



Texas Medicaid Provider Procedures Manual

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Provider Handbooks

Behavioral Health and Case Management Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

BEHAVIORAL HEALTH AND CASE MANAGEMENT SERVICES HANDBOOK

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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, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), psychologist, physician, advanced practice registered nurse (APRN), physician assistant (PA), or providers of intellectual and developmental disability (IDD) case management, mental health targeted case management, and mental health rehabilitative services.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7.1.2, "Reporting Child Abuse or Neglect" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) and subsection 1.7.1.5, "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" (Vol. 1, General Information). 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 health-care services or items to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. 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, health-care items and services to Medicaid eligible persons in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Referto: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Section 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook (Vol. 2, Provider Handbooks)* for information about this program.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Referto: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for additional information about the payment window reimbursement guidelines.

2 Blind Children’s Vocational Discovery and Development Program (BCVDDP)

2.1 Overview

BCVDDP services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family’s needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

BCVDDP services include the following:

- Assisting the child in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management, recreational activities, and grooming
- Supplying information to families about additional resources

2.2 Enrollment

Texas Health and Human Services Commission (HHSC) Blind Children’s Vocational Discovery and Development Program (BCVDDP) is the Medicaid provider of case management for persons who are 22 years of age and 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 BCVDDP case management activities.

Referto: 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.

2.3 Services, Benefits, Limitations, and Prior Authorization

Services eligible for reimbursement are limited to one contact per month, per person, regardless of the number of contacts that are made during the month. HHSC BCVDDP providers should bill procedure code G9012.

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

Referto: Subsection A.8, “Texas Health and Human Services Commission Blind Children’s Vocational Discovery and Development Program (BCVDDP)” in “Appendix A: State, Federal, and TMHP Contact Information” (*Vol. 1, General Information*).

2.3.1 Prior Authorization

Prior authorization is not required for BCVDDP case management services.

2.4 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.

2.5 Claims Filing and Reimbursement

BCVDDP case management services must be submitted to the Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper 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 person turns 21 years of age.

Claims may be submitted up to 365 days from the date of service in accordance with 1 TAC §354.1003.

Any child who has a suspected or diagnosed visual impairment may be referred to BCVDDP. HHSC BCVDDP 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 HHS website at www.hhs.texas.gov/.

Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Referto: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 2.9, "Federal Medical Assistance Percentage (FMAP)" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for federal matching percentage.

3 Case Management for Children and Pregnant Women

3.1 Overview

Case management services are provided to help Medicaid eligible persons gain access to necessary medical, social, educational, and other services. Case managers assess a person's need for these services and then develop a service plan to address those needs. Case management for children and pregnant women (CPW) services are outlined in Title 25 Texas Administrative Code (TAC) Part 1, Chapter 27, subchapters A-C.

3.1.1 Eligibility

CPW services are a benefit for children birth through 20 years of age who:

- Are enrolled in Medicaid or are Medicaid eligible.

- Have a health condition or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles compared to healthy same age peers in the general areas of physical, cognitive, emotional, or social growth and development.
- Need assistance in gaining access to necessary medical, social, educational, or other services related to their health condition or health risk.
- Desire case management services.

CPW services are a benefit for pregnant women of any age who:

- Are enrolled in Medicaid, or are Medicaid eligible.
- Are pregnant with a high-risk condition, including medical conditions or psychosocial condition(s) that place the woman and her fetus at a greater than average risk for complications, either during pregnancy, delivery, or following birth.
- Need assistance in gaining access to necessary medical, social, educational, or other services related to their high-risk condition.
- Desire case management services.

Verbal or written consent must be obtained from the person or parent or legal guardian prior to the initiation of any CPW services. If the person receiving CPW services is a child or youth 17 years of age or younger, all CPW services and visits must be completed with a parent or legal guardian.

3.1.2 Referral Process

To refer a Medicaid eligible person for Case Management for Children and Pregnant Women services, providers may do one of the following:

- Visit www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women to obtain a referral form.
- Call THSteps toll free at 877-847-8377 from 8 a.m. to 6 p.m., Central Time, Monday through Friday.
- Contact a Case Management for Children and Pregnant Women provider directly at www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women. A case management provider will contact the family to offer a choice of providers and obtain information necessary to request prior authorization for case management services.

A referral for Case Management for Children and Pregnant Women services can be received from any source.

3.2 Enrollment

Providers must be enrolled in Medicaid and approved by the Health and Human Services Commission (HHSC) to provide CPW services. Enrollment for Case Management for Children and Pregnant Women providers is a two-step process.

Step 1

Potential providers must submit a Health and Human Services Commission (HHSC) Case Management for Children and Pregnant Women provider application to the HHSC 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. Registered nurses with associate degrees must also have at least two years of cumulative, paid, full-time work experience or two years of supervised full-time, educational, internship/practicum experience in the past ten years. The experience must be with pregnant women or with children who are 20 years of age and younger.

The experience must include assessing psychosocial and health needs and making community referrals for these populations. Registered nurses with bachelor or advance degrees and social workers do not have to meet any experience requirements.

For more information about provider qualifications and enrollment, or visit the case management website at www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women.

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

Step 2

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

Referto: 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.

3.3 Services, Benefits, Limitations, and Prior Authorization

Case Management for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Procedure code G9012 is to be used for all Case Management for Children and Pregnant Women services. Modifiers are used to identify which service component is provided.

| Procedure Code | Procedure Description | Additional Information |
|----------------|---|------------------------|
| G9012 | Comprehensive visit (in-person) | Modifier U2 and U5 |
| G9012 | Comprehensive visit (synchronous audiovisual) | Modifier U2, U5 and 95 |
| G9012 | Follow-up visit (in-person) | Modifier U5 and TS |
| G9012 | Follow-up visit (synchronous audiovisual) | Modifier U5, TS and 95 |
| G9012 | Follow-up visit telephone (audio only) | Modifier TS and 93 |

| Modifier | Description |
|----------|---|
| 93 | Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System |
| 95 | Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System |
| TS | Follow-up service |
| U2 | Comprehensive visit |

| Modifier | Description |
|----------|--------------------|
| U5 | Face to face visit |

Comprehensive visits completed in-person must be billed with procedure code G9012 and modifiers U2 and U5.

Comprehensive visits completed using synchronous audiovisual technology must be billed with procedure code G9012 and modifiers U2, U5 and 95.

Comprehensive visits may not be completed or billed using synchronous telephone (audio-only) technology.

Follow-up visits completed in-person must be billed with procedure code G9012 and modifiers U5 and TS.

Follow-up visits completed using synchronous audiovisual technology must be billed with procedure code G9012 and modifiers U5, TS and 95.

Follow-up visits completed using synchronous telephone (audio-only) technology must be billed with procedure code G9012 and modifiers TS and 93.

Procedure code G9012 is limited to once per day, any service, any provider.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for information on policy restrictions for services delivered by synchronous telephone (audio-only) technologies. Services delivered using audio-only technologies must be billed using the 93 modifier.

Providers must adhere to Case Management for Children and Pregnant Women program rules, policies, and procedures.

Note: *Case Management for Children and Pregnant Women 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 §27.11.*

Case Management for Children and Pregnant Women services are not billable when a person 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 HHSC.

CPW services may be provided using synchronous audiovisual technologies if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

Note: *For CPW services delivered through a managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorization, reimbursement, and specific claim processing procedures.*

During a Declaration of State Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

3.3.1 Initial Intake

CPW providers must complete an initial intake with the person or family/guardian to determine the need for CPW services. The following information must be obtained during the initial intake:

- The health condition(s), health risk, or high-risk condition of the person who would receive case management services
- How the health condition, health risk, or high-risk condition impacts the person's level of functioning
- Detailed information about the person's current need(s) related to the health condition, health risk, or high-risk condition
- How the CPW provider will assist the person with their current need(s)

If the person to receive services is a child or youth who is 17 years of age or younger, the initial intake must be completed with the person's parent or legal guardian.

The CPW initial intake service is not billable. If the CPW initial intake indicates the person is eligible for services and a need for CPW services is identified, the provider must submit an Initial Prior Authorization Request for CPW services.

3.3.2 Comprehensive Visits

Comprehensive visits require prior authorization. The comprehensive visit must be completed within seven business days of the prior authorization approval. If the person receiving CPW services is a child or youth who is 17 years of age or younger, the comprehensive visit must be completed with the person's parent or legal guardian. The comprehensive visit must include the completion of a Family Needs Assessment (FNA) and a Service Plan (SP).

Note: *The FNA and SP forms are available on the HHSC CPW website at: www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women*

The FNA is completed to determine the need for any medical, educational, social, or other services required to address the person's short- and long-term health and the overall well-being of the person. The FNA must include but is not limited to:

- Completing a personal and family medical, mental health, and medication history.
- Identifying the person's needs.
- Addressing personal and family issues that impact the person's health condition, health risk, or high-risk condition.
- Obtaining information from other sources, such as family members, medical providers, social workers, and educators.

The Service Plan (SP) must be completed during the comprehensive visit. The Service Plan (SP) is completed to determine a planned course of action based on needs identified in the Family Needs Assessment (FNA). The service plan must include, but is not limited to:

- Activities and goals that are developed with the person or the person's parent or guardian to address the medical, social, educational, and other services that are needed by the person receiving CPW services.
- A course of action to respond to the assessed needs of the person receiving CPW services.

The Service Plan may also include:

- Coordinating services with third parties such as medical or behavioral health providers, government agencies, community resources, schools, Medicaid managed care plans, other service coordinators, medical equipment and supply providers, and medical transportation agencies.

- Contacting third parties to find resources, obtain information, or provide information related to service plan needs.
- Participating in meetings.
- Providing referrals.
- Providing resource information.
- Advocating for the person.

The Service Plan Consent form must be signed by the person or the person's parent or legal guardian.

The Comprehensive Visit may be completed in-person or through the use of synchronous audiovisual technology. Comprehensive visits using synchronous audiovisual technology should only be provided if agreed to by the person or the person's parent or legal guardian.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for information on policy restrictions for services delivered by synchronous telephone (audio-only) technologies.

3.3.3 Follow-up Visits

Follow-up visits require prior authorization. Follow-up visits may only be completed after the comprehensive visit has been completed. If the person receiving CPW services is a child or youth who is 17 years of age or younger, the follow-up visit must be completed with the person's parent or legal guardian.

Note: Follow-up visit forms are available on the HHSC CPW website at: www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women

Follow-up visits are completed to ensure the service plan is implemented and adequately addresses the person's needs. A follow-up visit must include but is not limited to:

- Ensuring services are being furnished in accordance with the person's service plan.
- Ensuring services in the service plan are adequate.
- Ensuring the service plan is modified when the person's need(s) changes.

Activities during the follow-up visit include but are not limited to:

- Reviewing all outstanding needs documented on the Service Plan.
- Problem solving with the person or the person's parent or guardian.
- Problem solving when the person or the person's parent or guardian has not followed through with identified Service Plan action steps.
- Assessing for new needs.
- Determining the next course of action to address outstanding needs.

A follow-up visit may be completed in-person or through the use of synchronous audiovisual technology, or synchronous telephone (audio-only) technology. Follow-up visits completed using synchronous audiovisual technology or synchronous telephone (audio-only) technology should only be provided if agreed to by the person or the person's parent or guardian.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for information on policy restrictions for services delivered by synchronous telephone (audio-only) technologies.

CPW activities that occur between follow-up visits are necessary components of case management for children and pregnant women services, but are not billable. These activities may include, but are not limited to:

- Phone calls to the person or the person's parent or guardian between billable follow-up visits.
- Collateral contacts on behalf of the person or the person's parent or guardian.

CPW follow-up contacts with pregnant women with a high-risk condition may occur through the 59th day post-partum. When all needs related to the health condition, health risk, or high-risk pregnancy have been addressed, CPW services must no longer be provided.

3.3.4 Prior Authorization

All CPW services must be prior authorized, including the comprehensive visit and follow-up visits. People receiving CPW services must meet one of the following eligibility requirements:

- Pregnant woman of any age may have a high risk pregnancy, medical conditions, or psychosocial conditions that place the woman and her fetus at a greater than average risk for complications during pregnancy, delivery or after childbirth.
- Children birth through 20 years of age who may have a health condition or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles compared to healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

Prior authorization requests for CPW services must be submitted to TMHP within three business days of the initial intake. TMHP CPW prior authorization forms may be found on the TMHP website.

Referto: www.tmhp.com/topics/prior-authorization

A TMHP CPW Initial Prior Authorization Request form must be submitted to TMHP within three business days of the initial intake. TMHP CPW Initial Prior Authorization Request forms and CPW Prior Authorization Request For Additional Visits forms may be submitted to TMHP using the TMHP Prior Authorization (PA) Portal or by mail.

The information indicated on the Initial Intake form must be entered into the TMHP CPW Initial Prior Authorization Request form, including but not limited to:

- The health condition(s), health risk, or high-risk condition of the person who would receive case management services
- How the health condition, health risk, or high-risk condition impacts the person's level of functioning
- Detailed information about the person's current need(s) related to the health condition, health risk, or high-risk condition
- How the CPW provider will assist the person with their current need(s)

A TMHP CPW Initial Prior Authorization Request form must be submitted and approval received prior to the initiation of CPW services including the comprehensive visit. The information provided on the TMHP CPW Initial Prior Authorization Request form must support the need for CPW services.

Needs identified that do not support the need for CPW services include, but are not limited to:

- Needs identified are not related to health condition, health-risk, or if pregnant, a high-risk condition
- Needs identified are anticipatory
- Needs identified are not current
- Needs identified are for monitoring the client's health only

- Need identified is a routine Medicaid need (e.g., finding a doctor or dentist, [unless there is a documented barrier to finding a provider])
- Needs identified are for other family members only
- Need identified is for support group(s)

Needs identified are for basic information and referral (example: baby supplies, financial assistance, school supplies, GED/parents' educational needs, etc.).

Approved TMHP CPW Initial Prior Authorization Request forms will include one comprehensive visit and two follow-up visits.

CPW prior authorization approvals are valid for one year. Prior authorization is a condition of reimbursement, not a guarantee of payment.

3.3.4.1 Prior Authorization for Additional Follow-up Visits

Additional CPW follow-up visits may be considered when:

- All previously authorized follow-up visits have been completed
- The person still meets eligibility requirements
- Additional visits are needed to resolve previously identified needs or newly identified needs
- Documentation supports the reason(s) needs originally identified have not been addressed

A TMHP CPW Prior Authorization Request for Additional Visits form must be submitted to TMHP, using the TMHP PA Portal or by mail, when an additional follow-up visit is requested. Approved TMHP CPW Prior Authorization Request for Additional Visits will include one follow-up visit. CPW prior authorization approvals are valid for one year.

3.4 Technical Assistance

Providers may contact HHSC 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 HHSC program staff at askcm@hhs.texas.gov.

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

3.5 Documentation Requirements

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

Case Management for Children and Pregnant Women services are subject to retrospective review and recoupment if documentation does not support the service billed.

Documentation in the person's record must include that verbal or written consent was obtained from the person or the person's parent or legal guardian prior to the initiation of any CPW services.

Prior authorization requests must be submitted to TMHP using a TMHP CPW Initial Prior Authorization Request form or CPW Prior Authorization Request for Additional Visits form. CPW forms including the Family Needs Assessment, Service Plan, Follow-Up form, follow-up documentation, and progress notes must be completed and maintained in the person's record.

Signatures must be included on all forms and documents that require signatures. All forms and documents completed in relation to CPW services must be maintained in the person's record.

All contacts with or on behalf of the person or the person's parent or guardian must be documented and maintained in the person's record. Documentation of activities, not otherwise documented on CPW required forms, must be recorded on progress notes. Documentation in the person's record must include the reason(s) a CPW service was not provided or completed.

Records are subject to review by HHSC or its designee.

All needs identified during the completion of the service plan must be documented on the Service Plan form. CPW activities that occur between follow-up visits must be documented on a progress note and maintained in the person's chart.

Note: CPW documentation forms are available on the HHSC CPW website at: www.hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women

3.6 Claims Filing and Reimbursement

3.6.1 Claims Information

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

Claims submitted for services that have not been prior authorized will be denied.

The comprehensive visit must not be billed until the FNA and SP are completed, and the SP Consent form is signed by the person or the person's parent or legal guardian. The CPW initial intake service is not billable.

Activities that occur between follow-up visits are necessary components of case management but are not billable. These activities must be documented on a progress note. These activities may include, but are not limited to:

- Phone calls to the person or the person's parent or guardian between billable follow-up visits.
- Collateral contacts on behalf of a person or a person's parent or guardian.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement.

