</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96110</td>
<td>N/A</td>
<td>30 minutes</td>
</tr>
<tr>
<td>96111</td>
<td>N/A</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96116</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96118</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

N/A = Not Applicable

<table>
<thead>
<tr>
<th>Total Time</th>
<th>Rounded Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.71 hours</td>
<td>11.7 hours</td>
</tr>
<tr>
<td>11.72 hours</td>
<td></td>
</tr>
<tr>
<td>11.73 hours</td>
<td></td>
</tr>
<tr>
<td>11.74 hours</td>
<td></td>
</tr>
<tr>
<td>11.75 hours</td>
<td>11.8 hours</td>
</tr>
<tr>
<td>11.76 hours</td>
<td></td>
</tr>
<tr>
<td>11.77 hours</td>
<td></td>
</tr>
<tr>
<td>11.78 hours</td>
<td></td>
</tr>
<tr>
<td>11.79 hours</td>
<td></td>
</tr>
</tbody>
</table>
### 7.3.3 Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12 hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of 0.5 for payment.

<table>
<thead>
<tr>
<th>TPI Base</th>
<th>TPI Suffix</th>
<th>Client</th>
<th>Code Billed</th>
<th>Amount Applied*</th>
<th>Total Time Paid</th>
<th>Qty.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567</td>
<td>01</td>
<td>A</td>
<td>90807</td>
<td>50</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>02</td>
<td>B</td>
<td>90828</td>
<td>80</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>C</td>
<td>90807</td>
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<td>50</td>
<td>1</td>
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<tr>
<td>1234567</td>
<td>03</td>
<td>D</td>
<td>90828</td>
<td>80</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
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<td>01</td>
<td>E</td>
<td>90807</td>
<td>50</td>
<td>50</td>
<td>1</td>
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<tr>
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<td>02</td>
<td>G</td>
<td>90807</td>
<td>80</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>H</td>
<td>90827</td>
<td>50</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>J</td>
<td>90828</td>
<td>80</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>02</td>
<td>K</td>
<td>90828</td>
<td>80</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>Final claim for the day</td>
<td>Subtotal</td>
<td>680 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>L</td>
<td>90828</td>
<td>80</td>
<td>40</td>
<td>.5</td>
</tr>
</tbody>
</table>

| Total | 760 billed minutes for 1 day | 720 paid minutes for 1 day |

* Time applies towards the 12-hour limit.

**Reminder:** The procedure codes listed above have time ranges built in so the quantity billed should be reflected in quantities of 1 versus the actual amount of time spent with the client, i.e., procedure code 90804 is for 20 to 30 minutes of time spent with the client. The provider would bill a quantity of 1 when submitting a claim.

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Claims submitted for psychological evaluation or testing performed by a qualified provider at the request of the DFPS, or by a court order, are not counted against the benefit limitations. These claims must be submitted with the following information:

- The provider must submit the claim using modifier H9 with the procedure code(s) billed.
- If psychological services are court ordered, the claim must include a copy of the court order for outpatient treatment signed by the judge, and documentation of medical necessity.
- If psychological services are directed by DFPS, the claim must include the name and telephone number of the DFPS employee who provided the direction, the reason for the DFPS request, and documentation of medical necessity.

Texas Medicaid does not cover treatment for chronic diagnoses such as mental retardation and organic brain syndrome. Psychiatric daycare is not a covered service.
Refer to: Subsection 2.2, “Reimbursement Methodology” in Section 2, “Texas Medicaid Reimbursement” (Vol. 1, General Information) for more information about reimbursement methodologies. Section 8, “Managed Care” (Vol. 1, General Information) Form BH.1, “Outpatient Psychotherapy/Counseling Form” in Section 11 of this handbook. Section 5, “Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)” in this handbook.

7.4 Outpatient Behavioral Health Services
Outpatient behavioral health services performed by the following providers are benefits to clients of any age with a diagnosis as outlined below when provided in the office, home, skilled nursing or intermediate care facility, outpatient hospital, extended care facility, or in other locations:

- CNS
- LCSW
- LPC
- LMFT
- Licensed Psychologist
- Licensed LPA under the direct supervision of a psychologist in accordance with the TSBEP
- PA
- Physicians/psychiatrist
- NP

7.4.1 Annual Encounters/Visits Limitations
Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client, for each calendar year. An encounter/visit is defined as any/all outpatient behavioral health services (i.e., examination, therapy, psychological and/or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes outpatient encounters/visits by all practitioners.

Each individual encounter/visit and each hour of psychological/neuropsychological testing will count toward the 30-encounter/visit limitation even when services are performed by different providers on the same date of service.

Services exceeding 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization must be obtained before providing the 25th service in a calendar year.

7.4.2 Prior Authorization Requirements after the Annual Encounter/Visit Limitations Has Been Met
All outpatient behavioral health services for all provider types approved to deliver outpatient services will require prior authorization with the exception of the following:

- CDTF services
- County Indigent Health Care Program (CIHCP) services
- FQHC and rural health clinic (RHC) services
- Laboratory and radiology services
- MHMR services
• Pharmacological regimen oversight (procedure code M0064) and pharmacological management (procedure code 90862)

• SHARS behavioral health rehabilitation services

• One psychiatric diagnostic interview (procedure code 90801 or 90802) per year, per client, per provider (same provider)

Prior authorization will be considered in increments of up to ten services per request once the annual encounter/visit limitation has been met. If the client changes providers during the year and the new provider is unable to obtain complete information on the client, prior authorization may be made when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the 25th encounter/visit and before rendering services. This information must be submitted in addition to the usual medical necessity information.

Prior authorization will not be granted to providers who have been seeing a client and have a well established relationship or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit.

All requests for prior authorization with the exception of psychological and neuropsychological testing must include a completed Outpatient Psychotherapy/Counseling Request Form dated and signed by the performing provider with the following information:

• Client name, Medicaid number, date of birth, age, and sex

• Provider name and identifier

• A complete diagnosis as listed in the current edition of the DSM-IV-TR

• History of substance abuse

• Current medications

• Current living condition

• Clinical update, including specific symptoms and responses to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and the planned frequency of encounters/visits)

• Number of services requested for each type of therapy and the dates based on the frequency of encounters/visits that the services will be provided

• The date on which current treatment is to begin

• A indication of court-ordered or DFPS-directed services

The Outpatient Psychotherapy/Counseling Request Form may be mailed to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization Department  
12357-B Riata Trace Parkway, Suite 150 
Austin, TX 78727

The form may also be faxed to 1-512-514-4214 or submitted online on the TMHP website at www.tmhp.com.

All of the required areas on the request form must be completed. If additional room is needed for a particular section of the form, providers may state “see attached” in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.
The request must be signed and received no later than the start date listed on the request form and no earlier than 30 days prior to the start date listed on the form.

To avoid unnecessary denials, the provider must provide correct and complete information, including accurate documentation of medical necessity for the services requested. The provider must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for outpatient behavioral health services.

The diagnosis code that supports medical necessity for the billed outpatient behavioral health service must be referenced on the claim.

### 7.5 Chemical Dependency Treatment Facility (CDTF)

CDTF services are a benefit of Texas Medicaid and are limited to clients 20 years of age or younger.

**Refer to:** Section 2, “Chemical Dependency Treatment Facility Services” in *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for more information about CDTF services.

### 7.6 Court-Ordered and DFPS-Directed Services

A request for prior authorization of court-ordered or DFPS-directed services must be submitted no later than seven calendar days after the date on which the services began.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional psychological or neuropsychological testing hours may be considered when supported by court-order or DFPS-direction, or as an exception on a case-by-case basis. All documentation must be maintained by the provider in the client's record.

Court-ordered services are not subject to the five day admission limitation or the seven day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from the DFPS direction, the additional services will be reviewed for medical necessity. Requested services beyond those directed by DFPS are subject to medical necessity review.

Court-ordered services are not subject to the 12-hour system limitation per provider per day when billed with modifier H9.

Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day.
7.7 Electroconvulsive Therapy (ECT)
ECT (procedure code 90870) is the induction of convulsions by the passage of an electric current through the brain. It is used in the treatment of certain psychiatric disorders. ECT treatments are limited to one per day.

ECT performed by the following providers may be provided in the office, outpatient hospital, and inpatient hospital setting:
- Physicians
- CNS
- PA
- NP

Authorization is not required for ECT services.

Psychotherapy billed in addition to ECT on the same day will be denied as part of another procedure on the same day.

Hospital subsequent care (procedure codes 99231, 99232, or 99233) billed on the same day as ECT is not separately payable. Hospital subsequent care for diagnoses unrelated to the ECT will be considered on appeal.

7.8 Family Therapy/Counseling Services
When providing family counseling services (procedure code 90847), the client and a family member must be present during the face-to-face visit.

According to the definition of family provided by the HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. The following specific relatives are included in family counseling services:
- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
• Foster parent
• Legal guardian

Regardless of the number of family members present per outpatient session, family counseling/psychotherapy (procedure code 90847) is reimbursed for only one Medicaid eligible client per session.

Procedure code 90847 is limited to one outpatient service per family per day.

Psychiatric diagnostic interviews (procedure code 90801 or 90802), pharmacological regimen oversight (procedure code M0064), pharmacological management (procedure code 90862) and any E/M service will be denied as part of family outpatient psychotherapy/counseling (procedure code 90847).

7.9 Pharmacological Regimen Oversight and Pharmacological Management Services

Pharmacological regimen oversight (procedure code M0064) and pharmacological management (procedure code 90862) services are a benefit of Texas Medicaid when provided by a physician, CNS, NP, or PA and are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29040 29041 29042 29043 2910 2911 2912 2913 2915 29181</td>
</tr>
<tr>
<td>29189 2919 2920 29211 29212 29281 29282 29283 29284 29289</td>
</tr>
<tr>
<td>2929 2930 29381 29382 29383 29384 29389 2939 2940 29410</td>
</tr>
<tr>
<td>29411 2948 29510 29520 29530 29540 29560 29570 29590</td>
</tr>
<tr>
<td>29600 29601 29602 29603 29604 29605 29606 29620 29621 29622</td>
</tr>
<tr>
<td>29623 29624 29625 29626 29630 29631 29632 29633 29634 29635</td>
</tr>
<tr>
<td>29665 29666 2967 29680 29689 29690 2971 2973 2988 2989</td>
</tr>
<tr>
<td>29900 29901 29910 29911 30000 30001 30002 30011 30012 30013</td>
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</tr>
<tr>
<td>3014 30150 3016 3017 30181 30182 30183 3019 3022 3023</td>
</tr>
<tr>
<td>3024 3026 30270 30271 30272 30273 30274 30275 30276 30279</td>
</tr>
<tr>
<td>30281 30282 30283 30284 30285 30289 3029 30300 30390 30400</td>
</tr>
<tr>
<td>30410 30420 30430 30440 30450 30460 30480 30490 30500 30520</td>
</tr>
<tr>
<td>30530 30540 30550 30560 30570 30590 30651 3070 3071 30720</td>
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</tr>
<tr>
<td>31289 3129 31323 31381 31382 31389 3139 31400 31401 3149</td>
</tr>
<tr>
<td>31500 3151 3152 31531 31532 31534 31539 3154 3159 V6101 V6102</td>
</tr>
<tr>
<td>V6103 V6104 V6105 V6106 V6109 V6221 V6222 V6229</td>
</tr>
</tbody>
</table>
The focus of a pharmacological management visit is the use of medication to treat a client’s signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal outpatient psychotherapy/counseling in a given day, the focus of the service is broader and would be outpatient psychotherapy/counseling rather than pharmacological management.

Pharmacological regimen oversight and pharmacological management services do not count towards the 12-hour per day per provider system limitation or the 30 encounter/visit annual limitation.

### 7.9.1 Indications for Pharmacological Regimen Oversight and Pharmacological Management Services

Pharmacological regimen oversight refers to a brief, face to face office encounter/visit for the sole purpose of evaluating, monitoring, or changing drug prescriptions or simple drug dosage adjustments and is a lesser level of drug monitoring than pharmacological management.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects, and represents a very skilled aspect of client care. It is intended for use for clients who are being managed primarily by psychotropics, antidepressants, ECT, and/or other types of psychopharmacologic medications. Pharmacological management cannot be billed when only a brief office visit to evaluate the client’s state is provided.

Pharmacological management can be provided in both the inpatient and outpatient settings.

Pharmacological management must be provided during a face-to-face visit with the client and any inpatient or outpatient psychotherapy/counseling provided during the pharmacological management visit must be less than 20 minutes.

Pharmacological management describes a physician service and cannot be provided by a nonphysician or ‘incident to’ a physician service, with the exception of CNSs, NPs, and PAs whose scope of license in this state permits them to prescribe.

### 7.9.2 Prior Authorization

Pharmacological regimen oversight and pharmacological management do not require prior authorization.

### 7.9.3 Documentation Requirements

Documentation of medical necessity for pharmacological management must be dated (month/date/year) and signed by the performing provider and address all of the following information in the client’s medical record in legible format:

- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- Medication history
- Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment
- Problems, reactions, and side effects, if any, to medications and/or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)
Documentation of medical necessity for pharmacological regimen oversight must address all of the following in the client's medical record:

- The client is evaluated and determined to be stable, but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels
- The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment
- Provider has documented the medication history in the client's records with current signs and symptoms, new medication modifications with anticipated outcome.

The treating provider must document the medical necessity of the chosen treatment, and must list on the claim and in the client's medical record the DSM-IV-TR diagnosis code that most accurately describes the condition of the client that necessitated the need for the pharmacological management. The DSM-IV-TR diagnosis code must be referenced on the claim. The medical record (hospital or outpatient records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the pharmacological regimen oversight or pharmacological management treatment and the outcome.

7.9.4 Reimbursement

Texas Medicaid does not reimburse pharmacological regimen oversight or pharmacological management for the actual administration of medication, or for observation of the client taking an oral medication. Administration and supply of oral medication are noncovered services.

Only one pharmacological regimen oversight or pharmacological management procedure code will be reimbursed for the same date of service. If the two procedure codes are billed for the same date of service by any provider, procedure code M0064 will be denied as part of procedure code 90862.

Pharmacological management, neurobehavioral status exam (procedure code 96116), and any E/M service will be denied as part of a diagnostic interview (procedure code 90801 or 90802) when billed for the same date of service by the same provider.

E/M services include pharmacological regimen oversight and pharmacological management. Pharmacological regimen oversight or pharmacological management will be denied as part of any E/M service billed for the same date of service, by the same provider.

If the primary reason for the office encounter visit is for inpatient or outpatient psychotherapy/counseling, then the specific inpatient or outpatient psychotherapy/counseling procedure code should be billed. Pharmacological regimen oversight or pharmacological management will be denied as part of any inpatient or outpatient psychotherapy/counseling service billed for the same date of service, by the same provider.

Pharmacological regimen oversight or pharmacological management is limited to one service per day, per client, by any provider in any setting. Pharmacological management is limited to the office setting.

Anesthesia for ECT (procedure code 00104) will be denied as part of pharmacological management when billed on the same date of service by the same provider.

7.10 Psychiatric Diagnostic Interviews

Psychiatric diagnostic interviews (procedure code 90801 or 90802) are benefits of Texas Medicaid when provided by psychiatrists, psychologists, NPs, CNSs, and PAs when performed in the inpatient and outpatient setting and are based on medical necessity.
A psychiatric diagnostic interview examination (procedure code 90801) includes a history, mental status and a disposition. It includes communication with family members. Medical interpretation of laboratory and other medical diagnostic studies are considered part of the service. Documentation time and time spent on medical records is not reimbursed separately but is part of the diagnostic interview service.