3.6.1.1 Exclusions

CPW services are limited to one service per day, any provider.

CPW services are not billable when provided in the inpatient setting.

3.6.2 Managed Care Clients

Case Management for Children and Pregnant Women services are carved in to Medicaid managed care and must be billed to the client's managed care organization (MCO).

4 Outpatient Mental Health Services

Outpatient mental health services are used for the treatment of mental illness and emotional disturbances in which the clinician establishes a professional contract with the person and, utilizing therapeutic interventions, attempts to alleviate the symptoms of mental illness or emotional disturbance, and reverse, change, or ameliorate maladaptive patterns of behavior.

Outpatient mental health services include psychiatric diagnostic evaluation, psychotherapy (including individual, family, or group), psychological, neurobehavioral, or neuropsychological testing, pharmacological management, and electroconvulsive therapy (ECT).

Outpatient mental health services are benefits when provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations.

Outpatient mental health services are benefits of Texas Medicaid when provided to persons who are experiencing a mental health condition that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

Note: Claims will require the corresponding diagnosis code(s) from the current edition of the International Classification of Diseases (ICD).

4.1 Provider Enrollment

Mental health service providers include physicians, PAs, APRNs, LCSWs, LMFTs, LPCs, psychologists, licensed psychological associates (LPAs), provisionally licensed psychologists (PLPs), post-doctoral fellows, and pre-doctoral psychology interns.

Referto: 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.

4.1.1 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.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only 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.

4.1.2 Physician Assistants (PAs)

To enroll in Texas Medicaid, a PA must be licensed as a PA and be recognized as a PA by the Texas Physician Assistant Board. All PAs are enrolled within the categories of practice as determined by the Texas Medicaid Board. PAs can enroll as an individual, group, or as a performing provider into a clinic/group practice. If enrolling into a Medicare enrolled clinic/group practice, Medicare enrollment is required.

4.1.3 Advanced Practice Registered Nurses (APRNs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, a nurse practitioner (NP) or clinical nurse specialist (CNS) recognized as an APRN must be licensed by the Texas Board of Nursing (TBON). NP/CNSs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based NP/CNSs is enrolling as part of a Medicare-enrolled group, then the NP/CNSs must also be enrolled in Medicare.

Providers that hold a temporary license are not eligible to enroll in Medicaid. NP/CNSs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.4 Licensed Clinical Social Workers (LCSWs)

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.

4.1.5 Licensed Marriage and Family Therapists (LMFTs)

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 clinic/group practice 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.

4.1.6 Licensed Professional Counselors (LPCs)

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 a clinic/group practice 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.

4.1.7 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.

4.1.8 Licensed Psychological Associates (LPAs)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scope 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 required supervision of a licensed, Medicaid-enrolled psychologist.
- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The LPA performing the service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

Psychological services provided by an LPA must be billed under the supervising psychologist's National Provider Identifier (NPI) or the NPI of the legal entity employing the supervising psychologist.

4.1.9 Provisionally Licensed Psychologists (PLPs)

PLPs must be licensed by TSBEP. A PLP may perform all of the services that are benefits of Texas Medicaid when the services are performed by a psychologist.

PLPs are expected to abide by their scope and standards of practice. Services performed by a PLP are a Medicaid-covered benefit when the following conditions are met:

- The services must be performed under the required supervision of a licensed psychologist in accordance with the TSBEP guidelines.
- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The PLP who is performing the service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

The TSBEP requires a PLP to work under the required supervision of a licensed psychologist and does not allow a PLP to engage in independent practice. Therefore, a PLP will not be independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

Psychological services provided by a PLP must be billed under the supervising psychologist's NPI or the NPI of the legal entity employing the supervising psychologist.

4.1.10 Post-Doctoral Fellows

Post-doctoral psychology fellows who satisfy the provisional licensure examination requirements but have not yet been awarded the PLP designation are eligible to perform delegated psychological services within their scope of practice and under the required supervision of a licensed psychologist.

Psychology interns are not independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

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

4.1.11 Pre-doctoral Psychology Interns

Pre-doctoral psychology interns who are participating in a pre-doctoral psychology internship at a site that is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) are eligible to perform delegated psychological services within their scope of practice and under the required supervision of a licensed psychologist.

Psychology interns are not independently enrolled in the Medicaid program and must provide services under the delegating psychologist's NPI.

4.2 Services, Benefits, Limitations

The following procedure codes may be reimbursed for outpatient mental health services:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90791 | 90792 | 90832 | 90833 | 90834 | 90836 | 90837 | 90838 | 90846 | 90847 |
| 90853 | 90870 | 90899 | 96116 | 96121 | 96130 | 96131 | 96132 | 96133 | 96136 |
| 96137 | | | | | | | | | |

Note: Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.

The following psychotherapy procedure codes are limited to 30 visits per calendar year. Additional services require prior authorization:

| Procedure codes | | | | | | | | | |
|--|--------|-------|--------|-------|--------|-------|-------|-------|--|
| 90832 | 90833+ | 90834 | 90836+ | 90837 | 90838+ | 90846 | 90847 | 90853 | |
| + Add-on procedure code must be billed with the appropriate E/M code | | | | | | | | | |

Procedure codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853 are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F0390 | F03911 | F03918 | F0392 | F0393 | F0394 | F03A0 | F03A11 |
| F03A18 | F03A2 | F03A3 | F03A4 | F03B0 | F03B11 | F03B18 | F03B2 |
| F03B3 | F03B4 | F03C0 | F03C11 | F03C18 | F03C2 | F03C3 | F03C4 |
| F04 | F05 | F060 | F061 | F062 | F0630 | F0631 | F0632 |
| F0633 | F0634 | F064 | F0670 | F0671 | F068 | F070 | F0781 |
| F0789 | F09 | F1010 | F1011 | F10120 | F10121 | F10130 | F10131 |
| F10132 | F10139 | F1014 | F10150 | F10151 | F10159 | F10180 | F10181 |
| F10182 | F10188 | F1019 | F1020 | F1021 | F10220 | F10221 | F10230 |
| F10231 | F10232 | F10239 | F1024 | F10250 | F10251 | F10259 | F1026 |
| F1027 | F10280 | F10281 | F10282 | F10288 | F1029 | F1090 | F1091 |
| F10921 | F10930 | F10931 | F10932 | F10939 | F1094 | F10950 | F10951 |
| F10959 | F1096 | F10980 | F10981 | F10982 | F10988 | F1099 | F1110 |
| F1111 | F11120 | F11121 | F11122 | F11129 | F1113 | F1114 | F11150 |
| F11151 | F11159 | F11181 | F11182 | F11188 | F1119 | F1120 | F1121 |
| F11220 | F11221 | F11222 | F11229 | F1123 | F1124 | F11250 | F11251 |
| F11259 | F11281 | F11282 | F11288 | F1129 | F1191 | F11920 | F11921 |
| F11922 | F11929 | F1193 | F1194 | F11950 | F11951 | F11959 | F11981 |
| F11982 | F11988 | F1199 | F1210 | F1211 | F12120 | F12121 | F12122 |
| F12129 | F1213 | F12150 | F12151 | F12159 | F12180 | F12188 | F1219 |
| F1220 | F1221 | F12220 | F12221 | F12222 | F12229 | F1223 | F12250 |
| F12251 | F12259 | F12280 | F12288 | F1229 | F1291 | F12920 | F12921 |
| F12922 | F12929 | F1293 | F12950 | F12951 | F12959 | F12980 | F12988 |
| F1299 | F1310 | F1311 | F13120 | F13121 | F13129 | F13130 | F13131 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F13132 | F13139 | F1314 | F13150 | F13151 | F13159 | F13180 | F13181 |
| F13182 | F13188 | F1320 | F1321 | F13220 | F13221 | F13229 | F13230 |
| F13231 | F13232 | F13239 | F1324 | F13250 | F13251 | F13259 | F1326 |
| F1327 | F13280 | F13281 | F13282 | F13288 | F1391 | F13920 | F13921 |
| F13929 | F13930 | F13931 | F13932 | F13939 | F1394 | F13950 | F13951 |
| F13959 | F1396 | F1397 | F13980 | F13981 | F13982 | F13988 | F1399 |
| F1410 | F1411 | F14120 | F14121 | F14122 | F14129 | F1413 | F1414 |
| F14150 | F14151 | F14159 | F14180 | F14181 | F14182 | F14188 | F1419 |
| F1420 | F1421 | F14220 | F14221 | F14222 | F14229 | F1423 | F1424 |
| F14250 | F14251 | F14259 | F14280 | F14281 | F14282 | F14288 | F1429 |
| F1491 | F14920 | F14921 | F14922 | F14929 | F1493 | F1494 | F14950 |
| F14951 | F14959 | F14980 | F14981 | F14982 | F14988 | F1499 | F1510 |
| F1511 | F15120 | F15121 | F15122 | F15129 | F1513 | F1514 | F15150 |
| F15151 | F15159 | F15180 | F15181 | F15182 | F15188 | F1519 | F1520 |
| F1521 | F15220 | F15221 | F15222 | F15229 | F1523 | F1524 | F15250 |
| F15251 | F15259 | F15280 | F15281 | F15282 | F15288 | F1529 | F1591 |
| F15920 | F15921 | F15922 | F15929 | F1593 | F1594 | F15950 | F15951 |
| F15959 | F15980 | F15981 | F15982 | F15988 | F1599 | F1610 | F1611 |
| F16120 | F16121 | F16122 | F16129 | F1614 | F16150 | F16151 | F16159 |
| F16180 | F16183 | F16188 | F1619 | F1620 | F1621 | F16220 | F16221 |
| F16229 | F1624 | F16250 | F16251 | F16259 | F16280 | F16283 | F16288 |
| F1629 | F1691 | F16920 | F16921 | F16929 | F1694 | F16950 | F16951 |
| F16959 | F16980 | F16983 | F16988 | F1699 | F1810 | F1811 | F18120 |
| F18121 | F18129 | F1814 | F18150 | F18151 | F18159 | F1817 | F18180 |
| F18188 | F1819 | F1820 | F1821 | F18220 | F18221 | F18229 | F1824 |
| F18250 | F18251 | F18259 | F1827 | F18280 | F18288 | F1829 | F1890 |
| F1891 | F18920 | F18921 | F18929 | F1894 | F18950 | F18951 | F18959 |
| F1897 | F18980 | F18988 | F1899 | F1910 | F1911 | F19120 | F19121 |
| F19122 | F19129 | F19130 | F19131 | F19132 | F19139 | F1914 | F19150 |
| F19151 | F19159 | F1916 | F1917 | F19180 | F19181 | F19182 | F19188 |
| F1919 | F1920 | F1921 | F19220 | F19221 | F19222 | F19229 | F19230 |
| F19231 | F19232 | F19239 | F1924 | F19250 | F19251 | F19259 | F1926 |
| F1927 | F19280 | F19281 | F19282 | F19288 | F1929 | F1991 | F19920 |
| F19921 | F19922 | F19930 | F19931 | F19932 | F19939 | F1994 | F19950 |
| F19951 | F19959 | F1996 | F1997 | F19980 | F19981 | F19982 | F19988 |
| F1999 | F200 | F201 | F202 | F203 | F205 | F2081 | F2089 |
| F209 | F21 | F22 | F23 | F24 | F250 | F251 | F258 |
| F259 | F28 | F29 | F3010 | F3011 | F3012 | F3013 | F302 |
| F303 | F304 | F308 | F309 | F310 | F3110 | F3111 | F3112 |
| F3113 | F312 | F3130 | F3131 | F3132 | F314 | F315 | F3160 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| F3161 | F3162 | F3163 | F3164 | F3171 | F3172 | F3173 | F3174 |
| F3175 | F3176 | F3177 | F3178 | F3181 | F3189 | F319 | F320 |
| F321 | F322 | F323 | F324 | F325 | F3281 | F3289 | F329 |
| F32A | F330 | F331 | F332 | F333 | F338 | F3341 | F3342 |
| F339 | F340 | F341 | F3481 | F3489 | F349 | F39 | F4001 |
| F4002 | F4010 | F4011 | F40210 | F40218 | F40220 | F40228 | F40230 |
| F40231 | F40232 | F40233 | F40240 | F40241 | F40242 | F40243 | F40248 |
| F40290 | F40291 | F40298 | F408 | F409 | F410 | F411 | F413 |
| F418 | F419 | F422 | F423 | F424 | F428 | F429 | F430 |
| F4310 | F4311 | F4312 | F4320 | F4321 | F4322 | F4323 | F4324 |
| F4325 | F4329 | F4381 | F4389 | F439 | F440 | F441 | F442 |
| F444 | F445 | F446 | F447 | F4481 | F4489 | F449 | F450 |
| F451 | F4520 | F4521 | F4522 | F4529 | F4541 | F4542 | F458 |
| F459 | F481 | F482 | F488 | F489 | F5000 | F5001 | F5002 |
| F502 | F5081 | F5082 | F5089 | F509 | F5101 | F5102 | F5103 |
| F5104 | F5105 | F5109 | F5111 | F5112 | F5113 | F5119 | F513 |
| F514 | F515 | F518 | F519 | F520 | F521 | F5221 | F5222 |
| F5231 | F5232 | F524 | F525 | F526 | F528 | F529 | F530 |
| F531 | F54 | F550 | F551 | F552 | F553 | F554 | F558 |
| F600 | F601 | F602 | F603 | F604 | F605 | F606 | F607 |
| F6081 | F6089 | F609 | F630 | F631 | F632 | F633 | F6381 |
| F6389 | F639 | F640 | F641 | F642 | F648 | F649 | F650 |
| F651 | F652 | F653 | F654 | F6551 | F6552 | F6581 | F6589 |
| F659 | F66 | F6810 | F6811 | F6812 | F6813 | F68A | F69 |
| F70 | F800 | F801 | F802 | F804 | F8082 | F809 | F8181 |
| F819 | F82 | F840 | F842 | F843 | F845 | F849 | F900 |
| F901 | F902 | F908 | F909 | F910 | F911 | F912 | F913 |
| F918 | F919 | F930 | F938 | F939 | F940 | F941 | F942 |
| F948 | F949 | F950 | F951 | F952 | F959 | F980 | F981 |
| F9821 | F9829 | F983 | F984 | F985 | F988 | F989 | G300 |
| G301 | G308 | G309 | G3101 | G3109 | G3184 | G4720 | G4721 |
| G4722 | G4723 | G4724 | G4725 | G4726 | G4727 | G4729 | I69212 |
| O906 | R413 | R41840 | R41841 | R41842 | R41843 | R41844 | R4189 |
| R45850 | R45851 | R4588 | T5892XD | T5892XS | T7401XA | T7401XD | T7401XS |
| T7402XA | T7412XD | T7412XS | T7421XA | T7421XD | T7421XS | T7422XA | T7422XD |
| T7422XS | T7431XA | T7431XD | T7431XS | T7432XA | T7432XD | T7432XS | T7451XA |
| T7451XD | T7451XS | T7452XA | T7452XD | T7452XS | T7461XA | T7461XD | T7461XS |
| T7462XA | T7462XD | T7462XS | T7601XA | T7601XD | T7601XS | T7602XA | T7602XD |
| T7602XS | T7611XA | T7611XD | T7611XS | T7612XA | T7612XD | T7612XS | T7621XA |
| T7621XD | T7621XS | T7622XA | T7622XD | T7622XS | T7631XA | T7631XD | T7631XS |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T7632XA | T7632XD | T7632XS | T7651XA | T7651XD | T7651XS | T7652XA | T7652XD |
| T7652XS | T7661XA | T7661XD | T7661XS | T7662XA | T7662XD | T7662XS | Z0389 |
| Z600 | Z608 | Z609 | Z620 | Z621 | Z6221 | Z6222 | Z6223 |
| Z6224 | Z62810 | Z62811 | Z62812 | Z62813 | Z62820 | Z62821 | Z62822 |
| Z62823 | Z62831 | Z62832 | Z62833 | Z62890 | Z62892 | Z6331 | Z6332 |
| Z634 | Z635 | Z6372 | Z638 | Z644 | Z654 | Z655 | Z658 |
| Z69010 | Z69011 | Z69020 | Z69021 | Z6912 | Z6982 | Z72810 | Z72811 |
| Z736 | Z781 | Z818 | Z8651 | Z9151 | Z9152 | Z9183 | |

In addition to the diagnosis codes listed in the table above, procedure code 90791 or 90792 is a benefit when submitted with the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-----|-----|-------|-------|-----|--|--|
| F71 | F72 | F73 | F78A1 | F78A9 | F79 | | |

Procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| A8100 | A8101 | A8109 | A8181 | A8183 | B1001 | B1009 | B451 |
| D8681 | E7500 | E7501 | E7502 | E7509 | E7510 | E7511 | E7519 |
| E7523 | E7525 | E7526 | E7529 | E754 | F0150 | F01511 | F01518 |
| F0152 | F0153 | F0154 | F01A0 | F01A11 | F01A18 | F01A2 | F01A3 |
| F01A4 | F01B0 | F01B11 | F01B18 | F01B2 | F01B3 | F01B4 | F01C0 |
| F01C11 | F01C18 | F01C2 | F01C3 | F01C4 | F0280 | F02811 | F02818 |
| F0282 | F0283 | F0284 | F02A0 | F02A11 | F02A18 | F02A2 | F02A3 |
| F02A4 | F02B0 | F02B11 | F02B18 | F02B2 | F02B3 | F02B4 | F02C0 |
| F02C11 | F02C18 | F02C2 | F02C3 | F02C4 | F0390 | F03911 | F03918 |
| F0392 | F0393 | F0394 | F03A0 | F03A11 | F03A18 | F03A2 | F03A3 |
| F03A4 | F03B0 | F03B11 | F03B18 | F03B2 | F03B3 | F03B4 | F03C0 |
| F03C11 | F03C18 | F03C2 | F03C3 | F03C4 | F04 | F05 | F060 |
| F061 | F062 | F0630 | F0631 | F0632 | F0633 | F0634 | F064 |
| F0670 | F0671 | F068 | F070 | F0781 | F0789 | F09 | F1010 |
| F10120 | F10121 | F10129 | F10130 | F10131 | F10132 | F10139 | F1014 |
| F10150 | F10151 | F10159 | F10180 | F10181 | F10182 | F10188 | F1019 |
| F1020 | F1021 | F10220 | F10221 | F10229 | F10230 | F10231 | F10232 |
| F10239 | F1024 | F10250 | F10251 | F10259 | F1026 | F1027 | F10280 |
| F10281 | F10282 | F10288 | F1029 | F1090 | F1091 | F10920 | F10921 |
| F10929 | F10930 | F10931 | F10932 | F10939 | F1094 | F10950 | F10951 |
| F10959 | F1096 | F1097 | F10980 | F10981 | F10982 | F10988 | F1099 |
| F11120 | F11121 | F11122 | F11129 | F1113 | F1114 | F11150 | F11151 |
| F11159 | F11181 | F11182 | F11188 | F1119 | F1120 | F1121 | F11220 |

***Add-on procedure codes must be billed with the appropriate primary code**

| Diagnosis Codes | | | | | | | |
|---|--------|--------|--------|--------|--------|--------|--------|
| F11221 | F11222 | F11229 | F1123 | F1124 | F11250 | F11251 | F11259 |
| F11281 | F11282 | F11288 | F1129 | F1191 | F11920 | F11921 | F11922 |
| F11929 | F1193 | F1194 | F11950 | F11951 | F11959 | F11981 | F11982 |
| F1199 | F1210 | F1211 | F12120 | F12121 | F12122 | F12129 | F1213 |
| F12150 | F12151 | F12159 | F12180 | F12188 | F1219 | F1220 | F1221 |
| F12220 | F12221 | F12222 | F12229 | F1223 | F12250 | F12251 | F12259 |
| F12280 | F12288 | F1229 | F1290 | F1291 | F12920 | F12921 | F12922 |
| F12929 | F1293 | F12950 | F12951 | F12959 | F12980 | F12988 | F1299 |
| F1311 | F1314 | F13120 | F13121 | F13129 | F13130 | F13131 | F13132 |
| F13139 | F13150 | F13151 | F13159 | F13180 | F13181 | F13182 | F13188 |
| F1320 | F1321 | F13220 | F13221 | F13229 | F13230 | F13231 | F13232 |
| F13239 | F1324 | F13250 | F13251 | F13259 | F1326 | F1327 | F13280 |
| F13281 | F13282 | F13288 | F1391 | F13920 | F13921 | F13929 | F13930 |
| F13931 | F13932 | F13939 | F1394 | F13950 | F13951 | F13959 | F1396 |
| F13980 | F13981 | F13982 | F13988 | F1399 | F1410 | F1411 | F14120 |
| F14121 | F14122 | F14129 | F1413 | F1414 | F14150 | F14151 | F14159 |
| F14180 | F14181 | F14182 | F14188 | F1419 | F1420 | F1421 | F14220 |
| F14221 | F14222 | F14229 | F1423 | F1424 | F14250 | F14251 | F14259 |
| F14280 | F14281 | F14282 | F14288 | F1429 | F1491 | F14920 | F14921 |
| F14922 | F14929 | F1493 | F1494 | F14950 | F14951 | F14959 | F14980 |
| F14982 | F14988 | F1499 | F1510 | F1511 | F15120 | F15121 | F15122 |
| F15129 | F1513 | F1514 | F15150 | F15151 | F15159 | F15180 | F15181 |
| F15182 | F15188 | F1519 | F1520 | F1521 | F15220 | F15221 | F15222 |
| F15229 | F1523 | F1524 | F15250 | F15251 | F15259 | F15280 | F15281 |
| F15282 | F15288 | F1529 | F1591 | F15920 | F15921 | F15922 | F15929 |
| F1594 | F15950 | F15951 | F15959 | F15980 | F15981 | F15982 | F15988 |
| F1599 | F1610 | F1611 | F16120 | F16121 | F16122 | F16129 | F1614 |
| F16150 | F16151 | F16159 | F16180 | F16183 | F16188 | F1619 | F1620 |
| F1621 | F16220 | F16221 | F16229 | F1624 | F16250 | F16251 | F16259 |
| F16280 | F16283 | F16288 | F1629 | F1691 | F16920 | F16921 | F16929 |
| F1694 | F16950 | F16951 | F16959 | F16980 | F16983 | F16988 | F1699 |
| F1811 | F18120 | F18121 | F18129 | F1814 | F18150 | F18151 | F18159 |
| F1817 | F18180 | F18188 | F1819 | F1820 | F1821 | F18220 | F18221 |
| F18229 | F1824 | F18250 | F18251 | F18259 | F1827 | F18280 | F18288 |
| F1829 | F1890 | F1891 | F18920 | F18921 | F18929 | F18950 | F18951 |
| F1897 | F18980 | F18988 | F1894 | F1899 | F1910 | F1911 | F19120 |
| F19121 | F19122 | F19129 | F19130 | F19131 | F19132 | F19139 | F1914 |
| F19150 | F19151 | F19159 | F1916 | F1917 | F19180 | F19181 | F19182 |
| F19188 | F1919 | F1920 | F1921 | F19220 | F19221 | F19222 | F19229 |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

| Diagnosis Codes | | | | | | | |
|---|--------|--------|--------|--------|--------|--------|--------|
| F19230 | F19231 | F19232 | F19239 | F1924 | F19250 | F19251 | F19259 |
| F1926 | F1927 | F19280 | F19281 | F19282 | F19288 | F1929 | F1991 |
| F19920 | F19921 | F19922 | F19929 | F19930 | F19931 | F19932 | F19939 |
| F19950 | F19951 | F19959 | F1996 | F1997 | F19980 | F19981 | F19982 |
| F19988 | F1999 | F200 | F201 | F202 | F203 | F205 | F2081 |
| F2089 | F209 | F21 | F22 | F23 | F24 | F250 | F251 |
| F258 | F259 | F28 | F29 | F3010 | F3011 | F3012 | F3013 |
| F302 | F303 | F304 | F308 | F309 | F310 | F3110 | F3111 |
| F3112 | F3113 | F312 | F3130 | F3131 | F3132 | F314 | F315 |
| F3160 | F3161 | F3162 | F3163 | F3164 | F3170 | F3171 | F3172 |
| F3173 | F3174 | F3175 | F3176 | F3177 | F3178 | F3181 | F3189 |
| F319 | F320 | F321 | F322 | F323 | F324 | F325 | F3281 |
| F3289 | F329 | F32A | F330 | F331 | F332 | F333 | F3341 |
| F3342 | F338 | F339 | F340 | F341 | F3481 | F3489 | F349 |
| F39 | F4001 | F4002 | F4010 | F4011 | F40210 | F40218 | F40220 |
| F40228 | F40230 | F40231 | F40232 | F40233 | F40240 | F40241 | F40242 |
| F40243 | F40248 | F40290 | F40291 | F40298 | F408 | F409 | F410 |
| F411 | F413 | F418 | F419 | F422 | F423 | F424 | F428 |
| F429 | F430 | F4310 | F4311 | F4312 | F4320 | F4321 | F4322 |
| F4323 | F4324 | F4325 | F4329 | F4381 | F4389 | F439 | F440 |
| F441 | F442 | F444 | F445 | F446 | F447 | F4481 | F4489 |
| F449 | F450 | F451 | F4520 | F4521 | F4522 | F4529 | F4541 |
| F4542 | F458 | F459 | F481 | F482 | F488 | F489 | F5000 |
| F5001 | F5002 | F502 | F5081 | F5082 | F5089 | F509 | F5101 |
| F5102 | F5103 | F5104 | F5105 | F5109 | F5111 | F5112 | F5113 |
| F5119 | F513 | F514 | F515 | F518 | F519 | F520 | F521 |
| F5221 | F5222 | F5231 | F5232 | F524 | F525 | F526 | F528 |
| F529 | F530 | F531 | F54 | F550 | F551 | F552 | F553 |
| F554 | F558 | F600 | F601 | F602 | F603 | F604 | F605 |
| F606 | F607 | F6081 | F6089 | F609 | F630 | F631 | F632 |
| F633 | F6381 | F6389 | F639 | F640 | F641 | F642 | F648 |
| F649 | F650 | F651 | F652 | F653 | F654 | F6551 | F6552 |
| F6581 | F6589 | F659 | F66 | F6810 | F6811 | F6812 | F6813 |
| F68A | F688 | F69 | F70 | F71 | F72 | F73 | F78A1 |
| F78A9 | F79 | F800 | F801 | F802 | F804 | F8082 | F8089 |
| F809 | F810 | F812 | F8181 | F819 | F82 | F840 | F842 |
| F843 | F845 | F848 | F849 | F88 | F89 | F900 | F901 |
| F902 | F908 | F909 | F910 | F911 | F912 | F913 | F918 |
| F919 | F930 | F938 | F939 | F940 | F941 | F942 | F948 |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

| Diagnosis Codes | | | | | | | |
|---|--------|--------|--------|--------|--------|--------|--------|
| F949 | F950 | F951 | F952 | F958 | F959 | F980 | F981 |
| F9821 | F9829 | F983 | F984 | F985 | F988 | F989 | G000 |
| G001 | G002 | G003 | G008 | G009 | G01 | G02 | G030 |
| G031 | G032 | G038 | G039 | G0400 | G0401 | G0402 | G042 |
| G0430 | G0431 | G0432 | G0439 | G0481 | G0482 | G0489 | G0490 |
| G0491 | G053 | G054 | G060 | G061 | G062 | G07 | G210 |
| G300 | G301 | G308 | G309 | G3101 | G3109 | G311 | G312 |
| G3180 | G3181 | G3182 | G3183 | G3184 | G3185 | G3186 | G3189 |
| G319 | G3289 | G35 | G40001 | G40009 | G40011 | G40019 | G40B01 |
| G40B09 | G40B11 | G40B19 | G40C01 | G40C09 | G40C11 | G40C19 | G40101 |
| G40109 | G40111 | G40119 | G40201 | G40209 | G40211 | G40219 | G40301 |
| G40309 | G40311 | G40319 | G40501 | G40509 | G40801 | G40802 | G40803 |
| G40804 | G40811 | G40812 | G40813 | G40814 | G40821 | G40822 | G40823 |
| G40824 | G4089 | G40901 | G40909 | G40911 | G40919 | G40A01 | G40A09 |
| G40A11 | G40A19 | G44209 | G450 | G451 | G452 | G454 | G458 |
| G459 | G468 | G4720 | G4721 | G4722 | G4723 | G4724 | G4725 |
| G4726 | G4727 | G4729 | G910 | G911 | G912 | G928 | G929 |
| G930 | G931 | G9340 | G9341 | G9342 | G9343 | G9344 | G9349 |
| G937 | G9381 | G9389 | G939 | G94 | H93291 | H93292 | H93293 |
| H93A1 | H93A2 | H93A3 | H93A9 | I6000 | I6001 | I6002 | I6010 |
| I6011 | I6012 | I602 | I6030 | I6031 | I6032 | I604 | I6050 |
| I6051 | I6052 | I606 | I607 | I608 | I609 | I610 | I611 |
| I612 | I613 | I614 | I615 | I616 | I618 | I619 | I6200 |
| I6201 | I6202 | I6203 | I621 | I629 | I6300 | I63011 | I63012 |
| I63013 | I63019 | I6302 | I63031 | I63032 | I63033 | I63039 | I6309 |
| I6310 | I63111 | I63112 | I63113 | I63119 | I6312 | I63131 | I63132 |
| I63133 | I63139 | I6319 | I6320 | I63211 | I63212 | I63213 | I63219 |
| I6322 | I63231 | I63232 | I63233 | I63239 | I6329 | I6330 | I63311 |
| I63312 | I63313 | I63319 | I63321 | I63322 | I63323 | I63329 | I63331 |
| I63332 | I63333 | I63339 | I63341 | I63342 | I63343 | I63349 | I6339 |
| I6340 | I63411 | I63412 | I63413 | I63419 | I63421 | I63422 | I63423 |
| I63429 | I63431 | I63432 | I63433 | I63439 | I63441 | I63442 | I63443 |
| I63449 | I6349 | I6350 | I63511 | I63512 | I63513 | I63519 | I63521 |
| I63522 | I63523 | I63529 | I63531 | I63532 | I63533 | I63539 | I63541 |
| I63542 | I63543 | I63549 | I6359 | I6381 | I6389 | I6501 | I6502 |
| I6503 | I6509 | I651 | I6521 | I6522 | I6523 | I6529 | I658 |
| I659 | I6601 | I6602 | I6603 | I6609 | I6611 | I6612 | I6613 |
| I6619 | I6621 | I6622 | I6623 | I6629 | I663 | I668 | I669 |
| I671 | I672 | I674 | I675 | I676 | I677 | I6781 | I6782 |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

| Diagnosis Codes | | | | | | | |
|---|---------|---------|---------|---------|---------|---------|---------|
| I67850 | I67858 | I6789 | I679 | I680 | I682 | I688 | I6900 |
| I69010 | I69011 | I69012 | I69013 | I69014 | I69015 | I69018 | I69019 |
| I69020 | I69021 | I69022 | I69023 | I69028 | I69031 | I69032 | I69033 |
| I69034 | I69039 | I69041 | I69042 | I69043 | I69044 | I69049 | I69051 |
| I69052 | I69053 | I69054 | I69059 | I69061 | I69062 | I69063 | I69064 |
| I69065 | I69069 | I69090 | I69091 | I69092 | I69093 | I69098 | I6910 |
| I69110 | I69111 | I69112 | I69113 | I69114 | I69115 | I69118 | I69119 |
| I69120 | I69121 | I69122 | I69123 | I69128 | I69131 | I69132 | I69133 |
| I69134 | I69139 | I69141 | I69142 | I69143 | I69144 | I69149 | I69151 |
| I69152 | I69153 | I69154 | I69159 | I69161 | I69162 | I69163 | I69164 |
| I69165 | I69169 | I69190 | I69191 | I69192 | I69193 | I69198 | I6920 |
| I69210 | I69211 | I69212 | I69213 | I69214 | I69215 | I69218 | I69219 |
| I69220 | I69221 | I69222 | I69223 | I69228 | I69231 | I69232 | I69233 |
| I69234 | I69239 | I69241 | I69242 | I69243 | I69244 | I69249 | I69251 |
| I69252 | I69253 | I69254 | I69259 | I69261 | I69262 | I69263 | I69264 |
| I69265 | I69269 | I69290 | I69291 | I69292 | I69293 | I69298 | I6930 |
| I69310 | I69311 | I69312 | I69313 | I69314 | I69315 | I69318 | I69319 |
| I69320 | I69321 | I69322 | I69323 | I69328 | I69331 | I69332 | I69333 |
| I69334 | I69339 | I69341 | I69342 | I69343 | I69344 | I69349 | I69351 |
| I69352 | I69353 | I69354 | I69359 | I69361 | I69362 | I69363 | I69364 |
| I69365 | I69369 | I69390 | I69391 | I69392 | I69393 | I69398 | I6980 |
| I69810 | I69811 | I69812 | I69813 | I69814 | I69815 | I69818 | I69819 |
| I69820 | I69821 | I69822 | I69823 | I69828 | I69831 | I69832 | I69833 |
| I69834 | I69839 | I69841 | I69842 | I69843 | I69844 | I69849 | I69851 |
| I69852 | I69853 | I69854 | I69859 | I69861 | I69862 | I69863 | I69864 |
| I69865 | I69869 | I69890 | I69891 | I69892 | I69893 | I69898 | I6990 |
| I69910 | I69911 | I69912 | I69913 | I69914 | I69915 | I69918 | I69919 |
| I69920 | I69921 | I69922 | I69923 | I69928 | I69931 | I69932 | I69933 |
| I69934 | I69939 | I69941 | I69942 | I69943 | I69944 | I69949 | I69951 |
| I69952 | I69953 | I69954 | I69959 | I69961 | I69962 | I69963 | I69964 |
| I69965 | I69969 | I69990 | I69991 | I69992 | I69993 | I69998 | O906 |
| P102 | P103 | P520 | P521 | P5221 | P5222 | P523 | P525 |
| P84 | P90 | P9160 | P9161 | P9162 | P9163 | R0901 | R0902 |
| R413 | R41840 | R41841 | R41842 | R41843 | R41844 | R4189 | R450 |
| R453 | R454 | R457 | R45850 | R45851 | R4586 | R4587 | R4588 |
| R4589 | R5600 | R5601 | R569 | S060X0A | S060X0D | S060X0S | S060X1A |
| S060X1D | S060X1S | S060X9A | S060X9D | S060X9S | S060XAA | S060XAD | S060XAS |
| S06306A | S06306D | S06306S | S0630AA | S0630AD | S0630AS | S06310A | S06310D |
| S06310S | S06311A | S06311D | S06311S | S06312A | S06312D | S06312S | S06313A |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