An interactive psychiatric diagnostic interview may be covered to the extent that it is medically necessary and are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29040 29041 29042 29043 2910 2911 2912 2913 2915 29181</td>
</tr>
<tr>
<td>29189 2919 2920 29211 29212 29281 29282 29283 29284 29289</td>
</tr>
<tr>
<td>2929 2930 29381 29382 29383 29384 29389 2939 2940 29410</td>
</tr>
<tr>
<td>29411 2948 2949 29510 29520 29530 29540 29560 29570 29590</td>
</tr>
<tr>
<td>29600 29601 29602 29603 29604 29605 29606 29620 29621 29622</td>
</tr>
<tr>
<td>29623 29624 29625 29626 29630 29631 29632 29633 29634 29635</td>
</tr>
<tr>
<td>29636 29640 29641 29642 29643 29644 29645 29646 29650 29651</td>
</tr>
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Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A psychiatric diagnostic interview may be incorporated into an E/M service provided the required elements of the E/M service are fulfilled. An E/M procedure code may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a diagnostic interview.
Due to the nature of these visits, the general time frame for such a diagnostic interview visit is one hour. A psychiatric diagnostic interview or an interactive psychiatric diagnostic interview examination counts towards the 12-hour per day per provider system limitation.

7.10.1 Prior Authorization
Psychiatric diagnostic interviews performed in the inpatient setting are not limited to once per year, but must be based on medical necessity.

Psychiatric diagnostic interviews are limited to once per client by the same provider per year and do not require prior authorization when performed in the office, home, nursing facility, outpatient hospital, or other settings. Psychiatric diagnostic interviews are limited to once per day per client by any provider, regardless of the number of professionals involved in the interview.

Additional psychiatric diagnostic interviews may be considered for prior authorization on a case-by-case basis when submitted with supporting documentation, including but not limited to the following:

- A court order or a DFPS directive
- If a new episode of illness occurs after a hiatus

7.10.2 Documentation Requirements
In addition to the inpatient and outpatient psychotherapy/counseling documentation requirements outlined in this section, supporting documentation for psychiatric diagnostic interview examinations must include:

- Reason for referral/presenting problem
- Prior history, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- Recommendations, including expected long term and short term benefits
- For the interactive psychiatric diagnostic interview (procedure code 90802), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques

7.10.3 Domains of a Clinical Evaluation
The following domains must be included in the evaluation documentation:

- Reason for the evaluation
- History of the present illness
- Past psychiatric history
- History of alcohol and other substance use
- General medical history
- Developmental, psychosocial, and sociocultural history
- Occupational and military history
- Legal history
- Family history of psychiatric disorder
- Mental status examination
The treating provider must document the medical necessity of the chosen treatment and list the
diagnosis code that most accurately describes the condition of the client that necessitated the need for
the psychiatric diagnostic interview in the client’s medical record. The medical record (inpatient or
outpatient hospital records, reports, or progress notes) must be signed and dated by the performing
provider, and should be clear and concise, documenting the reasons for the psychiatric diagnostic
interview and the outcome.

7.10.4 Reimbursement

A psychiatric diagnostic interview will be denied as part of an interactive psychiatric diagnostic
interview when billed for the same date of service by the same provider.

Psychiatric diagnostic interviews will be denied as part of another service when billed within 30 days of
any consultation (procedure codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, and
99255) by the same provider.

Psychiatric diagnostic interviews and pharmacological management will be denied as part of another
service when billed for the same date of service by the same provider as inpatient psychotherapy
(procedure code 90816, 90817, 90818, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829,
90835, or 90857), Narcosynthesis for psychiatric diagnostic and therapeutic purposes (procedure code
90865), and ECT (procedure code 90870).

Psychiatric diagnostic interviews, insight oriented behavior modifying and/or supportive psychotherapy
(procedure code 90816), pharmacological management, and any E/M service will be denied as part of
another service when billed for the same date of service by the same provider as individual psycho-
therapy 20-30 minutes with medical E/M services (procedure code 90817).

Psychiatric diagnostic interviews, insight oriented behavior modifying and/or supportive psychotherapy
(procedure code 90816 or 90817), and pharmacological management will be denied as part of another
service when billed for the same date of service by the same provider as individual psychotherapy 45-50
minutes (procedure code 90818).

Psychiatric diagnostic interviews, insight oriented behavior modifying and/or supportive psychotherapy
(procedure code 90816 or 90817), pharmacological management, and any E/M service will be
denied as part of another service when billed for the same date of service by the same provider as
individual psychotherapy 45-50 minutes with medical E/M services (procedure code 90819).

Psychiatric diagnostic interviews, insight oriented behavior modifying and/or supportive psychotherapy
(procedure code 90816, 90817, or 90818), and pharmacological management will be denied as part of
another service when billed for the same date of service by the same provider as individual psycho-
therapy 75-80 minutes (procedure code 90821).

Psychiatric diagnostic interviews, insight oriented behavior modifying and/or supportive psychotherapy
(procedure code 1-90816, 1-90817, 1-90818, or 1-90819), pharmacological management, and any E/M
service will be denied as part of another service when billed for the same date of service by the same
provider as individual psychotherapy 75-80 minutes with medical E/M services (procedure code 90822).

Psychiatric diagnostic interviews, interactive psychotherapy (procedure code 90823), pharmacological
management, and any E/M service will be denied as part of another service when billed for the same date
of service by the same provider as interactive psychotherapy 20-30 minutes with medical E/M
(procedure code 90824).

Psychiatric diagnostic interviews, interactive psychotherapy (procedure code 90823 or 90824), and
pharmacological management will be denied as part of another service when billed for the same date of
service by the same provider as interactive psychotherapy 45-50 minutes (procedure code 90826).
Psychiatric diagnostic interviews, interactive psychotherapy (procedure code 90824 or 90826), pharmacological management, and any E/M service will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 45-50 minutes with medical E/M (procedure code 90827).

Psychiatric diagnostic interviews, interactive psychotherapy (procedure code 90826), and pharmacological management will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 75-80 minutes (procedure code 90828).

Psychiatric diagnostic interviews, interactive psychotherapy (procedure code 90828), pharmacological management, and any E/M service will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 75-80 minutes with medical E/M (procedure code 90829).

Psychiatric diagnostic interviews, pharmacological management, and any E/M service will be denied as part of another service when billed for the same date of service by the same provider as narcosynthesis (procedure code 90865).

Pharmacological regimen oversight, pharmacological management, a neurobehavioral status exam (procedure code 96116), and any E/M service will be denied as part of a psychiatric diagnostic interview when billed for the same date of service by the same provider.

Psychiatric diagnostic interviews, pharmacological management, and any E/M service will be denied as part of group outpatient psychotherapy/counseling (procedure code 90853 or 90857).

### 7.11 Psychological and Neuropsychological Testing

Psychological testing (procedure code 96101) and neuropsychological testing (procedure code 96118) are covered services when provided by a psychiatrist, psychologist, or LPA under the direct supervision of the psychologist and are limited to the following diagnosis codes:

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Psychologists licensed by the TSBEP and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness/debility.

Psychological and neuropsychological testing are not covered benefits when provided by a CNS, NP, or PA. Each hour of psychological or neuropsychological testing does count toward the 12-hour per day per provider system limitation.

### 7.11.1 Prior Authorization

Psychological or neuropsychological testing require prior authorization in all places of service except the inpatient setting, with documentation of medical necessity, after the 30 encounter/visit annual limitation has been met, if more than four hours of testing per day, or more than eight hours of testing per calendar year are medically necessary and must be submitted on a Psychological/Neuropsychological Testing Request Form.

If the client requires more than four hours of testing per day, or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional testing hours may be considered as an exception on a case-by-case basis when supported by medical necessity. The number of hours prior authorized are based on the client’s medical necessity as supported by the submitted documentation. All documentation must be maintained by the provider in the client's medical record.

### 7.11.2 Documentation Requirements

The treating provider must document the medical necessity of the chosen treatment and list the DSM-IV-TR diagnosis code that most accurately describes the condition of the client that necessitated the need for the psychological/neuropsychological testing in the client’s medical record. The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychological/neuropsychological testing and the outcome.
In addition, the following documentation must be maintained by the provider in the client's medical record:

- The Psychological/Neuropsychological Testing Request Form
- The name of the tests that were performed (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI])
- How the tests were scored
- The location at which the test was performed
- The name and credentials of each of the providers who were involved in the administration, interpretation, and preparation of the test
- The interpretation of the test, which must include narrative descriptions of the findings of the tests
- The length of time that each provider spent in face-to-face administration, interpretation, reporting the test, integrating the test interpretation, and writing the comprehensive report based on the integrated data
- The treatment being administered, including how the test results affect the prescribed treatment
- Any recommendation for further testing, including an explanation that substantiates its necessity
- An explanation of any rationale or extenuating circumstance that kept the test from being completed, including, but not limited to, situations in which the client’s condition required testing over a two-day period and the client did not return or the client’s condition precluded the completion of the test

### 7.11.3 Reimbursement

Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing is limited to a total of four hours per day, and eight hours per client per calendar year for any provider. Hours billed beyond four hours per day will be denied without prior authorization. All supporting documentation must be maintained by the provider in the client's medical record.

Claims for psychological and neuropsychological testing may be reimbursed for both the face-to-face time spent administering the test and the time spent scoring and interpreting the test.

If the administration, interpretation, and scoring of a test occurs over more than one date of service, providers must bill the services on a single claim and must use a separate detail for each date of service. Claims must not be submitted until the administration, interpretation, and scoring of the test has been completed.

The correct modifier AH or UC must be appended to the code to identify who rendered the service. If both the LPA and psychologist perform services on the same date one detail must be submitted for each provider with each detail accurately representing the time spent by the psychologist or LPA. Time billed for services performed on the same client must not be billed for the same time and date of service.

Services provided by both the psychologist and LPA count toward the total four hours of testing allowed per client per day.

Psychological and neuropsychological testing will not be reimbursed to a CNS, NP, or a PA. Behavioral health testing may be performed during an assessment by a CNS, NP, or a PA, but will not be reimbursed separately. The most appropriate office encounter/visit code must be billed. Behavioral health testing performed by a CNS, NP, or a PA during an assessment will be denied as part of another service when billed.
Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial diagnostic interview or interactive psychiatric diagnostic interview examination. Psychological testing performed on the same date of service as neuropsychological testing will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial psychiatric diagnostic interview or interactive psychiatric diagnostic interview examination.

Psychological testing performed on the same date of service as neuropsychological testing will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

Providers must bill the preponderance of each half hour of testing and indicate that number of units on the claim form.

7.12 Psychotherapy/Counseling

Psychotherapy/counseling is the treatment for mental illness and behavioral disturbances, in which the clinician establishes a professional contract with the client and, through definitive therapeutic communication or therapeutic interactions, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy/counseling is limited to the following diagnosis codes:

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The appropriate service is chosen based on the type of inpatient or outpatient psychotherapy/counseling, the place of service, the face-to-face time spent with the client during inpatient or outpatient psychotherapy/counseling, and whether E/M services are furnished on the same date of service as inpatient or outpatient psychotherapy/counseling.

The treating provider must document the medical necessity of the chosen treatment and list the diagnosis code that most accurately describes the condition of the client that necessitated the need for the psychotherapy/counseling in the client’s medical record. The medical record (inpatient and outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the psychotherapy/counseling and the outcome.

Inpatient and outpatient psychotherapy/counseling counts towards the 12-hour per day per provider system limitation.

### 7.12.1 Prior Authorization

Prior authorization for inpatient psychotherapy/counseling is not required. After the 30 encounter/visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters/visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter/visit annual limit must include a completed Outpatient Psychotherapy/Counseling Request Form, including:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name identifier
- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- History of substance abuse
- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided
- Date on which the current treatment is to begin
- Indication of court-ordered or DFPS-directed services

All areas of the request form must be completed with the information required by the form. If additional room is needed for a particular section of the form, providers may state, "see attached," in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.
The number of visits authorized will be dependent upon the client’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional request(s) must include new documentation concerning the client’s current condition.

Prior authorization requests will be reviewed by HHSC or its designee’s Medical Director. The number of encounters/visits authorized will be dependent upon the patient’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional request(s) must include new documentation concerning the patient’s current condition.

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

### 7.12.2 Documentation Requirements

Each client for whom services are provided must have supporting documentation included in their medical record. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider. Those services not supported by the documentation in the client’s medical record are subject to recoupment. Documentation must include the following:

- Notations of the session beginning and ending times; and
- All pertinent information regarding the client’s condition to substantiate the need for services, including, but not limited to, the following:
  - A complete diagnosis as listed in the current edition of the DSM-IV-TR
  - Background, symptoms, impression
  - Narrative description of the assessment
  - Behavioral observations during the session
  - Narrative description of the counseling session
  - Treatment plan and recommendations

### 7.12.3 Initial Outpatient Psychotherapy/Counseling for an Individual, Group, or Family

#### Client Condition Requirements

The following documentation requirements must be submitted when requesting prior authorization of outpatient services:

- A description of why treatment is being sought at the present time
- A mental status examination which validates a diagnosis as listed in the current edition of the DSM-IV-TR
- A description of any existing psychosocial and/or environmental problems
- A description of the current level of social and occupational/educational functioning

#### Initial Assessment Requirements

There must be a pertinent history that contains all of the following:

- A chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment
- A social and family history
- An educational and occupational history
**Active Treatment Plan Requirements**
The treatment plan must contain the following elements:

- A description of the primary focus of the treatment
- Clearly defined discharge goals that indicate treatment can successfully be concluded
- The expected number of sessions it will take to reach the discharge goals, and standards of practice for the client's diagnosis
- Family therapy services are appropriately planned unless there are valid clinical contraindications

When a medication regimen is planned by a psychiatrist, PA, NP, or CNS, it must meet the following:

- Guidelines specific to the medication or medications prescribed
- Accepted standard of practice for the diagnosis for which it is prescribed
- Accepted standard of practice for the age group for which it is prescribed

**Discharge Plan Requirements**
Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals
- An identification of the client's aftercare needs that includes a transition plan

**7.12.4 Subsequent Outpatient Psychotherapy/Counseling for an Individual, Group or Family**

**Client Condition Requirements**
All of the requirements for the first authorized treatment sessions must be met in addition to an assessment of the client's response to treatment that indicates one of the following:

- The client has not achieved the discharge goal necessary to conclude treatment, but the description of the client's progress indicates that treatment can be concluded within a short period of time.
- The client's psychiatric condition has not responded to a trial of short term outpatient therapy and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).
- The client's condition is one which includes long standing, pervasive symptoms and/or patterns of maladaptive behavior.