| Diagnosis Codes | | | | | | | |
|---|---------|---------|---------|---------|---------|---------|---------|
| S06313D | S06313S | S06314A | S06314D | S06314S | S06315A | S06315D | S06315S |
| S06316A | S06316D | S06316S | S06319A | S06319D | S06319S | S0631AA | S0631AD |
| S0631AS | S06320A | S06320D | S06320S | S06321A | S06321D | S06321S | S06322A |
| S06322D | S06322S | S06323A | S06323D | S06323S | S06324A | S06324D | S06324S |
| S06325A | S06325D | S06325S | S06326A | S06326D | S06326S | S06329A | S06329D |
| S06329S | S0632AA | S0632AD | S0632AS | S06330A | S06330D | S06330S | S06331A |
| S06331D | S06331S | S06332A | S06332D | S06332S | S06333A | S06333D | S06333S |
| S06334A | S06334D | S06334S | S06335A | S06335D | S06335S | S06336A | S06336D |
| S06336S | S06339A | S06339D | S06339S | S0633AA | S0633AD | S0633AS | S06340A |
| S06340D | S06340S | S06341A | S06341D | S06341S | S06342A | S06342D | S06342S |
| S06343A | S06343D | S06343S | S06344A | S06344D | S06344S | S06345A | S06345D |
| S06345S | S06346A | S06346D | S06346S | S06349A | S06349D | S06349S | S0634AA |
| S0634AD | S0634AS | S06350A | S06350D | S06350S | S06351A | S06351D | S06351S |
| S06352A | S06352D | S06352S | S06353A | S06353D | S06353S | S06354A | S06354D |
| S06354S | S06355A | S06355D | S06355S | S06356A | S06356D | S06356S | S06359A |
| S06359D | S06359S | S0635AA | S0635AD | S0635AS | S06360A | S06360D | S06360S |
| S06361A | S06361D | S06361S | S06362A | S06362D | S06362S | S06363A | S06363D |
| S06363S | S06364A | S06364D | S06364S | S06365A | S06365D | S06365S | S06366A |
| S06366D | S06366S | S06369A | S06369D | S06369S | S0636AA | S0636AD | S0636AS |
| S06370A | S06370D | S06370S | S06371A | S06371D | S06371S | S06372A | S06372D |
| S06372S | S06373A | S06373D | S06373S | S06374A | S06374D | S06374S | S06375A |
| S06375D | S06375S | S06376A | S06376D | S06376S | S06379A | S06379D | S06379S |
| S0637AA | S0637AD | S0637AS | S06380A | S06380D | S06380S | S06381A | S06381D |
| S06381S | S06382A | S06382D | S06382S | S06383A | S06383D | S06383S | S06384A |
| S06384D | S06384S | S06385A | S06385D | S06385S | S06386A | S06386D | S06386S |
| S06389A | S06389D | S06389S | S0638AA | S0638AD | S0638AS | S064X0A | S064X0D |
| S064X0S | S064X1A | S064X1D | S064X1S | S064X2A | S064X2D | S064X2S | S064X3A |
| S064X3D | S064X3S | S064X4A | S064X4D | S064X4S | S064X5A | S064X5D | S064X5S |
| S064X6A | S064X6D | S064X6S | S064X9A | S064X9D | S064X9S | S064XAA | S064XAD |
| S064XAS | S065X0A | S065X0D | S065X0S | S065X1A | S065X1D | S065X1S | S065X2A |
| S065X2D | S065X2S | S065X3A | S065X3D | S065X3S | S065X4A | S065X4D | S065X4S |
| S065X5A | S065X5D | S065X5S | S065X6A | S065X6D | S065X6S | S065X7A | S065X8A |
| S065X9A | S065X9D | S065X9S | S065XAA | S065XAD | S065XAS | S066X0A | S066X0D |
| S066X0S | S066X1A | S066X1D | S066X1S | S066X2A | S066X2D | S066X2S | S066X3A |
| S066X3D | S066X3S | S066X4A | S066X4D | S066X4S | S066X5A | S066X5D | S066X5S |
| S066X6A | S066X6D | S066X6S | S066X9A | S066X9D | S066X9S | S066XAA | S066XAD |
| S066XAS | S06890A | S06890D | S06890S | S06891A | S06891D | S06891S | S06892A |
| S06892D | S06892S | S06893A | S06893D | S06893S | S06894A | S06894D | S06894S |
| S06895A | S06895D | S06895S | S06896A | S06896D | S06896S | S06897A | S06899A |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

| Diagnosis Codes | | | | | | | |
|------------------------|---------|---------|---------|---------|---------|---------|---------|
| S06899D | S06899S | S0689AA | S0689AD | S0689AS | S069X0A | S069X0D | S069X0S |
| S069X1A | S069X1D | S069X1S | S069X2A | S069X2D | S069X2S | S069X3A | S069X3D |
| S069X3S | S069X4A | S069X4D | S069X4S | S069X5A | S069X5D | S069X5S | S069X6A |
| S069X6D | S069X6S | S069X9A | S069X9D | S069X9S | S069XAA | S069XAD | S069XAS |
| T40411A | T40411D | T40411S | T40412A | T40412D | T40412S | T40413A | T40413D |
| T40413S | T40414A | T40414D | T40414S | T40415A | T40415D | T40415S | T40416A |
| T40416D | T40416S | T40421A | T40421D | T40421S | T40422A | T40422D | T40422S |
| T40423A | T40423D | T40423S | T40424A | T40424D | T40424S | T40425A | T40425D |
| T40425S | T40426A | T40426D | T40426S | T40491A | T40491D | T40491S | T40492A |
| T40492D | T40492S | T40493A | T40493D | T40493S | T40494A | T40494D | T40494S |
| T40495A | T40495D | T40495S | T40496A | T40496D | T40496S | T40711A | T40711D |
| T40711S | T40712A | T40712D | T40712S | T40713A | T40713D | T40713S | T40714A |
| T40714D | T40714S | T40715A | T40715D | T40715S | T40716A | T40716D | T40716S |
| T40721A | T40721D | T40721S | T40722A | T40722D | T40722S | T40723A | T40723D |
| T40723S | T40724A | T40724D | T40724S | T40725A | T40725D | T40725S | T40726A |
| T40726D | T40726S | T50912A | T50912D | T50912S | T50914A | T50914D | T50914S |
| T5801XA | T5801XD | T5801XS | T5802XA | T5802XD | T5802XS | T5803XA | T5803XD |
| T5803XS | T5804XA | T5804XD | T5804XS | T5811XA | T5811XD | T5811XS | T5812XA |
| T5812XD | T5812XS | T5813XA | T5813XD | T5813XS | T5814XA | T5814XD | T5814XS |
| T582X1A | T582X1D | T582X1S | T582X2A | T582X2D | T582X2S | T582X3A | T582X3D |
| T582X3S | T582X4A | T582X4D | T582X4S | T588X1A | T588X1D | T588X1S | T588X2A |
| T588X2D | T588X2S | T588X3A | T588X3D | T588X3S | T588X4A | T588X4D | T588X4S |
| T5891XA | T5891XD | T5891XS | T5892XA | T5892XD | T5892XS | T5893XA | T5893XD |
| T5893XS | T5894XA | T5894XD | T5894XS | T71111A | T71111D | T71111S | T71112A |
| T71112D | T71112S | T71113A | T71113D | T71113S | T71114A | T71114D | T71114S |
| T71121A | T71121D | T71121S | T71122A | T71122D | T71122S | T71123A | T71123D |
| T71123S | T71124A | T71124D | T71124S | T71131A | T71131D | T71131S | T71132A |
| T71132D | T71132S | T71133A | T71133D | T71133S | T71134A | T71134D | T71134S |
| T71141A | T71141D | T71141S | T71143A | T71143D | T71143S | T71144A | T71144D |
| T71144S | T71151A | T71151D | T71151S | T71152A | T71152D | T71152S | T71153A |
| T71153D | T71153S | T71154A | T71154D | T71154S | T71161A | T71161D | T71161S |
| T71162A | T71162D | T71162S | T71163A | T71163D | T71163S | T71164A | T71164D |
| T71164S | T71191A | T71191D | T71191S | T71192A | T71192D | T71192S | T71193A |
| T71193D | T71193S | T71194A | T71194D | T71194S | T7120XA | T7120XD | T7120XS |
| T7121XA | T7121XD | T7121XS | T71221A | T71221D | T71221S | T71222A | T71222D |
| T71222S | T71223A | T71223D | T71223S | T71224A | T71224D | T71224S | T71231A |
| T71231D | T71231S | T71232A | T71232D | T71232S | T71233A | T71233D | T71233S |
| T71234A | T71234D | T71234S | T7129XA | T7129XD | T7129XS | T719XXA | T719XXD |
| T719XXS | T7401XA | T7401XD | T7401XS | T7402XA | T7402XD | T7402XS | T7411XA |

***Add-on procedure codes must be billed with the appropriate primary code**

| Diagnosis Codes | | | | | | | |
|---|---------|---------|---------|---------|---------|---------|---------|
| T7411XD | T7411XS | T7412XA | T7412XD | T7412XS | T7421XA | T7421XD | T7421XS |
| T7422XA | T7422XD | T7422XS | T7431XA | T7431XD | T7431XS | T7432XA | T7432XD |
| T7432XS | T7451XA | T7451XD | T7451XS | T7452XA | T7452XD | T7452XS | T7461XA |
| T7461XD | T7461XS | T7462XA | T7462XD | T7462XS | T751XXA | T751XXD | T751XXS |
| T7601XA | T7601XD | T7601XS | T7602XA | T7602XD | T7602XS | T7611XA | T7611XD |
| T7611XS | T7612XA | T7612XD | T7612XS | T7621XA | T7621XD | T7621XS | T7622XA |
| T7622XD | T7622XS | T7631XA | T7631XD | T7631XS | T7632XA | T7632XD | T7632XS |
| T7651XA | T7651XD | T7651XS | T7652XA | T7652XD | T7652XS | T7661XA | T7661XD |
| T7661XS | T7662XA | T7662XD | T7662XS | Z608 | Z634 | Z644 | Z658 |
| Z72810 | Z72811 | Z736 | Z73810 | Z73811 | Z73812 | Z73819 | Z781 |
| Z818 | Z8651 | Z8659 | Z87820 | Z87890 | Z9151 | Z9152 | Z9183 |
| *Add-on procedure codes must be billed with the appropriate primary code | | | | | | | |

4.2.1 Telemedicine and Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person’s choice and not provider convenience.

Providers must provide outpatient mental health services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, outpatient mental health services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

4.2.1.1 Synchronous Audiovisual Technology

The following outpatient mental health services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Outpatient mental health services provided by synchronous audiovisual technology must be billed using modifier 95.

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)
- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only
- Neurobehavioral services (procedure codes 96116 and 96121).
- Neuropsychological and psychological testing services (procedure codes 96130, 96131, 96132, 96133, 96136 and 96137) if the following conditions are met:

- The psychometric test must be available in an online format, except for tests that are administered and responded to orally;
- The provider, or test administrator, must observe the person, in real-time, for the duration of the test; and
- The provider delivers the psychometric test in accordance with their licensing board and professional guidelines.

4.2.1.2 Synchronous Telephone (audio-only) Technology

The following outpatient mental health services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and, if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as, the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of outpatient mental health services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology.

Outpatient mental health services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)
- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual outpatient mental health service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: “Same billing provider” refers to providers that are within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (e.g., a clinic/group practice, federally qualified health clinic or rural health clinic, and can include providers within the same community mental health center).

Note: The required in-person or synchronous audiovisual-delivered outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

The billing provider is required to conduct at least one in-person or synchronous audiovisual outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological] or ECT) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or

synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person’s medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person’s condition(s)

| Modifiers for Telemedicine and Telehealth | Description |
|---|--|
| 95 | Delivered by synchronous audiovisual technology |
| FQ | Delivered by synchronous telephone (audio-only) technology |

Note: *The required in-person or synchronous audiovisual-delivered outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) may be delivered by another authorized professional or paraprofessional of the same billing provider (see note above for the definition of same billing provider) as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology.*

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

4.2.2 Psychotherapy Services

Individual psychotherapy is defined as therapy that focuses on a single person.

Group psychotherapy is defined as a type of psychotherapy that involves one or more therapists working with several persons at the same time.

Family psychotherapy is defined as therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family’s problem solving and communication skills.

Providers must bill a modifier to identify a separate and distinct service when performing individual psychotherapy (procedure code 90832, 90834, or 90837) and family psychotherapy (procedure code 90846 or 90847) on the same day for the same person. When billing for these services, providers must submit the family psychotherapy procedure code with the modifier on the claim to indicate that the procedure or service was distinct or independent from other services performed on the same day for the same person. Documentation that supports the provision of distinct or independent services must be maintained in the person’s medical record and made available to Texas Medicaid upon request.

Note: *The add-on codes may only be billed by physician, APRN, or PA providers.*

Referto: Subsection 9.2.59.6, “Prolonged Physician Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about prolonged physician services.

Psychotherapy (individual, family, or group) is limited to 4 hours per person, per day.

Psychotherapy is limited to 30 individual, group, or family psychotherapy visits per person, per calendar year. Additional psychotherapy services must be prior authorized. Prior authorization requests in increments of up to 10 additional visits may be considered. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:

- Identifying information for the person receiving services
- Provider name and NPI
- Current DSM diagnosis(es)
- Current psychotropic medications
- Current symptoms requiring additional psychotherapy
- Treatment plan, including measurable short-term goals, specific therapeutic interventions utilized, and measurable expected outcomes of therapy
- Number and type of services requested and anticipated dates that the services will be provided
- Indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services

Providers with an established relationship with a person receiving services must request prior authorization when they determine the person is approaching 30 psychotherapy visits for the calendar year. If the person changes providers during the year and the new provider is unable to obtain complete information on the person's previous treatment history, providers are encouraged to obtain prior authorization before rendering services. Requests submitted on the same day as the initial session with a new provider will be considered based on medical necessity criteria.

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

LMFTs must bill with modifier U8 to differentiate from LPCs.

Supporting documentation for individual, family, or group psychotherapy services must include:

- Start and end time of session
- Modality or modalities utilized
- Frequency of psychotherapy sessions
- Clinical notes for each visit must include diagnosis, symptoms, functional status, focused mental status examination (if indicated), treatment plan (goals and objectives addressed), prognosis, and progress, and the name, signature, and credentials of the individual performing the services.