**7.12.4.1 Active Treatment Plan Requirements**
There must be an assessment, which explains the client's inability to achieve the treatment objectives as expected. This assessment must address the following:

- Factors which interfered or are interfering with the client's ability to make progress as expected
- The continued appropriateness of the treatment goals
- The continued appropriateness of the type of therapy being utilized
- The need for obtaining consultation
- The current diagnosis and the need for revisions and/or additional assessments

The ongoing treatment plan must reflect the initial treatment plan requirements and the following additional information must also be included:

- Changes in primary treatment focus or discharge goals have been identified and are consistent with the client's current condition
• The expected progress toward the discharge goals is described within the extended time frame
• Appropriate adjustments have been made in the medication regimen based on the client’s therapeutic response
• No contraindications to the use of the prescribed medications are present

7.12.4.2 Discharge Plan Requirements
Discharge planning must reflect the following:
• A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
• An identification of the client’s aftercare needs that includes a transition plan

The following procedure codes may be submitted when billing for inpatient psychotherapy/counseling services: 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, and 90847.

Outpatient psychotherapy/counseling is limited to no more than four hours per client, per day.

When more than one type of session is provided on the same date of service (inpatient/outpatient individual, group, or family psychotherapy/counseling) each session type will be reimbursed individually. Services are reimbursed only for the Medicaid eligible client per session.

When multiples of each type of session is billed, the most inclusive code from each type of session is paid and the others are denied.

A CNS, NP, PA, or psychiatrist may bill an E/M visit if less than 20 minutes of outpatient psychotherapy/counseling is provided.

Only the CNS, LCSW, LMFT, LPC, NP, or PA actually performing the mental health service may bill Texas Medicaid. The CNS, LCSW, LMFT, LPC, NP, or PA must not bill for services performed by people under their supervision. A psychiatrist may bill for services performed by people under their supervision. A psychologist may bill for services performed by a LPA under their direct supervision.

The services of a psychiatric nurse or behavioral health worker are not covered by the Texas Medicaid program and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Interpretation and documentation time, including time to document test results in the client’s medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes. Providers must bill the preponderance of each half hour of group counseling sessions and indicate that number of units on the claim form.

A psychiatric diagnostic interview, pharmacological regimen oversight, pharmacological management, or any E/M service will be denied as part of narcissynthesis (procedure code 90865).

Procedure codes 90847, 90853, 90857, and 90804 will be denied as part of narcissynthesis when billed on the same date of service by the same provider.

Psychotherapy will be denied as part of narcissynthesis when billed for the same date of service by the same provider.
7.12.5 **Insight Oriented Behavior Modifying and/or Supportive Outpatient Psychotherapy/Counseling**

Psychiatric diagnostic interviews, pharmacological regimen oversight, and pharmacological management will be denied as part of the following outpatient psychotherapy/counseling services when billed on the same date of service by the same provider in addition to the limitations detailed below by procedure code:

- Insight oriented outpatient psychotherapy/counseling without medical E/M services (procedure code 90804, 90806, or 90808):
  - Procedure codes 36640, 90801, 90802, 90806, and M0064 will be denied as part of procedure code 90804 (20-30 minutes)
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, and M0064 will be denied as part of procedure code 90806 (45-50 minutes)
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90862, and M0064 will be denied as part of procedure code 90808 (75-80 minutes)

- Insight oriented outpatient psychotherapy/counseling with medical E/M services (procedure code 90805, 90807, or 90809):
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, 90807, 90862, M0064, and any E/M service will be denied as part of procedure code 90805 (20-30 minutes)
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90862, M0064, and any E/M service will be denied as part of procedure code 90807 (45-50 minutes)
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, M0064, and any E/M service will be denied as part of procedure code 90809 (75-80 minutes)

- Interactive outpatient psychotherapy/counseling without medical E/M services (procedure code 90810, 90812, or 90814):
  - Procedure codes 36640, 90801, 90802, 90806, and M0064 will be denied as part of procedure code 90810 (20-30 minutes)
  - Procedure codes 36640, 90801, 90802, 90804, 90805, 90806, and M0064 will be denied as part of procedure code 90812 (45-50 minutes)
  - Procedure codes 36640, 90801, 90802, 90812, 90806, 90862, and M0064 will be denied as part of procedure code 90814 (75-80 minutes)

- Interactive outpatient psychotherapy/counseling with medical E/M services (procedure code 90811, 90813, or 90815):
  - Procedure codes 36640, 90801, 90802, 90810, 90806, 90862, M0064, and any E/M service will be denied as part of procedure code 90811 (20-30 minutes)
  - Procedure codes 36640, 90801, 90802, 90811, 90808, 90862, M0064, and any E/M service will be denied as part of procedure code 90813 (45-50 minutes)
  - Procedure codes 36640, 90801, 90802, 90812, 90813, 1-90814, 90862, M0064, and any E/M service will be denied as part of procedure code 90815 (75-80 minutes)

7.13 **Narcosynthesis**

Narcosynthesis (procedure code 90865) is a benefit of Texas Medicaid when billed by a physician.
7.14 Non-covered Services
The following services are not benefits of Texas Medicaid:

- Adult and individual activities
- Biofeedback
- Day-care
- Family psychotherapy without client present (procedure code 90846)
- Hypnosis
- Intensive outpatient program services
- Marriage counseling
- Multiple family group psychotherapy (procedure code 90849)
- Music/dance therapy
- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
- Psychoanalysis (procedure code 90845)
- Recreational therapy
- Services provided by a psychiatric nurse, mental health worker or psychiatric assistant (excluding Master’s level LPA)
- Thermogenic therapy

7.15 Inpatient Behavioral Health Services
Inpatient behavioral health services, provided in the inpatient hospital setting and performed by the following providers are benefits to clients of any age with the diagnoses outlined below when provided in the inpatient hospital setting:

- CNS
- Hospitals
- Licensed psychologist
- LPA
- Licensed psychologist groups
- PA
- Physician/psychiatrist
- Physician/psychiatrist groups
- NP

Inpatient psychiatric treatment is a benefit of Texas Medicaid if the following apply:

- The client has a psychiatric condition that requires inpatient treatment
- The inpatient treatment is directed by a psychiatrist
- The inpatient treatment is provided in a nationally accredited facility or hospital
- The provider is enrolled in Texas Medicaid
Physicians, psychologists, CNSs, PAs, and NPs are not required to obtain prior authorization for inpatient behavioral health services.

### 7.16 Psychiatric Services for Hospitals

Inpatient admissions to acute care hospitals for adults and children for psychiatric conditions are a benefit of Texas Medicaid. Admissions must be medically necessary and are subject to the Texas Medicaid’s retrospective UR requirements. The UR requirements are applicable regardless of the hospital’s designation of a unit as a psychiatric unit versus a medical/surgical unit.

Clients 20 years of age or younger may be admitted to a freestanding psychiatric facility or a state psychiatric facility. Clients 21 years of age or older may be admitted only to an acute care facility. A certification of need must be completed and placed in the client’s medical record within 14 days of the admission or once the client becomes Medicaid eligible while in the facility.

Inpatient psychiatric treatment is a benefit of Texas Medicaid if all the following apply:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Inpatient admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not a benefit of Texas Medicaid. Additionally, admissions for chronic diagnoses such as mental retardation, organic brain syndrome, or chemical dependency or abuse are not covered benefits for acute care hospitals without an accompanying medical complication or medical condition. The UB-04 CMS-1450 paper claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Supporting documentation (certification of need) must be documented in the individual client’s record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review when requested by HHSC or its designee.

Additional coverage may be allowed for clients who are eligible for Medicaid and birth through 20 years of age through the THSteps-Comprehensive Care Program (CCP). Use revenue code 124 to bill for inpatient psychiatric services.

### 7.16.1 Prior Authorization Requirements

Prior authorization is not required for fee-for-service clients admitted to psychiatric units in acute care hospitals. Prior authorization is required for Primary Care Case Management (PCCM) clients admitted to acute care hospitals. Urgent or emergent admissions for inpatient PCCM psychiatric services require retrospective prior authorization. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility.

For clients 20 years of age or younger, initial admission to a state psychiatric facility or freestanding psychiatric facility may be prior authorized through CCIP for a maximum of five days based on Medicaid eligibility and documentation of medical necessity. Court-ordered services are not subject to the five day admission limitation.

**Note:** NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists who provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHO.
Refer to: Subsection 3.11.3, “Prior Authorization and Documentation Requirements” in the Children’s Services Handbook (Vol. 2 Provider Handbooks) for more information about inpatient psychiatric services.

Section 8, "Managed Care" (Vol. 1, General Information) for more information, or contact the client’s BHO.

Providers rendering services to STAR and STAR+PLUS clients must contact the respective managed care plan.

### 7.16.2 Documentation Requirements

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client’s condition in a proximate time period.

### 7.16.3 Psychological and Neuropsychological Testing Services

Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility, do not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing services performed while the client is an inpatient. Psychological and neuropsychological testing services are diagnosis restricted.

### 7.16.4 Inpatient Hospital Discharge

Procedure codes 99238 and 99239 must be submitted when billing for a hospital discharge.

Procedure code 99238 will be denied as part of another service when billed for the same date of service by the same provider as procedure code 99239.

### 7.16.5 Inpatient Consultations

Procedure codes 99251, 99252, 99253, 99254, and 99255 will be denied as part of another service when billed for the same date of service by the same provider as pharmacological management (procedure code 90862).

### 7.17 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid. Medicaid’s responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client’s Medicare card for Part B coverage before billing Texas Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. Texas Medicaid is responsible for the coinsurance and deductible of Medicare allowed services on a crossover basis only.

Claims for behavioral health services must be submitted to TMHP in an approved electronic format or on the CMS-1500 or UB-04 CMS-1450 claim form. Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 or UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. An FQHC is reimbursed for psychological services according to its specific Prospective Payment System (PPS) rate per visit calculated in accordance with 1 TAC §355.8261.

A freestanding psychiatric hospital/facility is reimbursed for psychological services in accordance with 1 TAC §355.8063.

Refer to: Section 3, “TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.

Section 3, “Federally Qualified Health Center” in Outpatient Services Handbook (Vol. 2, Provider Handbooks) for more information.

Subsection 4.9.2, “Medicare Part B Crossovers” in Section 4, Client Eligibility (Vol. 1, General Information)


Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.


Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement.


8. SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients with substance use disorders and those at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention.

SBIRT is targeted to clients who are from 14 years of age through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are from 10 years of age through 13 years of age.

The first SBIRT session, including screening and brief intervention, must be billed by the hospital using an appropriate revenue code and procedure code H0050. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital. The second, third, and fourth sessions cannot be billed if clients were not referred from the hospital.

Additional services, outside the four sessions, will not be provided as SBIRT.
8.1 Screening
Screening to identify clients with problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed. Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

8.2 Brief Intervention
Brief intervention is performed during the first session following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention, directed to the client, involves motivational discussion focused on raising the client’s awareness of their substance use and its consequences, and motivated them toward behavioral change. Successful brief intervention encompasses support of the client’s empowerment to make behavioral changes. A client found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to 3 sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SBIRT documentation for the first session must include:

- The client has an alcohol or drug-related traumatic injury or condition.
- Positive screening by a standardized screening tool.
- Laboratory results such as blood alcohol content, toxicology screen, or other measures showing at least a moderate risk for alcohol or substance abuse.
- The name, address, and phone number of the provider to which the client is referred, if a referral is made.

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

8.3 Brief Treatment
A client found to have a moderate-to-high risk for substance abuse should be referred for brief treatment. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital emergency department or inpatient setting.

Brief treatment, although it includes a motivational discussion and client empowerment, is a more comprehensive intervention than the first session. Brief treatment includes assessment, education, problem solving, coping mechanisms, building a supportive social environment, goal setting, and a plan of action.
Procedure code H0050 will be eligible for reimbursement to the following provider types for the second, third, and fourth sessions:

- NP
- CNS
- PA
- LPC
- Social worker enrolled in CCP
- Physician and physician group
- Psychologist and psychologist group
- LCSW

8.4 Referral to Treatment

If the provider determines that the client is in need of more extensive treatment or has a severe risk for substance abuse, the client must be referred to an appropriate chemical dependency treatment center or outpatient behavioral health provider.

Referral to more extensive treatment is a proactive process that facilitates access to care for clients who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because referral ensures that all clients who are screened have access to the appropriate level of care.

Referral to more extensive treatment must be integrated during the second, third, and fourth SBIRT sessions, if necessary, unless the client’s condition changes. Referral to more extensive treatment may also occur during the first session.

Providers must refer the client to more extensive treatment as soon as the need is determined.

8.5 Reimbursement and Limitations

SBIRT is limited to clients who are from 10 through 20 years of age.

SBIRT is limited to a maximum of 3 dates of service following the first session, per calendar year, by any provider. If a client requires more than 3 dates of services per year, the client must be referred for chemical dependency treatment.

Procedure code H0050 must be submitted in 15-minute increments, with a maximum of 3 units (45 minutes) per date of service by any provider. The reimbursement rate for procedure code H0050 is $26.93 per 15 minutes.

Procedure code H0050 will be denied if it is billed for the same date of service, by the same provider, as any of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801 90802 90804 90805 90806 90807 90808 90809 90810 90811</td>
</tr>
<tr>
<td>90812 90813 90814 90815 90847 90853 90857 90862 90865 90870</td>
</tr>
<tr>
<td>96101 96118 H0004 H0005 M0064</td>
</tr>
</tbody>
</table>
8.6 Documentation Requirements

Client record documentation must support medical necessity for the services provided and must be maintained and made readily available for review when requested by the Health and Human Services Commission (HHSC) or its designee. SBIRT documentation must include the following:

- An indication that the client has an alcohol- or drug related traumatic injury or condition
- Positive screening by a standardized substance-abuse screening tool
- Laboratory results, such as blood alcohol content, toxicology screen, or other measures, that show at least a moderate risk for substance abuse
- If a referral is made, the name, address, and telephone number of the provider to whom the client was referred
- A written, client-centered plan for the delivery of medically necessary SBIRT. The plan must be completed at the time the client is admitted to the second session (referral). The plan must include the following:
  - Real-life goals expected
  - Strategies to achieve the goals
  - Support system such as family members, a legal guardian, friends, or anyone the client identifies as important to them
  - A mechanism for following up with the client to ensure that the client keeps appointments for additional sessions

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

If inappropriate payments are identified on retrospective review for any provider, the payments will be recouped.

8.7 Claims Filing and Reimbursement

SBIRT services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.


Texas Medicaid rates for Hospitals are calculated according to 1 TAC §355.8061.

According to 1 TAC §355.8091, the Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.
Texas Medicaid rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid rates for Nurse Practitioners and Clinical Nurse Specialists are calculated in accordance with TAC §355.8281. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician’s or RHC’s provider identifier are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

9. CLAIMS RESOURCES

Refer to the following sections and/or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Blind Children’s Vocational Discovery and Development Program (BCVDDP)</td>
<td>Form BH.2, Section 12 of this handbook</td>
</tr>
<tr>
<td>Claim Form Example</td>
<td></td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker (LCSW) Claim Form Example</td>
<td>Form BH.6, Section 12 of this handbook</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapist (LMFT) Claim Form Example</td>
<td>Form BH.7, Section 12 of this handbook</td>
</tr>
<tr>
<td>Licensed Professional Counselor (LPC) Claim Form Example</td>
<td>Form BH.8, Section 12 of this handbook</td>
</tr>
<tr>
<td>Mental Health Case Management Claim Form Example</td>
<td>Form BH.9, Section 12 of this handbook</td>
</tr>
<tr>
<td>Psychiatric Inpatient Initial Admission Request Form</td>
<td>Form CH.9, Children’s Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>Psychologist Claim Form Example</td>
<td>Form BH.10, Section 12 of this handbook</td>
</tr>
<tr>
<td>Outpatient Psychotherapy/Counseling Form</td>
<td>Form BH.1, Section 11 of this handbook</td>
</tr>
<tr>
<td>State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Case Management for Early Childhood Intervention (ECI) Claim Example</td>
<td>Form BH.3, Section 12 of this handbook</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