4.2.2.1 Family Psychotherapy

Family psychotherapy may be provided to Medicaid eligible persons 20 years of age and younger using procedure code 90846 or persons of any age using procedure code 90847.

Family psychotherapy is only reimbursable for one Medicaid eligible person per session regardless of the number of family members present per session.

Family psychotherapy for Medicaid eligible persons 20 years of age and younger may be provided to the child's parent(s), foster parent(s), or legal guardian without the child present, as clinically appropriate, using procedure code 90846. Parent- or guardian-only sessions may be indicated when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

Only the following specific relatives may participate in family psychotherapy services:

- Biological parent, foster parent, or legal guardian

- Child
- Grandfather or grandmother
- Sibling (biological, foster, or kinship)
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

4.2.2.2 Treatment for Alzheimer’s Disease and Dementia

Psychotherapy for persons with Alzheimer’s disease or dementia is a benefit of Texas Medicaid for persons with very mild or mild cognitive decline.

Documentation to support the treatment for Alzheimer’s disease or dementia must be maintained in the person’s medical record and may be subject to retrospective review. Psychotherapy services must not be continued if no longer beneficial to the person due to diminished cognitive functioning.

4.2.3 Delegated Services

Services provided by a psychologist, LPA, PLP, psychology intern, or post-doctoral fellow must be billed with a modifier on each detail. Psychological services provided by an LPA, PLP psychology intern, or post-doctoral fellow must be billed under the supervising psychologist’s NPI or the NPI of the legal entity employing the supervising psychologist.

Services performed by a LPA or PLP will be reimbursed at 70 percent of the psychologist rate. Services performed by the psychology intern or post-doctoral fellow will be reimbursed at 50 percent of the psychologist rate.

The following modifiers are to be used with procedure codes for licensed psychologist and delegated services:

| Modifier | Description |
|-----------------|--|
| AH | Identifies service provided by a clinical psychologist |
| UB | Identifies service provided by a pre-doctoral psychology intern or post-doctoral psychology fellow |
| UC | Identifies service provided by an LPA |
| U9 | Identifies service provided by a PLP |

Claims submitted without a modifier or with two of these modifiers on the same detail will be denied.

Only the LCSW, LMFT, LPC, APRN, or PA performing the mental health service may bill Texas Medicaid. The LCSW, LMFT, LPC, APRN, or PA must not bill for services performed by people under his or her supervision.

4.2.4 Pharmacological Management Services

Pharmacological management is the in-depth management of psychopharmacological agents to treat a person’s mental health symptoms.

Pharmacological management is a physician service and cannot be provided by a non-physician or “incident to” a physician service, except for APRNs and PAs whose scope of license in this state permits them to prescribe.

Pharmacological management is limited to one service per day, per person, by any provider in any setting.

The treating provider should use the most appropriate E/M code for the pharmacological management visit depending on the place of service and complexity of the person's condition, along with modifier UD to designate the visit as primarily focused on pharmacological management.

Supporting documentation for pharmacological management services must include:

- Complete diagnosis utilizing diagnostic criteria from the current edition of the DSM
- Current list of medications
- Current psychiatric symptoms and problems, including presenting mental status
- Problems, reactions, and side effects, if any, to medications
- Any medication modifications made during a visit and the reasons for medication adjustments, changes, or discontinuation
- Desired therapeutic drug levels, if applicable, for medications requiring blood level monitoring, e.g. Lithium
- Current laboratory values, if applicable, for medications requiring monitoring for potential side effects, e.g. hyperglycemia caused by anti-psychotic medications
- Treatment goals

4.2.5 Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is the induction of convulsions by the passage of an electric current through the brain used in the treatment of certain psychiatric disorders.

Individual psychotherapy, psychological, neurobehavioral, or neuropsychological testing billed in addition to ECT on the same day, by any provider will be denied as part of another procedure on the same day.

ECT billed in addition to psychiatric diagnostic evaluation or group or family psychotherapy on the same day, by the same provider will be denied as part of another procedure.

4.2.6 Psychiatric Diagnostic Evaluation Services

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. Psychiatric diagnostic evaluation with medical services also includes a medical assessment, other physical examination elements as indicated, and may also include prescription of medications, and laboratory or other diagnostic studies.

A psychiatric diagnostic evaluation without medical services (procedure code 90791) may be reimbursed to physicians, psychologists, APRNs, PAs, LCSWs, LPCs, LMFTs, PLPs, psychology interns, and post-doctoral fellows.

A psychiatric diagnostic evaluation with medical services (procedure code 90792) may be reimbursed to physicians, APRNs, and PAs.

Psychiatric diagnostic evaluations with and without medical services (procedure codes 90791 and 90792) are limited to once per person, per rolling year, same provider in the office, home, outpatient hospital, or other settings, regardless of the number of professionals involved in the interview. Additional psychiatric diagnostic evaluations may be considered for prior authorization on a case-by-case basis when submitted on an Outpatient Mental Health Services Request Form with supporting documentation, including but not limited to:

- A court order or a DFPS directive
- If a major change of status occurs

Supporting documentation for psychiatric diagnostic evaluation services must include:

- Reason for referral or presenting problem
- Prior diagnoses and any prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and results of mental status examination
- Complete diagnosis utilizing diagnostic criteria from the current edition of the DSM
- Recommendations, including expected long- and short-term goals

4.2.7 Psychological, Neurobehavioral, and Neuropsychological Testing Services

Psychological, neurobehavioral, and neuropsychological testing involves the use of formal tests and other assessment tools to measure and assess a person's emotional, and cognitive functioning in order to arrive at a diagnosis and guide treatment.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to eight hours per person, per calendar year. Additional hours require prior authorization when medically necessary. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:

- Identifying information for the person receiving services
- Provider name and NPI
- Current DSM diagnoses
- Indication of court-ordered or DFPS-directed services
- Type of testing requested (psychological, neurobehavioral, or neuropsychological) including specific procedure codes
- Rationale for requested testing, to include the current symptoms of the person receiving services
- Previous history and testing results

Psychological, neurobehavioral, and neuropsychological testing will not be reimbursed to an APRN or a PA. The most appropriate office visit procedure code must be billed. Mental health screening may be performed during an assessment by an APRN or a PA, but will not be reimbursed separately.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) or neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (procedure code 90791 or 90792).

Neurobehavioral testing (procedure code 96116) may not be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (procedure code 90791 or 90792) to the same provider.

Neurobehavioral testing (procedures codes 96116 and 96121) will not be paid for the same date of service to the same provider as psychological testing (procedure codes 96130, 96131, 96136 and 96137) or neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137). All documentation must be maintained by the provider in the person's medical record.

The reimbursement for procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 includes the face-to-face testing and the scoring and interpretation of the results. The number of units of testing on the claim for procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 must be in accordance with the allowable activities outlined in each code description.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.*

Assessment, treatment planning, and documentation time, including time to document test results in the person's medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes.

4.2.7.1 Testing in Facilities

Psychological testing, neurobehavioral testing, or neuropsychological testing may be reimbursed when provided in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) as clinically indicated. Testing may be indicated, for example, when a person has experienced significant change in mental status requiring specialized testing, or to evaluate a person's competency to return to a community-based setting. Persons with well-established mental or cognitive issues do not require additional testing.

Psychological, neurobehavioral, or neuropsychological testing will not be reimbursed in a SNF, ICF, or ECF when conducted prior to the performance of initial intake assessments such as the Minimum Data Set or Preadmission Screening and Resident Review (PASRR) (a completed Level I Screening and a Level II Evaluation, as applicable).

Supporting documentation for psychological, neurobehavioral, or neuropsychological testing services must include:

- Reason for referral or presenting problem
- The name of the tests (e.g., WAIS-R, Rorschach, MMPI) performed
- The scoring of the test
- Location where the testing is performed
- The name and credentials of each provider involved in administering, interpreting, and preparing the report
- Test interpretations, including narrative descriptions of the test findings
- Length of time spent by each provider, as applicable, in administration, interpretation, integrating the test interpretation, and documenting the comprehensive report based on the integrated data
- Recommended treatment, including how test results affect the prescribed treatment
- Recommendations for further testing, including an explanation to substantiate the necessity for retesting, if applicable
- Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the person's condition requires testing over two days and the person does not return, or the person's condition precludes completion of the testing.

Original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC.

When psychological, neurobehavioral, or neuropsychological testing is performed in a SNF, ICF, or ECF, a copy of the test and the resulting report must also be maintained in the person's medical record at the facility.

4.3 Prior Authorization

Prior authorization requests must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Performing providers may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Referto: Subsection 5.5.1.2, “Document Requirements and Retention” in “Section 5: Fee-for-Service Prior Authorizations” (*Vol. 1, General Information*) for additional information about electronic signatures.

All providers must adhere to prior authorization requirements.

4.3.1 Services Requiring Prior Authorization

Prior Authorization is required for the following services:

- Psychiatric diagnostic evaluation (procedure code 90791 or 90792) after the one evaluation per person, per provider, per rolling year limitation has been met
- Individual, family, or group psychotherapy (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853) after the 30 visit per calendar year limitation has been met
- Neurobehavioral testing (procedure codes 96116 and 96121) after the 4 hour per day limitations have been met
- Psychological testing (procedure code 96130, 96131, 96136, or 96137) or neuropsychological testing (procedure code 96132, 96133, 96136, or 96137) after the 8 hour per calendar year limitations have been met
- Unlisted psychiatric service or procedure (procedure code 90899)

Requests for prior authorization for procedure code 90899 must be submitted by the provider to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form with documentation supporting medical necessity including:

- Diagnosis(es)
- Prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the evidence-based service or procedure to be performed, and the intended fee for the service or procedure
- The reason for recommending this particular service or procedure
- A procedure code that is comparable to the service or procedure being requested
- Documentation that this service or procedure is not investigational or experimental

4.3.2 Prior Authorization Not Required

Prior authorization is not required for the following services:

- One psychiatric diagnostic evaluation (procedure codes 90791 and 90792) per person, per rolling year, per provider (same provider)
- 30 individual, family, or group psychotherapy (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853) visits per person per calendar year
- 4 hours of psychotherapy services per person per day
- 4 hours of neuropsychological testing (procedure codes 96116 and 96121) per person per day
- 8 hours of psychological, neurobehavioral, or neuropsychological testing (procedure codes 96130, 96131, 96132, 96133, 96136, or 96137) per person, per calendar year
- ECT (procedure code 90870)

4.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including mental health services. The documentation must support the medical necessity of the treatment for its entire duration.

Mental health services outlined in this handbook are subject to retrospective review to ensure that the documentation in the person’s medical record supports the medical necessity of the services provided. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

4.5 Twelve Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of persons seen for outpatient mental health services:

- Psychologist
- APRN
- PA
- LCSW
- LMFT
- LPC

The following table lists the procedure codes for mental health services 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.

| Procedure Code | Time Applied |
|--|--------------|
| 90791 | 60 minutes |
| 90792 | 60 minutes |
| 90832 | 30 minutes |
| 90833+ | 30 minutes |
| 90834 | 45 minutes |
| 90836+ | 45 minutes |
| 90837 | 60 minutes |
| 90838+ | 60 minutes |
| 90846 | 50 minutes |
| 90847 | 50 minutes |
| 96116 | 60 minutes |
| 96121+ | 60 minutes |
| 96130 | 60 minutes |
| 96131+ | 60 minutes |
| 96132 | 60 minutes |
| + Add-on procedure codes to be billed with the most appropriate E/M procedure code. | |

| Procedure Code | Time Applied |
|--|--------------|
| 96133+ | 60 minutes |
| 96136 | 30 minutes |
| 96137+ | 30 minutes |
| + Add-on procedure codes to be billed with the most appropriate E/M procedure code. | |

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

Physicians are not subject to the 12-hour system limitation since they can delegate and may submit claims in excess of 12 hours per day.

Psychologists can delegate to multiple LPAs, PLPs, interns, or post-doctoral fellows and therefore delegated services are not subject to the 12-hour system limitation since they may submit claims for delegated services in excess of 12 hours per day.

4.6 Court-Ordered Services

The court-ordered services listed below for persons who are age 20 years of age and younger or 65 years of age and older are not subject to utilization management reviews, including prior authorization, concurrent reviews, or retrospective reviews that have the effect of denying, reducing, or controverting the court-ordered service. In these situations, the court order is considered the determination of medical necessity.

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

Federal law prohibits the use of federal Medicaid funding for medical care provided to persons who are considered incarcerated. A person is considered incarcerated when a criminal justice facility has custody of the person. Examples include:

- A person who is currently residing in a criminal justice facility and receiving treatment through a program at the criminal justice facility.
- A person who is committed under Title 1 Texas Code of Criminal Procedure §46(B), which addresses persons ages 18 and older who have been ordered to receive competency restoration.
- A person who is committed under Title 3 Texas Family Code §§55.01-55.45. These sections refer to persons committed to inpatient psychiatric care because they are deemed unfit to proceed.

The following court-ordered services are required to be provided to Medicaid eligible persons who are not considered incarcerated:

- Emergency detention ordered by a judge or magistrate under Title 7 Texas Health and Safety Code §§573.011-573.026.
- Mental health services ordered under Title 7 Texas Health and Safety Code §§574.01-574.110. Mental health services may include:
 - A mental health examination.
 - Inpatient or outpatient treatment.
 - Detention under protective custody and temporary mental health services.
- Treatment of persons who are found not guilty based on lack of responsibility under Title 3 Texas Family Code §55.
- Treatment that is a condition of probation.

- Treatment of persons with chemical dependencies ordered under Title 6 Texas Health and Safety Code §462.042.

For authorization of court-ordered services, the provider must submit documentation that includes:

- The court-order.
- Information about the statute under which the court is ordering the services.
- Verification of the person's incarceration status.

For court-ordered inpatient admissions, providers must submit documentation that includes:

- A copy of the doctor's certificate.
- All court-ordered commitment papers signed by the judge.

For persons with fee-for-service benefits, this supporting documentation must be submitted with the Psychiatric Inpatient Extended Stay Request Form.

Requested services beyond those that are court-ordered are subject to medical necessity review.

4.7 Exclusions

The following services are not benefits of Texas Medicaid:

- Psychoanalysis
- Multiple family group psychotherapy
- Marriage or couples counseling
- Narcosynthesis
- Biofeedback training as part of psychophysiological therapy
- Psychiatric day treatment programs
- Services provided by a psychiatric assistant, psychological assistant (excluding master's level LPA), or a licensed chemical dependency counselor

4.8 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid when a person is eligible for services under both programs. Medicaid's responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the person's Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by LCSW providers.*

Referto: Subsection 2.7.3, "Part B" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

Subsection 4.9.2, "Medicare Part B Crossovers" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

LCSW, LMFT, and LPC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 paper 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.

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

Subsection 6.1, “Claims Information” in “Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper 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 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.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the [Reimbursement Rate Changes](#) page of the TMHP website at www.tmhp.com.

Note: *Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by LCSW providers.*

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

Subsection 4.5, “Twelve Hour System Limitation” in this handbook for details about the 12-hours-per-day behavioral health services limitation.

4.9 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicaid Claims Processing manuals, which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

Whenever Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5 Intellectual Disability Service Coordination, Mental Health Targeted Case Management, and Mental Health Rehabilitative Services

5.1 Enrollment

5.1.1 Local Intellectual and Developmental Disability Authority (LIDDA) Providers

A LIDDA provider who is authorized by HHSC to provide service coordination must be enrolled as a Long Term Care provider, and must submit claims through the Long Term Care system.

LIDDAs are the only entities that provide case management (service coordination) services to persons who have an intellectual disability.

Referto: The TMHP website at www.tmhp.com for additional information about Long Term Care enrollment and billing requirements.

5.1.2 Local Mental Health Authority (LMHA) Providers

LMHA providers are authorized by the HHSC to provide targeted case management services and mental health rehabilitative services. To enroll in Texas Medicaid, LMHA providers must contact HHSC at performance.contracts@hhsc.state.tx.us to be approved.

5.1.3 Non-Local Mental Health Authority (Non-LMHA) Providers

Non-LMHAs are private providers of both mental health (MH) case management and MH rehabilitative services, but they are not LMHAs. They must comply with all applicable federal and local laws and all of the regulations that are related to the services they provide. After receiving approval for enrollment in Texas Medicaid, the Non-LMHA provider must be credentialed by a Texas Medicaid managed care organization (MCO) to provide services to Texas Medicaid eligible persons.

Non-LMHA providers also must register to use the DSHS Clinical Management for Behavioral Health Services (CMBHS) clinical record-keeping system before providing services to Texas Medicaid eligible persons.