10. CONTACT TMHP

Providers can call the TMHP Contact Center at 1-800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.
11. FORMS
BH.1  Outpatient Psychotherapy/Counseling Form

### Outpatient Psychotherapy/Counseling Request Form

<table>
<thead>
<tr>
<th>1. Identifying Information</th>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number:</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Client name</td>
<td>First:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Middle Initial:</td>
</tr>
<tr>
<td>Current living arrangements:</td>
<td>With parent(s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Provider Identifier (ID):</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

2. Current DSM IV diagnoses (list all appropriate diagnosis codes):

<table>
<thead>
<tr>
<th>Axis I:</th>
<th>Axis II:</th>
<th>Axis III:</th>
<th>Axis IV:</th>
<th>Axis V [GAF*]:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current substance abuse?</td>
<td>None</td>
<td>Alcohol</td>
<td>Drugs</td>
<td>Alcohol and Drugs</td>
</tr>
</tbody>
</table>

3. Court ordered service?

- [ ] Yes
- [ ] No

Court order signed by judge must be attached.

4. DFPS directed service?

- [ ] Yes
- [ ] No

DFPS directive or summary signed by employee must be attached.

<table>
<thead>
<tr>
<th>DFPS employee’s name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFPS employee’s phone number:</td>
</tr>
</tbody>
</table>

5. Recent primary symptoms that require additional therapy/counseling

Include date of most recent occurrence, frequency, duration, and severity:

6. History

Psychiatric inpatient treatment

- [ ] Yes
- [ ] No

Age at first admission:

<table>
<thead>
<tr>
<th>Prior substance abuse?</th>
<th>None</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol and Drugs</th>
</tr>
</thead>
</table>

Significant medical disorders:

7. Current psychiatric medications (include dose and frequency):

8. Treatment plan

Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:

9. Number of sessions requested (limit 10 per request)

List the specific procedure codes requested:

<table>
<thead>
<tr>
<th>How many of each type?</th>
<th>IND</th>
<th>Group</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
<td>From (start of visits): / /</td>
<td>To (end of planned requested visits): / /</td>
<td></td>
</tr>
</tbody>
</table>

List specific procedure codes requested:

<table>
<thead>
<tr>
<th>Provider signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: / /</td>
</tr>
</tbody>
</table>

*GAF = Global Assessment of Functioning
**Psychological/Neuropsychological Testing Request Form**

### 1. Client information:
- Medicaid #: Date: / / 
- Last name: First name: Middle initial: 
- Date of birth: / / Age: Sex: Date of previous testing (or not applicable): / / 
- Performing Provider: Medicaid Provider Identifier (ID): 

### 2. Current DSM IV diagnoses (list all diagnosis codes):
- Axis I: 
- Axis II: 
- Axis IV: 
- Axis V (Globall assessment of functioning [GAF]): 
- Current substance abuse? ( ) none ( ) alcohol ( ) drugs ( ) alcohol and drugs 

### 3. Court ordered service:
- ( ) Yes ( ) No Court order signed by judge must be attached. 

### 4. DFPS directed service:
- ( ) Yes ( ) No DFPS directive or summary signed by employee must be attached. 
- DFPS employee’s name: __________________ DFPS employee’s phone number: __________________ 

### 5. Testing requested:
- ( ) Psychological testing ( ) Neuropsychological testing  
  (The time spent writing up the findings is included in the time to perform the testing and will not be reimbursed separately.) 

### 6. Number of hours requested: 

### 7. Rationale supporting medical necessity for requested testing: 
- Is the requested testing for screening purposes? ( ) Yes ( ) No If 'Yes', explain the rationale 

- Previous testing history and results: 

- List specific procedure codes requested: 

<table>
<thead>
<tr>
<th>Date from (start of testing): / /</th>
<th>Date to (end of testing): / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider signature: __________________</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Print name: __________________</td>
<td></td>
</tr>
</tbody>
</table>

Effective Date 01012009/Revised Date 10312008
12. CLAIM FORM EXAMPLES
### Blind Children’s Vocational Discovery and Development Program (BCVDDP)

#### HEALTH INSURANCE CLAIM FORM

**Approved by National Uniform Claim Committee 08/05**

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare</td>
<td>Medicare Policy Number #</td>
</tr>
<tr>
<td>2.</td>
<td>Medicaid</td>
<td>Medicaid Policy Number #</td>
</tr>
<tr>
<td>3.</td>
<td>Tricare</td>
<td>Tricare Policy Number #</td>
</tr>
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<td>CHAMPUS</td>
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<td>7.</td>
<td>BCVDDP</td>
<td>BCVDDP Policy Number #</td>
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</table>

#### Required Information

- **Patient’s Name:** Doe, John M.
- **Address:** 563 Magicians Ct., Pharr, TX 78535
- **Date of Birth:** 01-01-1993
- **SSN:** 123-45-6789
- **Employer’s Name:** Texas Commission for the Blind
- **Sponsor’s SSN:** 123-45-6789
- **Member ID:** 123-45-6789
- **Insurance Plan Name or Program Name:** BCVDDP
- **Signatures:**
  - Patient/Authorized Person:
  - Physician/Supplier:

#### Additional Information

- **Diagnosis or Nature of Illness or Injury:**
  - Code: G9012
  - Description: Vision Impairment

- **Place of Service:**
  - EMG
  - Hospital

- **Date of Service:**
  - 01-01-2009

- ** Amount Paid:**
  - $100.00

- **Billing Information:**
  - Provider:
    - Name: Richard Glass
    - NPI: 9876543021
    - Location: Pharr, TX 78201
    - Address: 1200 Front St.

#### Signature

- **Signed Date:** 01-10-2009

---

**Important Notice:**

- The information on this form is intended for use by licensed providers and suppliers who are authorized to render services to beneficiaries of the BCVDDP.
- All claims must be submitted within the timeframe specified in the program guidelines.
- Any changes to the BCVDDP coverage must be reflected in the claims submitted.
- The BCVDDP program reserves the right to review and verify all claims submitted for services provided to its beneficiaries.
BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES HANDBOOK

BH.4 Case Management for Children and Pregnant Women (CPW)

1500

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 6/95

1. MEDICARE [Medicare #] X
   [Medicare #]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Doe, Jane M.
3. PATIENT'S BIRTH DATE MM DD YY
   10 15 2001
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
   300 Atlantic Ave.

6. PATIENT RELATIONSHIP TO INSURED
   Self
7. INSURED'S ADDRESS (No., Street)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY GROUP OR FECA NUMBER
   a. EMPLOYMENT? (Current or Previous)
      YES
   b. AUTO ACCIDENT?
      NO
   c. EMPLOYER'S NAME OR SCHOOL NAME
   d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
      YES

10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

11. INSURED'S I.D. NUMBER (For Program in Item 1)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S DATE OF BIRTH

14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
    YES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICARE RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE
   b. TIMES OF SERVICE
   c. PROCEDURES, SERVICES OR SUPPLIES
   d. MODIFIER
   e. DIAGNOSIS RT. AMOUNT
   f. CATEGORY
   g. PROCEDURE CODE
   h. MODIFIER
   i. CATEGORY
   j. PROVIDER ID. #

25. MEDICAID NhSSUBMISSION CODE

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
   YES

28. INSURED'S I.D. NUMBER

29. INSURED'S ADDRESS (No., Street)

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH 

Robert Jackson
02 10 2009

Signed

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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EHX.5  Case Management for Early Childhood Intervention (ECI)

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE
   (Medicare #) X

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
   Doe, Jane

5. PATIENT’S ADDRESS (No., Street)
   612 Baker Drive

10. IS PATIENT’S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
    b. AUTO ACCIDENT?
    c. OTHER ACCIDENT?
    d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

12. PATIENTS OR AUTHORIZED PERSON’S SIGNATURE
    I authorize the release of any medical or other information necessary
    to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment
    below.