5.1.4 Provider Credentials for Facilities Delivering MHTCM and Mental Health Rehabilitative Services

Community Services Specialist (CSSP), Qualified Mental Health Professional - Community Services (QMHP-CS), family partners, and peer providers are eligible to deliver some or all of the mental health rehabilitative services and mental health targeted case management services. The credentialing requirements and services each provider may deliver are listed in the following sections.

Staff administering the assessment instruments must have documentation of current certification in the CANS or ANSA. Certification must be updated annually through an approved entity.

5.1.4.1 Community Services Specialist (CSSP)

CSSP providers are eligible to deliver Mental Health Targeted Case Management (MHTCM) and Mental Health (MH) Rehabilitative services and must meet the following minimum credentialing requirements:

- High school diploma or high school equivalency;
- Three continuous years of documented full-time experience in the provision of MH rehabilitative services prior to August 30, 2004; and
- Demonstrated competency in the provision and documentation of MHTCM and MH rehabilitative services.

A CSSP performing MHTCM and MH rehabilitative services must:

- Be an employee of the provider where MHTCM services are delivered.
- Be clinically supervised by at least a QMHP-CS.

5.1.4.2 Qualified Mental Health Professional - Community Services (QMHP-CS)

QMHP-CS providers are eligible to deliver MHTCM and MH rehabilitative services and must meet the following minimum credentialing requirements:

- Completed a standardized training curriculum
- Demonstrated competency in the work to be performed
- Obtained one of the following:

- A bachelor's degree from an accredited college or university with a minimum number of hours that are equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention
- A license as a registered nurse (RN)

Staff administering the functional assessment instruments must have documentation of current certification in either the Child and Adolescent Needs and Strengths Assessment (CANS) or the Adult Needs and Strengths Assessment (ANSA). Certification in either the CANS or ANSA must be updated annually through an approved entity.

An individual who possesses any of the following licenses is considered a Licensed Practitioner of the Healing Arts (LPHA) and is automatically certified as a QMHP-CS:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse
- Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)

A QMHP-CS must be clinically supervised by another QMHP-CS. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA.

5.1.4.3 Peer Provider

Peer providers must have a high school diploma or high school equivalency, one cumulative year of receiving mental health services, and be clinically supervised by an LPHA. The supervising LPHA must conduct at least monthly documented meetings with the peer provider and conduct an additional monthly documented observation of the peer providing services.

A peer provider must satisfy all staff credentialing, competency, training, and clinical supervision requirements.

Services provided by a peer provider must be included in the treatment plan.

5.1.4.4 Family Partner

A certified family partner (CFP) must have a high school diploma or high school equivalency and one cumulative year of participating in mental health services as the parent or legally authorized representative (LAR) of a child receiving mental health services.

A CFP must be supervised by at least a QMHP-CS and must satisfy all staff credentialing, competency, training, and clinical supervision requirements.

Services provided by a CFP must be included in the treatment plan.

Family partners must be credentialed as a CFP within one year of their hire date.

The family partner service is provided to parents or LARs for the benefit of the Medicaid eligible child.

5.1.4.5 Certifications for Mental Health Rehabilitative Services

The following provider certifications are required for mental health rehabilitative services:

| Service | Provider Types | | | | | |
|--|----------------|------|---------------|----------------------------|----------------|----|
| | QMHP-CS | CSSP | Peer Provider | Licensed Medical Personnel | Family Partner | RN |
| Medication Training and Support - Child, Youth, LAR, Primary Caregiver | X | X | | X | X | X |
| Medication Training and Support - adult or LAR | X | X | X | X | | X |
| Psychosocial Rehabilitation (adults only) | X | X | X | X | | X |
| Skills training and development - adult or LAR | X | X | X | X | | X |
| Skills training and development - child/youth or LAR | X | X | | X | X | X |
| Crisis Intervention | X | | | X | | X |
| Day Program for Acute Needs - Symptoms management and functioning skills | X | X | X | X | | X |
| Day Program for Acute Needs - Pharmacology issues | | | | X | | X |
| Day Program for Acute Needs - Psychiatric Nursing services | | | | X | | X |

5.2 Services, Benefits, Limitations, and Prior Authorization

5.2.1 Intellectual and Developmental Disabilities Service Coordination

Texas Medicaid provides the following:

- Service coordination for persons who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

Service coordination funded by Medicaid as TCM is reimbursed by encounter.

There are two types of encounters:

- *Comprehensive encounter (Type A):* A face-to-face contact with a person to provide service coordination. The comprehensive encounter is limited to one billable encounter per person per calendar month. HHSC will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per person per calendar month.

- *Supportive encounter (Type B):* A face-to-face, telephone, or telemedicine contact with a person or with a collateral on the person's behalf to provide service coordination.

A LIDDA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

The Type B encounters are not limited to three per person. Rather, the allowed Type B encounters may be delivered to any person who needs a Type B encounter. These Type B encounters are allowable as long as the person who received the Type B encounter also received a Type A encounter that same month.

For example, Sam and Mary receive a Type A encounter in June. It is allowable for the LIDDA to bill for one Type B encounter for Sam in June and five Type B encounters for Mary in June.

Payment for a person's Type B encounter is contingent on that the person having a Type A encounter within the same calendar month.

Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.

Prior authorization is not required for IDD coordination services.

5.2.2 Mental Health Targeted Case Management (MHTCM)

Mental health targeted case management (MHTCM) services are case management services to persons within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are persons, regardless of age, with a diagnosis or diagnoses of mental illness or serious emotional disturbance (SED) as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to need MHTCM services. Persons of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for MHTCM services.

MHTCM services are furnished to assist persons in gaining access to needed medical, social, behavioral, educational, and other services and supports. MHTCM activities and services include:

- A comprehensive initial assessment and periodic reassessment, as medically necessary, of the person's needs to determine the need for any medical, educational, social, behavioral, or other services.
- The development, and periodic revision, as medically necessary, of a trauma-informed and person-centered plan of care that:
 - Is based on the information collected through the uniform assessment;
 - Specifies the goals and actions to address the medical, social, behavioral, educational, and other services and supports needed by the person;
 - Includes activities, such as ensuring the active participation of the eligible person and working with the person, or the person's authorized health care decision maker, and others to develop these goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible person.
- Making referrals and performing other related activities, such as scheduling an appointment on behalf of the person, to help an eligible person obtain needed services and supports, including activities that help link a person with:
 - Medical, social, behavioral, and educational providers; and
 - Other programs and services that can provide needed services to address identified needs and achieve goals in the plan of care.

- Monitoring and performing the necessary follow-up that is necessary to ensure the plan of care is implemented and adequately addresses the needs of the person.

MHTCM activities may be with the person, family members, LAR, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:

- Services are being furnished in accordance with the person’s plan of care;
- Services in the plan of care are adequate in amount, scope, and duration to meet the needs of the person; and
- The plan of care and service arrangements are modified when the needs or status of the person changes.

MHTCM is a benefit for persons transitioning to a community setting for up to 180 consecutive days prior to leaving a nursing facility; however, MHTCM services are coordinated with, and do not duplicate activities provided, as part of nursing facility services and discharge planning activities.

MHTCM consists of intensive case management and routine case management. Intensive case management services are predominantly community-based case management activities provided to the child or youth or to the LAR on behalf of the child or youth (who may or may not be present) to assist a child or youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the child or youth’s needs. Routine case management services are primarily office-based case management activities that assist a person, caregiver, or LAR in obtaining and coordinating access to necessary care and services appropriate to the child’s or youth’s needs.

Intensive case management and routine case management are benefits for persons who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day.

Routine case management is a benefit for persons who are 21 years of age and older.

Providers must use procedure code T1017 and the appropriate modifier for MHTCM:

| Modifier | Description |
|----------|--|
| 95 | Delivered by synchronous audiovisual technology |
| FQ | Delivered by synchronous telephone (audio-only technology) |
| HA | Child/Adolescent Program |
| HZ | Funded by criminal justice agency |
| TF | Routine Case Management |
| TG | Intensive Case Management |

Procedure code T1017 is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| F060 | F061 | F062 | F0630 | F0631 | F0632 | F0633 | F0634 |
| F064 | F068 | F070 | F0789 | F09 | F200 | F201 | F202 |
| F203 | F205 | F2081 | F2089 | F209 | F21 | F22 | F23 |
| F24 | F250 | F251 | F258 | F259 | F28 | F29 | F3010 |
| F3011 | F3012 | F3013 | F302 | F303 | F304 | F309 | F310 |
| F3110 | F3111 | F3112 | F3113 | F312 | F3130 | F3131 | F3132 |
| F314 | F315 | F3160 | F3161 | F3162 | F3163 | F3164 | F3170 |
| F3171 | F3172 | F3173 | F3174 | F3175 | F3176 | F3177 | F3178 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| F3181 | F3189 | F319 | F320 | F321 | F322 | F323 | F324 |
| F325 | F3281 | F3289 | F329 | F32A | F330 | F331 | F332 |
| F333 | F3340 | F3341 | F3342 | F338 | F339 | F340 | F341 |
| F3481 | F348 | F349 | F39 | F4000 | F4001 | F4002 | F4010 |
| F4011 | F40210 | F40218 | F40220 | F40228 | F40230 | F40231 | F40232 |
| F40233 | F40240 | F40241 | F40242 | F40243 | F40248 | F40290 | F40291 |
| F40298 | F408 | F409 | F410 | F411 | F413 | F418 | F419 |
| F422 | F423 | F424 | F428 | F429 | F430 | F4310 | F4311 |
| F4312 | F4320 | F4321 | F4322 | F4323 | F4324 | F4325 | F4329 |
| F4381 | F4389 | F439 | F440 | F441 | F442 | F444 | F445 |
| F446 | F447 | F4481 | F4489 | F449 | F450 | F451 | F4520 |
| F4521 | F4522 | F4529 | F4541 | F4542 | F458 | F459 | F481 |
| F482 | F488 | F489 | F5000 | F5001 | F5002 | F502 | F5081 |
| F5082 | F5089 | F509 | F5101 | F5102 | F5103 | F5104 | F5105 |
| F5109 | F5111 | F5112 | F5113 | F5119 | F513 | F514 | F515 |
| F518 | F519 | F530 | F531 | F54 | F600 | F601 | F602 |
| F603 | F604 | F605 | F606 | F607 | F6081 | F6089 | F609 |
| F630 | F631 | F632 | F633 | F6381 | F6389 | F639 | F640 |
| F641 | F642 | F648 | F649 | F6810 | F6811 | F6812 | F6813 |
| F68A | F69 | F8082 | F900 | F901 | F902 | F908 | F909 |
| F910 | F911 | F912 | F913 | F918 | F919 | F930 | F938 |
| F939 | F940 | F941 | F942 | F948 | F949 | F980 | F981 |
| F9821 | F9829 | F983 | F984 | F985 | F988 | F989 | F99 |
| O906 | T7402XA | T7402XD | T7402XS | T7412XA | T7412XD | T7412XS | T7422XA |
| T7422XD | T7422XS | T7452XA | T7452XD | T7452XS | T7462XA | T7462XD | T7462XS |
| T7602XA | T7602XD | T7602XS | T7612XA | T7612XD | T7612XS | T7622XA | T7622XD |
| T7622XS | T7652XD | T7652XS | T7662XA | T7662XD | T7662XS | | |

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

MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services.

The following activities are included in the MHTCM rate and will not be reimbursed separately:

- Documenting the provision of MHTCM services to include developing and revising the plan of care and interventions that are appropriate to a person’s needs.
- On-going administration of the uniform assessment to determine amount, duration, and type of MHTCM.
- Travel time required to provide MHTCM services at a location not owned, operated, or under arrangement with the provider.

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

Note: *MHTCM claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA/Local Behavioral Health Authority (LBHA) claims are processed to pay cost-sharing. These claims will be carved-out of managed care and will not be sent to the person's MCO. MHTCM claims submitted by non-LMHAs for persons with Medicaid-only (all persons who are not dual-eligible) will be carved-in for managed care, meaning that FFS will pay the claims until the person chooses an MCO, and then the claims will be forwarded to the person's MCO for processing and reimbursement.*

5.2.2.1 Telemedicine and Telehealth

Providers of MHTCM services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide MHTCM services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, MHTCM services in full accordance with all applicable licensure and certification

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

5.2.2.1.1 Synchronous Audiovisual Technology

MHTCM services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the person receiving services. MHTCM services provided by synchronous audiovisual technology must be billed using modifier 95.

5.2.2.1.2 Synchronous Telephone (Audio-Only Technology)

MHTCM services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and, if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of MHTCM services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. MHTCM services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual MHTCM, mental health rehabilitation (MHR), or peer specialist service from the same billing provider within the six months prior to the initial service delivered by synchronous

telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual MHTCM, MHR, or peer specialist service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: “Same billing provider” refers to providers that are within the same entity, as identified by the entity’s NPI number or numbers, if the entity has multiple locations (i.e., the same LMHA/LBHA or same non-LMHA/private provider).

Note: The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

The billing provider is required to conduct at least one in-person or synchronous audiovisual MHTCM, MHR, or peer specialist service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person’s medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person’s condition(s).

Note: The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

5.2.2.2 Collateral Contacts

MHTCM may include contacts with non-eligible individuals who are directly related to identifying the eligible person’s needs and care for the purposes of helping the eligible person access services, identifying needs and supports to assist the eligible person in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible person’s needs.

MHTCM services involving collateral contacts are only payable when the person or LAR is also present during the case management session.

5.2.2.3 Intensive Case Management for Persons 20 Years of Age and Younger

Intensive case management services incorporate a wraparound approach to care planning and treatment plan implementation. The wraparound process is a strengths-based course of action involving a child or youth and their family, including any additional people identified by the child or youth, LAR, primary caregiver, and family, that results in a unique set of community services and natural supports that are individualized for the child or youth to achieve a positive set of identified outcomes.

Intensive case management services are primarily community-based, meaning that services are provided in whatever setting is clinically appropriate and person-centered, to include telehealth delivery.

A case manager assigned to a child or youth who is authorized to receive intensive case management services must have completed training in the National Wraparound Implementation Center's Wraparound Practice model and must incorporate wraparound process planning or other approved models in developing a plan of care that addresses the unmet needs of the child or youth across life domains.

The case manager must develop an intensive case management plan of care that is trauma-informed and person-centered and is based on the needs of the child or youth, which may include information across life domains from relevant sources.

The case manager must meet with the child or youth and the LAR or primary caregiver:

- Within seven days after the case manager is assigned to the child or youth; or
- Within seven days after discharge from an inpatient psychiatric setting, whichever is later; or
- Document the reasons the meeting did not occur and meet at the soonest available opportunity.

The case manager must identify the child's or youth's strengths, service needs, and assistance that will be required to address the identified needs in the plan of care.

The case manager must take steps that are necessary to assist the child or youth in gaining access to the needed services and service providers, including:

- Making referrals to potential service providers.
- Initiating contact with potential service providers.
- Arranging, and if necessary to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments.
- Arranging transportation to ensure the child or youth attendance.
- Advocating with service providers.
- Providing relevant information to service providers.
- Monitoring the child's or youth's progress toward the goals set forth in the plan.

5.2.2.3.1 Prior Authorization Requirements

Initial Authorization Requirements

Providers of MTHCM services must not bill Texas Medicaid for services prior to the establishment of a diagnosis of mental illness and the authorization or reauthorization of services.

Eligibility and continued eligibility determinations occur at the facility (provider) that is providing MHTCM services using the Clinical Management of Behavioral Health Services (CMBHS) software system. Criteria used to make these service determinations are from the recommended Level of Care (LOC) of the person generated by the CMBHS software system, as derived from the uniform assessment, the needs of the person, and the Texas Resilience and Recovery (TRR) Utilization Management Guidelines. Providers of MTHCM services must ensure the following:

- A Qualified Mental Health Professional-Community Services (QMHP-CS) or Licensed Practitioner of the Healing Arts (LPHA) performs a screening for eligibility using the uniform assessment;
- An LPHA determines the diagnosis, which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
- The clinical needs of the person are evaluated to determine if the amount of MHTCM services associated with the recommended LOC, described in the TRR Utilization Management Guidelines, is sufficient to meet those needs; and
- An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.

If the provider determines the type of MHTCM services associated with the recommended LOC generated by the CMBHS software system is sufficient to meet the needs of the person, the provider must submit a request for prior authorization according to the recommended LOC. If the provider determines that a LOC, other than the recommended LOC, is more appropriate for the person then the provider must submit a prior authorization deviation request that includes the following:

- The word ‘Deviation’ with a note that the request is for prior authorization of a LOC that is higher or lower than initially recommended; and
- The clinical justification for the request to include the specific reason(s) for why the person requires interventions higher or lower than the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification).

For persons enrolled in managed care, LMHAs/LBHAs and non-LMHAs (also referred to as private providers) contracted with MCOs must submit prior authorization requests to the MCO with whom the person is enrolled. MCOs must follow the requirements set forth in the Uniform Managed Care Manual regarding utilization management for MHTCM services. MCOs may choose to waive prior authorization submission requirements.

For persons in fee-for-service (FFS) Medicaid, LMHAs/LBHAs must obtain prior authorization from their internal utilization management department using the CMBHS software system. Non-LMHAs must obtain prior authorization from the TMHP Prior Authorization Department using the Special Medical Prior Authorization (SMPA) request form and the information obtained from the CMBHS software system. When completing the SMPA form for prior authorization, non-LMHAs must complete the following sections of the form as follows:

- Section A – Client information
 - Complete as indicated in the form.
- Section B – Requested procedure or service information
 - The type of request is ‘Other’
 - The expected dates of service are the start and end dates provided by CMBHS
 - The procedure related CPT code is the code for MHTCM and the appropriate modifier(s)
 - The comments text box must indicate if the prior authorization request is an ‘initial assessment’ or ‘reassessment’
- Section C – To be completed by requesting physician or requesting provider
 - The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
 - The statement of medical necessity section must indicate the recommended LOC generated by CMBHS software system. If the request is a deviation from the recommended LOC, then the provider must include the following:
 - The word ‘Deviation’ with a note that the request is for prior authorization of a LOC that is higher or lower than the recommended LOC;
 - The clinical justification for the request to include the specific reason(s) for why the person requires interventions outside the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification); and
 - If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
 - Complete provider information as indicated in the form
 - The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.

All plans of care are subject to retrospective review by the state.

Reauthorization Requirements

At a minimum, providers must ensure that a QMHP-CS administers the uniform assessment and obtains a recommended LOC from the CMBHS software system for the person receiving MHTCM services:

- Every 90 calendar days for persons 20 years of age and younger; or
- Every 180 calendar days for persons 21 years of age and older.

***Note:** Providers must follow the same process that is used for initial authorization for reauthorization of services at the specified intervals indicated above (i.e., every 90 or 180 calendar days, as applicable).*

5.2.2.4 Eligibility and Service Determinations for Persons Who are 20 Years of Age and Younger

MHTCM is a benefit for persons who are 20 years of age and younger (child or youth) with a diagnosis or diagnoses of mental illness, or SED, as defined in the latest edition of the APA's DSM (excluding a single diagnosis of IDD and related disorders, or a single diagnosis of SUD) and who:

- Have been determined via the uniform assessment process to have a serious functional impairment and to need MTHCM services; or
- Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or
- Are enrolled in a school system's special education program because of SED.

The initial assessment is the clinical process of obtaining and evaluating historical, social, behavioral, functional, psychiatric, developmental, or other information from the person seeking services to determine specific treatment and support needs.

Functioning is assessed using one of the following tools:

- The Child and Adolescent Needs and Strengths Assessment (CANS) for persons who are 17 years of age and younger
- The Adult Needs and Strengths Assessment (ANSA) and any necessary supplemental assessments for persons who are 18 to 20 years of age

Services and supports to be provided to the child or youth are determined jointly by the child or youth, family, and the provider.

Children and youth MHTCM services authorized for care by the provider through a clinical override are eligible for the duration of the authorization.

Continued eligibility for children and youth for MHTCM services is based on a reassessment every 90 calendar days and reauthorization of services by the provider of MHTCM services using the CMBHS software system. Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

5.2.2.5 Eligibility and Service Determinations for Persons who are 21 Years of Age and Older

MHTCM is a benefit for persons who are 21 years of age and older (adults) and who have serious mental illness (SMI), such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders (excluding a single diagnosis of IDD and related disorders or a single diagnosis of SUD) that require crisis resolution or ongoing and long-term support and treatment.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for services. Adults with any other mental health diagnosis require evidence of significant difficulty functioning across one or more domains, such as work or school, to be eligible for services.

The initial assessment is the clinical process of obtaining and evaluating historical, social, behavioral, functional, psychiatric, developmental, or other information from the person seeking services to determine specific treatment and support needs.

Functioning is assessed using the ANSA standardized assessment tool. Continued eligibility for adults for MHTCM services is based on a reassessment every 180 calendar days and reauthorization of services by the provider of MHTCM services using the CMBHS software system. Assignment of diagnosis in the CMBHS software system is required at any time the DSM diagnosis changes and at least annually from the last diagnosis entered into CMBHS software system.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for continued services. Adults with a diagnosis of major depressive disorder whose level of functioning qualified them initially are also automatically eligible for continued services, regardless of whether their level of functioning improved.

Adults with any other mental health diagnoses are eligible for continued services if their level of functioning continues to be significantly impaired, as evidenced by the results of the ANSA standardized assessment tool.

5.2.2.6 Documentation Requirements

A comprehensive diagnosis must be included in the person's medical record, including documentation of applicable diagnostic criteria according to the latest edition of the APA's DSM, as well as the specific justification of need for services.

MHTCM services, including attempts to provide MHTCM services, must be documented in the person's medical record.

For routine case management, the case manager must document the person's strengths, service needs, and assistance required to address the service needs as well as the steps that are necessary to accomplish the goals required to meet the person's service needs.

For intensive case management, the assigned case manager must include the intensive case management plan of care in the child's or youth's medical record and document steps taken to meet the child's or youth's goals and needs in the child's or youth's progress notes.

As a result of the assessments and reassessments conducted, the case manager must document the person's identified strengths, service needs, and assistance given to address the identified need, and specific goals and actions to be accomplished.

The case manager must document the following for all services provided:

- The event or behavior that occurs while providing the MHTCM service or the reason for the specific case management encounter
- The person, persons, or entity, including other case managers, with whom the encounter or contact occurred
- Collateral contacts such as contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the person access services and managing the person's care, including coordination with other case managers
- The recovery plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goal(s)
- The timeline for obtaining the needed services
- The specific intervention that is being provided

- The date the MHTCM service was provided
- The start and end time of the MHTCM service
- The mode of delivery used to provide the MHTCM service
- The name of the provider agency and the signature of the employee providing the MHTCM service, including their credentials
- The timeline for reevaluating the needed service

If the person refuses MHTCM services, the case manager must document the reason for the refusal in the most appropriate area of the person's medical record and request that the person sign a waiver of MHTCM services that is filed in the person's medical record.

The provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules, and regulations. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

5.2.2.7 Exclusions

The following services are not covered by MHTCM:

- Case management activities that are an integral component of another covered Medicaid service
- The provision of a medical, educational, social, behavioral, or other service to which a person has been referred, including for foster care programs, services such as, but not limited to, the following:
 - Research gathering and completion of documentation required by the foster care program
 - Assessing adoption placements
 - Recruiting or interviewing potential foster care parents
 - Serving legal papers
 - Home investigations
 - Providing transportation, including transporting the person to his/her LAR/primary caregiver
 - Administering foster care subsidies
 - Making placement arrangements
- Performing an activity that does not directly assist a person in gaining or coordinating access to needed services
- Providing medical or nursing services
- Performing preadmission or intake activities
- Monitoring the person's general health status
- Performing outreach activities
- Performing quality oversight of a service provider
- Conducting utilization review or utilization management activities
- Conducting quality assurance activities
- Authorizing services or authorizing the provision of services

- Services to inmates of public institutions

5.2.3 Mental Health Rehabilitative Services

Mental health rehabilitative services are defined as providing assistance in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goal as defined in their plan of care.

Mental health rehabilitative services are provided to a person with a serious mental illness (SMI), as defined in the latest edition of the American Psychiatric Association’s (APA’s) Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental health rehabilitative services are age-appropriate, individualized, and designed to ameliorate functional impairments that negatively affect any of the following:

- Community integration
- Community tenure
- Behaviors resulting from SMI or severe emotional disturbance (SED) that interfere with a person’s ability to remain in the community as a fully integrated and functioning member of that community

Mental health rehabilitative services may include:

- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention services
- Day programs for acute needs

Mental health rehabilitative services may only be provided by a member of the person’s therapeutic team. The therapeutic team must include enough staff to adequately address the rehabilitative needs of persons assigned to the team.

Team members must be appropriately credentialed and have completed required trainings to provide the full array of component services, have regularly scheduled team meetings either in person or by teleconference, and every member of the team must be knowledgeable of the needs and the services available to the specific persons assigned to the team.

Mental health rehabilitative services may be a benefit for persons residing in a nursing facility (NF) when medically necessary as determined by a uniform assessment protocol and determined through preadmission screening and resident review (PASRR) to require specialized services.

The following procedure codes are a benefit for mental health rehabilitation:

| Service Category | Procedure Codes | Modifiers |
|---------------------------------|-----------------|---|
| Day Program for Acute Needs | H2012 | |
| Medication Training and Support | H0034 | HQ: group services for adults HA/HQ: group services for child/youth |
| Crisis Intervention | H2011 | HA: child/youth |
| Skills Training and Development | H2014 | HQ: group services for adults HA: individual services for child/youth HA/HQ: group services for child/youth |

| Service Category | Procedure Codes | Modifiers |
|--------------------------------------|-----------------|--|
| Psychosocial Rehabilitation Services | H2017 | TD: individual services provided by RN HQ: group services HQ/TD: group services provided by RN ET: individual crisis services |

| Mental Health Rehabilitative Services Modifiers | Description |
|---|--|
| 95 | Delivered by synchronous audiovisual technology |
| ET | Emergent treatment |
| FQ | Delivered by synchronous telephone (audio-only) technology |
| HA | Child/adolescent program |
| HQ | Group setting |
| HZ | Funded by criminal justice agency |
| TD | Services provided by an RN |

Psychosocial rehabilitation is not reimbursable on the same day as MHTCM services or skills training and development.

Reimbursement for procedure codes H0034, H2012, H2014, and H2017 are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F060 | F061 | F062 | F0630 | F0631 | F0632 | F0633 | F0634 |
| F064 | F068 | F070 | F0789 | F09 | F200 | F201 | F202 |
| F203 | F205 | F2081 | F2089 | F209 | F21 | F22 | F23 |
| F24 | F250 | F251 | F258 | F259 | F28 | F29 | F3010 |
| F3011 | F3012 | F3013 | F302 | F303 | F304 | F309 | F310 |
| F3110 | F3111 | F3112 | F3113 | F312 | F3130 | F3131 | F3132 |
| F314 | F315 | F3160 | F3161 | F3162 | F3163 | F3164 | F3170 |
| F3171 | F3172 | F3173 | F3174 | F3175 | F3176 | F3177 | F3178 |
| F3181 | F3189 | F319 | F320 | F321 | F322 | F323 | F324 |
| F325 | F3281 | F3289 | F329 | F32A | F330 | F331 | F332 |
| F333 | F3340 | F3341 | F3342 | F338 | F339 | F340 | F341 |
| F3481 | F3489 | F349 | F39 | F4000 | F4001 | F4002 | F4010 |
| F4011 | F40210 | F40218 | F40220 | F40228 | F40230 | F40231 | F40232 |
| F40233 | F40240 | F40241 | F40242 | F40243 | F40248 | F40290 | F40291 |
| F40298 | F408 | F409 | F410 | F411 | F413 | F418 | F419 |
| F422 | F423 | F424 | F428 | F429 | F430 | F4310 | F4311 |
| F4312 | F4320 | F4321 | F4322 | F4323 | F4324 | F4325 | F4329 |
| F4381 | F4389 | F439 | F440 | F441 | F442 | F444 | F445 |
| F446 | F447 | F4481 | F4489 | F449 | F450 | F451 | F4520 |
| F4521 | F4522 | F4529 | F4541 | F4542 | F458 | F459 | F481 |
| F482 | F488 | F489 | F5000 | F5001 | F5002 | F502 | F5081 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| F5082 | F5089 | F509 | F5101 | F5102 | F5103 | F5104 | F5105 |
| F5109 | F5111 | F5112 | F5113 | F5119 | F513 | F514 | F515 |
| F518 | F519 | F530 | F531 | F54 | F600 | F601 | F602 |
| F603 | F604 | F605 | F606 | F607 | F6081 | F6089 | F609 |
| F630 | F631 | F632 | F633 | F6381 | F6389 | F639 | F640 |
| F641 | F642 | F648 | F649 | F6810 | F6811 | F6812 | F6813 |
| F68A | F69 | F8082 | F900 | F901 | F902 | F908 | F909 |
| F910 | F911 | F912 | F913 | F918 | F919 | F930 | F938 |
| F939 | F940 | F941 | F942 | F948 | F949 | F980 | F981 |
| F9821 | F9829 | F983 | F984 | F985 | F988 | F989 | F99 |
| O906 | T7402XA | T7402XD | T7402XS | T7412XA | T7412XD | T7412XS | T7422XA |
| T7422XD | T7422XS | T7452XA | T7452XD | T7452XS | T7462XA | T7462XD | T7462XS |
| T7602XA | T7602XD | T7602XS | T7612XA | T7612XD | T7612XS | T7622XA | T7622XD |
| T7622XS | T7652XD | T7652XS | T7662XA | T7662XD | T7662XS | | |

No diagnosis is required for crisis intervention services (procedure code H2011); however, all CMS 1500 claim forms require a diagnosis.

A Medicaid provider may only bill for medically necessary mental health rehabilitative services that are provided face-to-face to:

- A Medicaid-eligible person;
- The LAR of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person); or
- The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person).

Rehabilitative services delivered via group modality are limited to an 8-person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

Note: *MHR claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA/LBHA claims are processed to pay cost-sharing. These claims will be carved-out of managed care and will not be sent to the person’s MCO. MHR claims submitted by non-LMHAs for persons with Medicaid-only (all persons who are not dual-eligible) will be carved-in for managed care, meaning that FFS will pay the claims until the person chooses an MCO, and then the claims will be forwarded to the person’s MCO for processing and reimbursement.*

5.2.3.1 Telemedicine and Telehealth

Providers of MHR services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person’s choice and not provider convenience.

Providers must provide MHR services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, MHR services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

5.2.3.1.1 Synchronous Audiovisual Technology

The following MHR services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, except for crisis intervention services, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the person receiving services. MHR services provided by synchronous audiovisual technology must be billed using modifier 95.

- Medication training and support (procedure code H0034).
- Skills training and development (procedure code H2014).
- Psychosocial rehabilitation services (procedure code H2017).
- Crisis intervention services (procedure code H2011).
- Documented approval of the mode of delivery in the plan of care is not required prior to the delivery of crisis intervention services by synchronous audiovisual technology.

5.2.3.1.2 Synchronous Telephone (Audio-Only) Technology

The following MHR services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR. In addition, except for crisis intervention services, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of MHR services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. MHR services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Medication training and support (procedure code H0034)
- Skills training and development (procedure code H2014)
- Psychosocial rehabilitation services (procedure code H2017)
- Crisis intervention services (procedure code H2011)
- Synchronous telephone (audio-only) technology may only be used for crisis intervention services as a back-up mode of delivery only, meaning if the person who is in crisis, not the billing provider, is unwilling or has limited technological capabilities that prevent them from using a synchronous audiovisual platform at the time the crisis intervention services are delivered. Also, the existing clinical relationship requirement is waived.
- Documented approval of the use of synchronous telephone (audio-only) technology in the plan of care is not required prior to the delivery of crisis intervention services. However, providers must document the justification for using synchronous telephone (audio-only) technology to deliver crisis intervention services in the medical record.

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual MHR, MHTCM, or peer specialist service from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous MHR, MHTCM, or peer specialist audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: “Same billing provider” refers to providers that are within the same entity, as identified by the entity’s NPI number or numbers, if the entity has multiple locations (i.e., the same LMHA/LBHA or same non-LMHA/private provider).

Note: The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

The billing provider is required to conduct at least one in-person or synchronous audiovisual MHR, MHTCM, or peer specialist service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person’s medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person’s condition(s).

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

Note: The required in-person or synchronous audiovisual-delivered MHTCM, MHR, or peer specialist service may be delivered by another authorized professional or paraprofessional of the same LMHA/LBHA or the same non-LMHA as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

5.2.3.2 Eligibility and Service Determinations for Persons Who are 20 Years of Age and Younger

Certain mental health rehabilitative services (crisis intervention services, medication training and support, and skills training and development) are available to persons who are 20 years of age and younger with a diagnosis of mental illness or SED, as defined in the latest edition of APA’s DSM and who:

- Have been determined via the uniform assessment process to have a serious functional impairment;
- Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or
- Are enrolled in a school system’s special education program because of a SED.