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE
    I authorize payment of medical benefits to the undersigned physician or supplier for
    services described below.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    17a. EMPLOYER’S NAME OR SCHOOL NAME
        Doe, Jane
    17b. NPI

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
    21. A. B. C. D. E.

24. A. DATES(S) OF SERVICE
    (Explain Unusual Circumstances)
    24 A. B. C. D. E. F. G.

25. FEDERAL TAX I.D. NUMBER
    SSN  EIN

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    INCLUDING DEGREES OR CREDENTIALS
    [Signature on File]

32. SERVICE FACILITY LOCATION INFORMATION
    Early Childhood Program
    123 Springdale Drive
    Austin, TX 78606

33. BILLING PROVIDER INFO & PH #
    Early Childhood Program
    123 Springdale Drive
    Austin, TX 78606

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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**BH.6 Licensed Clinical Social Worker (LCSW)**

**HEALTH INSURANCE CLAIM FORM**

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<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>1. MEDICARE</td>
<td>MEDICAID</td>
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<tr>
<td>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>MM 01 01 1995</td>
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<tr>
<td>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Sophie Buschbaum, LCSW</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS (No., Street)</td>
<td>4630 Liebe Cove</td>
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<tr>
<td>6. PATIENT RELATIONSHIP TO INSURED</td>
<td>Self</td>
</tr>
<tr>
<td>7. INSURED'S ADDRESS (No., Street)</td>
<td>Dale, TX 78216</td>
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<tr>
<td>8. PATIENT STATUS</td>
<td>Single</td>
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<tr>
<td>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Dale</td>
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<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO:</td>
<td>Yes</td>
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<tr>
<td>11. INSURED'S POLICY GROUP OR FECA NUMBER</td>
<td>123456789</td>
</tr>
<tr>
<td>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
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<td>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>Sophie Buschbaum, LCSW</td>
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</table>

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**Signature on File**

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<tr>
<td>14. DATE OF CURRENT</td>
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<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
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<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>MM DD YY</td>
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<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
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<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
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<td>19. RESERVED FOR LOCAL USE</td>
<td>YES</td>
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<tr>
<td>20. OUTSIDE LAB?</td>
<td>YES</td>
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<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
<td>1296</td>
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<td>22. MEDICAID RESUBMISSION CODE</td>
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</table>

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**BH.7  Licensed Marriage and Family Therapist (LMFT)**

### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

**MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2**

**NUCC Instruction Manual available at:** www.nucc.org

---

**CARRIER**

1. **MEDICAID**
   - [Medicare #] X
   - [Medicaid #]

2. **PATIENT’S NAME** (Last Name, First Name, Middle Initial)
   - Doe, Jane

3. **PATIENT’S ADDRESS** (No., Street)
   - 1544 Lansing Street

4. **PATIENT’S BIRTH DATE**
   - 02/24/1993 M

5. **PATIENT’S SEX**
   - F

6. **PATIENT’S SIGNATURE**
   - SIGNED DATE

---

**INSURED**

7. **INSURED’S NAME** (Last Name, First Name, Middle Initial)
   - Susan Daines, LMFT

8. **INSURED’S ADDRESS** (No., Street)
   - 4063 Lilling Road

9. **INSURED’S BIRTH DATE**
   - 02/24/1965

10. **INSURED’S SEX**
    - F

11. **INSURED’S SIGNATURE**
    - SIGNED DATE

---

**FEDERAL TAX I.D. NUMBER  SSN  EIN**

12. **PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE**
    - I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.

13. **INSURED’S POLICY GROUP OR FECA NUMBER**

14. **INSURED’S DATE OF BIRTH**
    - MM DD YY

15. **RESERVED FOR LOCAL USE**

16. **AUTO ACCIDENT?**
    - NO

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE**
    - 17a. NPI
    - 17b. NPI

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**
    - MM/DD/YYYY

19. **RESERVED FOR LOCAL USE**

20. **OUTSIDE LAB? $ CHARGES**
    - YES NO

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
    - (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. **MEDICAID RESUBMISSION CODE**
    - ORIG. REF. NO.

23. **Prior Authorization Number**

---

**PHYSICIAN OR SUPPLIER INFORMATION**

24. **DATE(S) OF SERVICE**
    - MM DD YYYY

25. **FEDERAL TAX I.D. NUMBER**
    - SSN  EIN

26. **PATIENT’S ACCOUNT NO.**
    - 12345

27. **TOTAL CHARGE**
    - $ 60.00

28. **BALANCE DUE**
    - $ 0.00

29. **SIGNATURE OF PHYSICIAN OR SUPPLIER**
    - Signature on File

---

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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BH.8  Licensed Professional Counselor (LPC)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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NUGC Instruction Manual available at: www.nucc.org

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### BH.9 Mental Health Case Management

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

**TRICARE**

**CHAMPUS**

**HEALTH PLAN**

**FECA**

**INSURED'S I.D. NUMBER**

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
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- **Patent's Name**: Doe, Jane
- **Patient's Address**: 1200 Route 4
- **City**: Bastrop
- **State**: TX
- **ZIP Code**: 78602
- **Telephone**: (512) 555-1234

**CARRIER PATIENT AND INSURED INFORMATION**

- **Policy Number**: 123456789
- **Provider ID #**: NPI

**PHYSICIAN OR SUPPLIER INFORMATION**

- **Provider ID #**: NPI
- **Date**: 01 01 2009
- **Services**: G9012
- **Charges**: 63.89
- **Qualifier**: 1

**TDMR Facility**

411 Main Street
Bastrop, TX 78601

**SIGNED**

Sally Smith
01 10 2009

**NUCC Instruction Manual available at**: www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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## HEALTH INSURANCE CLAIM FORM

### APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<table>
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<th>Value</th>
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<td><strong>CHAMPVA</strong></td>
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<tr>
<td><strong>FECA SICKLING (SSN or ID)</strong></td>
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<td><strong>OTHER</strong></td>
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<th>Value</th>
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<tbody>
<tr>
<td><strong>1. SIGNED DATE</strong></td>
<td>Carla Herrera, Ph.D.</td>
</tr>
<tr>
<td><strong>2. SIGNATURE OF PHYSICIAN OR SUPPLIER</strong></td>
<td>1234567089</td>
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<tr>
<td><strong>3. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</strong></td>
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### Patient Information

- **Name**: Doe, Jane
- **Address**: 506 Medical Lane
- **City**: Terrell
- **State**: TX
- **ZIP Code**: 78218

### Insured Information

- **Name**: Jane Smith, M.D.
- **Address**: 463 Swan St.
- **City**: Crane, TX 79731
- **State**: TX
- **ZIP Code**: 78218

### Service Details

- **Date of Service**: 01 10 2009
- **Billing Provider Info & PH**: Carla Herrera, Ph.D.

### Charges

- **Total Charge**: $78.47
- **Amount Paid**: $1
- **Balance Due**: $78.46

### Additional Information

- **Accept Assignment**: YES
- **Reserved for Local Use**: YES
- **Diagnosis or Nature of Illness or Injury**: (Explain Unusual Circumstances)
- **Provider ID. #**: 1234567089
- **Rendering Provider ID. #**: 1234567089

### Instructions

- **Signed by Provider**: Carla Herrera, Ph.D. 01 10 2009
- **Signed by Patient**: Carla Herrera, Ph.D. 01 10 2009
- **NPI**: 9876543021

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**NUCC Instruction Manual available at**: www.nucc.org

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