Functioning is assessed using the Child and Adolescent Needs and Strengths Assessment (CANS) standardized assessment tool for persons who are 17 years of age and younger and the Adult Needs and Strengths Assessment (ANSA) for persons who are 18 to 20 years of age, as well as any supplemental assessments, as needed.

Continued eligibility for mental health rehabilitative services for persons who are 17 years of age and younger is based on a reassessment at least every 90 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider using the CMBHS software system. Persons who are 18 years of age and older are reassessed every 180 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider using the CMBHS software system.

Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

The LPHA determination of diagnosis must include an interview with the child or youth conducted either in person or by telemedicine or telehealth.

To complete a comprehensive diagnosis for a child or youth, documentation of the required diagnostic criteria according to the latest version of the APA's DSM, as well as the specific level of functioning, must be included in the child's or youth's record. This information must be included as part of the required assessment information.

5.2.3.3 Eligibility and Service Determinations for Persons Who Are 21 Years of Age and Older

Persons who are 21 years of age and older with SMI, determined to be medically necessary by a uniform assessment protocol, are eligible for mental health rehabilitative services if the adult is:

- A resident of the state of Texas;
- Determined by a uniform assessment and clinician observation to require mental health rehabilitative services; and
- An LPHA has determined that such services are medically necessary.

Mental health rehabilitative services are available to persons who are 21 years of age and older who have an SMI and significant functional impairments which require crisis resolution or ongoing treatment. Functioning is assessed using the ANSA standardized assessment tool.

Continued eligibility for adults for mental health rehabilitation services is based on a reassessment at least every 180 calendar days, or more frequently if clinically indicated by the provider, and reauthorization of services by the provider of mental health rehabilitation services using the CMBHS software system.

Assignment of diagnosis in the CMBHS software system is required at any time the APA DSM diagnosis changes and at least annually from the last diagnosis entered in the CMBHS software system.

The LPHA determination of diagnosis must include an interview with the adult conducted either in person or by telemedicine or telehealth.

To complete a comprehensive diagnosis for an adult, documentation of the required diagnostic criteria according to the latest version of the APA's DSM, as well as the specific level of functioning, must be included in the adult's record. This information must be included as part of the required assessment information.

Adults with a diagnosis of schizophrenia or bipolar disorder are automatically eligible for continued services. Adults with a diagnosis of major depressive disorder whose level of functioning qualified them initially are also automatically eligible for continued services, regardless of whether their level of functioning improved. Adults with any other mental health diagnosis are eligible should their level of functioning continue to be significantly impaired, as evidenced by the results of a standardized assessment tool called the ANSA.

5.2.3.4 Treatment Planning

Mental health rehabilitative services are part of a person's plan of care and are intended to:

- Reduce a person's functional impairments resulting from SMI for adults.
- Reduce SED in children or youth.
- Restore a person to their optimal functioning level in the community.

The treatment planning process for mental health rehabilitative services requires the active participation of the Medicaid eligible person or LAR when necessary due to the person's age or legal status. Plans of care are based on a comprehensive assessment and must address the person's strengths, areas of need, the person's preferences, and descriptions of the person's treatment goals.

5.2.3.5 Medication Training and Support

Medication training and support services consist of education and guidance about medications and their possible side effects. It is curriculum-based training and guidance that serves as an initial orientation for the person in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community.

Medication training and support includes:

- Assisting the person to manage symptomology and maximize functioning;
- Understanding the concepts of recovery and resilience within the context of the SMI or SED;
- Developing an understanding of the relationship between mental illness and the medications prescribed to treat the illness;
- The interaction of medication with other medications, diet, and mood altering substances;
- Understanding the overdose precautions of the person's medication;
- The identification and management of potential side effects;
- Learning self-administration of the person's medication and;
- Necessity of taking medications prescribed and following the physician's or other qualified health care professional's orders.

Medication training and support is available to eligible children, youth, and adults. The LAR or primary caregiver may receive medication training and support services on behalf of an eligible adult, child or youth.

5.2.3.6 Psychosocial Rehabilitative Services

Psychosocial rehabilitative services are social, behavioral, and cognitive interventions provided by members of a person's therapeutic team that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement, and other independent living skills that are affected by or the result of an SMI in persons who are 18 years of age and older.

Psychosocial rehabilitative services include independent living services, coordination services, and employment, housing, and medication-related services. Psychosocial rehabilitative services may also address the impact of co-occurring disorders upon the person's ability to reduce symptomology and increase daily functioning.

If psychosocial rehabilitative services are in the treatment plan, the treatment plan cannot simultaneously include skills training and development or targeted case management services.

Psychosocial rehabilitative services may not be provided to a person who is currently admitted to a crisis stabilization unit.

5.2.3.6.1 Independent Living Services

Independent living services assist a person in acquiring the most immediate, fundamental functional skills needed to enable the person to reside in the community and avoid more restrictive levels of treatment or reducing behaviors or symptoms that prevent successful functioning in the person's environment of choice.

Independent living services include skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.

Training for independent living includes skills related to:

- Personal hygiene.
- Transportation utilization.
- Money management.
- The development of natural supports.
- Access to needed services in the community (e.g., medical care, substance use services, legal services, living accommodations).
- Social skills (e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time).

5.2.3.6.2 Coordination Services

Coordination services are training activities that assist a person in improving his or her ability to gain and coordinate access to necessary care and services appropriate to the needs of the person.

Training for coordination skills includes instruction and guidance in such areas as:

- Identifying areas of need across all life domains.
- Prioritizing needs and setting goals.
- Identifying potential service providers and support systems.
- Initiating contact with providers and support systems.
- Participating in the development and subsequent revisions of their plan of care.
- Coordinating their services and supports.
- Advocating for necessary changes and improvements to ensure that they obtain maximum benefit from their services and supports.

5.2.3.6.3 Employment-Related Services

Employment-related services provide supports and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of SMI that interfere with a person's ability to make vocational choices or obtain or retain employment.

Included in employment-related services are activities such as:

- Skills training related to task focus, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming and communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation.
- Establishing supportive contacts related to the school or work-site situation to reduce or manage behaviors or symptoms related to the person's mental illness or emotional disturbance that interfere with job performance or progress towards the development of skills that would enable the person to obtain or retain employment.

5.2.3.6.4 Housing-Related Services

Housing-related services develop a person's strengths and abilities to manage the symptoms of the person's SMI that interfere with the person's capacity to obtain or maintain tenure in independent integrated housing.

Included in housing-related services are activities such as:

- Skills training related to home maintenance and cleanliness.
- Problem solving with landlord and other residents.
- Maintaining appropriate interpersonal boundaries.
- Establishing supportive contacts related to the housing situation to reduce or manage behaviors or symptoms related to the person's mental illness or emotional disturbance that interfere with maintaining independent integrated housing.

5.2.3.6.5 Medication-Related Services

Medication-related services provide individualized training regarding the person's medication adherence and is different from medication-training and support.

Services consist of training and supportive interventions that focus on person-specific needs and goals regarding the administration of medication, monitoring efficacy and side effects of medication, and other nursing services that enable the person to attain or maintain an optimal level of functioning.

Medication-related services do not include services or activities that are incidental to services performed by a physician (or other qualified health care professional) during an evaluation and management services visit.

5.2.3.7 Skills Training and Development

Skills training and development is training provided to an eligible person, the LAR, or primary caregiver on behalf of an eligible adult, child, or youth.

The training addresses:

- SMI or SED and symptom-related problems that interfere with the person's functioning and living, working, and learning environment.
- Provides opportunities for the person to acquire and improve skills needed to function as appropriately and independently as possible in the community.
- The person's community integration and increases his or her community tenure.

Skills training and supportive interventions focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.

Skills training and development may include:

- Skills related to personal hygiene.
- Pro-social skills.
- Assertiveness skills.
- Anger management skills.
- Stress reduction techniques.
- Communication skills.
- Transportation utilization.
- Money management.

- The development of natural supports.
- Access to needed services in the community, e.g., medical care, substance use services, legal services, living accommodations.
- Social skills (e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time).

Skills training and development services consist of increasing the LAR's or primary caregiver's understanding of and ability to respond to the person's needs identified in the uniform assessment or documented in the treatment plan.

Persons receiving skills training and development are not eligible to simultaneously receive psychosocial rehabilitative services and both services should not be simultaneously listed in the person's treatment plan.

5.2.3.8 Crisis Intervention

Crisis intervention services are intensive community-based one-to-one services provided to persons who require services to control acute symptoms that place the person at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

This service includes assessment, behavioral skills training, problem-solving, and reality orientation to help a person identify and manage their symptoms of mental illness, and cope with stressors.

Crisis intervention services may be provided in extended observation or crisis residential units. Crisis intervention services may not be provided to a person who is currently admitted to a crisis stabilization unit.

Crisis intervention services consist of the following interventions:

- An assessment of dangerousness of the person to self or others
- The provision of emergency care services that include crisis screening and response, telephone access, emergency case services, urgent care services, routine care services, and access to emergency medical/crisis services
- Behavior skills training to assist the person in reducing distress and managing symptoms
- Problem-solving
- Reality orientation to help the person identify and manage his or her symptoms of SMI or SED
- Providing instruction, structure, and emotional support to the person in adapting to and coping with immediate stressors

Crisis intervention services are available to eligible children youth and adults.

5.2.3.9 Day Programs for Acute Needs

Day programs for acute needs provide short term, intensive treatment to an eligible persons who is 18 years of age or older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Day program services are a site-based treatment provided in a group modality.

Day programs for acute needs are provided in a highly structured and safe environment with constant supervision and ensure an opportunity for frequent interaction between the adult and staff members.

Day programs for acute needs must at all times have sufficient staff to ensure safety and program adequacy according to an established staffing ratio and staff response times. This service focuses on intensive, medically-oriented, multidisciplinary interventions such as behavior skills training, crisis management, and nursing services that are designed to stabilize acute psychiatric symptoms.

These services may be provided in a residential facility; however, none of the residential facilities can contain greater than 16 beds.

Day programs for acute needs include:

- Psychiatric nursing services.
- Pharmacological instruction that addresses medication issues related to the crisis precipitating the need for provision of day programs for acute needs.
- Symptom management training.
- Functional skills training.

Day programs for acute needs must, at all times, have a sufficient number of staff members to ensure safety and program adequacy, and, at a minimum, include:

- One RN for every 16 persons at the day program's location,
- One physician to be available by phone, with a response time not to exceed 15 minutes,
- Two staff members who are QMHP-CSs, CSSPs, or peer providers at the day program's location,
- One additional QMHP-CS who is not assigned full-time to another day program to be physically available, with a response time not to exceed 30 minutes,
- Additional QMHP-CSs, CSSPs, or peer providers at the day program's location sufficient to maintain a ratio of one staff member to every four persons receiving care.

5.2.3.10 Prior Authorization Requirements

5.2.3.10.1 Initial Authorization

Except for crisis intervention services, providers of mental health rehabilitation services must not bill Texas Medicaid prior to the authorization or reauthorization of services.

Eligibility and continued eligibility determinations occur at the facility (provider) that is providing mental health rehabilitative services using the CMBHS software system.

Criteria used to make these service determinations are from the recommended LOC of the person generated by the CMBHS software system as derived from the uniform assessment, the needs of the person, and the Texas Resilience and Recovery (TRR) Utilization Management Guidelines.

Providers of mental health rehabilitative services must ensure the following:

- A QMHP-CS or LPHA performs a screening for eligibility using the uniform assessment;
- An LPHA determines the diagnosis which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
- The clinical needs of the person are evaluated to determine if the amount of mental health rehabilitation services associated with the recommended LOC, described in the TRR Utilization Management Guidelines, is sufficient to meet those needs; and
- An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.

If the provider determines that an LOC other than the recommended LOC is more appropriate for the person, then the provider must submit a prior authorization 'deviation' request that includes:

- The word 'Deviation' with a note that the request is for prior authorization of an LOC that is higher or lower than initially recommended and;
- The clinical justification for the request.

The clinical justification must include the specific reason(s) why the person requires interventions higher or lower than the recommended LOC. Refusal of recommended LOC by the person receiving services may be noted as part of the justification.

For persons enrolled in managed care, LMHAs/LBHAs and non-LMHAs (also referred to as private providers) contracted with MCOs must submit prior authorization requests to the MCO with whom the person is enrolled. MCOs must follow the requirements set forth in the Uniform Managed Care Manual regarding utilization management for mental health rehabilitation services. MCOs may choose to waive prior authorization submission requirements.

For persons in fee-for-service (FFS) Medicaid, LMHAs/LBHAs must obtain prior authorization from their internal utilization management department using the CMBHS software system. Non-LMHAs must obtain prior authorization from the TMHP Prior Authorization Department using the Special Medical Prior Authorization (SMPA) request form and the information obtained from the CMBHS software system. When completing the SMPA form for prior authorization, non-LMHAs must complete the following sections of the form as follows:

- Section A – Client information
 - Complete as indicated in the form
- Section B - Requested procedure or service information
 - The type of request is ‘Other’
 - The expected dates of service are the start and end dates provided by CMBHS
 - The procedure related CPT code is the code for the type of mental health rehabilitation service (e.g., medication training and support, psychosocial rehabilitation, and skills training and development) and the appropriate modifier(s)
 - The comments text box must indicate if the prior authorization request is an initial assessment or reassessment
- Section C – To be completed by requesting physician or requesting provider
 - The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
 - The statement of medical necessity section must indicate the recommended LOC generated by CMBHS software system. If the request is a deviation from the recommended LOC, then the provider must include the following:
 - The word ‘Deviation’ with a note that the request is for prior authorization of a LOC that is higher or lower than recommended LOC;
 - The clinical justification for the request to include the specific reason(s) for why the person requires interventions outside the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification); and
 - If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
 - Complete provider information as indicated in the form
 - The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.

Changes to the treatment plan regarding type, amount, or duration of services must be approved by an LPHA practicing within the scope of their licensure.

All plans of care are subject to retrospective review by the state.

5.2.3.10.2 Reauthorization Requirements

To determine the type, amount, and duration of mental health rehabilitation services, providers must ensure that, at a minimum, a QMHP-CS administers the uniform assessment and obtains a recommended LOC from the CMBHS software system for the person receiving mental health rehabilitation services:

- Every 90 calendar days for persons 20 years of age and younger; or
- Every 180 calendar days for persons 21 years of age and older.

Note: *Providers must follow the same process that is used for initial authorization for reauthorization of services at the specified intervals indicated above (i.e., every 90 or 180 calendar days, as applicable).*

Prior to the expiration of the authorization period or depletion of the amount of services authorized, providers must make a determination of whether the person continues to need mental health rehabilitative services. An LPHA must also determine whether the continuing need for mental health rehabilitative services meets the definition of medical necessity.

If the determination is that the person continues to need mental health rehabilitative services and that such services are medically necessary, the provider must:

- Request another authorization for the same type and amount of mental health rehabilitative service previously authorized; or
- Submit a request, with documented clinical reasons for such request, to change the type or amount of mental health rehabilitative services previously authorized if:
 - The provider determines the type or amount of mental health rehabilitative services previously authorized is inappropriate to address the person's needs.
 - The criteria described in the TRR Utilization Management Guidelines for changing the type or amount of mental health rehabilitative services has been met.

5.2.3.11 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered. An LPHA must document in the person's medical record that mental health rehabilitative services are medically necessary when the services are authorized and reauthorized.

Persons determined to need mental health rehabilitative services must have a treatment plan developed by the Medicaid enrolled provider of mental health rehabilitative services that describes in writing the type, amount, and duration of mental health rehabilitative services determined to be medically necessary to meet the needs of the person.

A rehabilitative services provider must document the following for all mental health rehabilitative services:

- The name of the person to whom the service was provided
- The type of service provided
- The specific goal or objective addressed, and the modality and method used to provide the service
- The date the service was provided
- The start and end time of the service
- The location where the service was provided
- The signature of the staff member providing the service and a notation of their credentials
- Any pertinent event or behavior relating to the person's treatment which occurs during the provision of the service

- The outcome or progress in achieving treatment plan goals

In addition to the general requirements described above, when providing crisis services, a provider must document the following information:

- Risk of suicide or homicide
- Substance use
- Trauma, abuse, or neglect
- The outcome of the crisis (e.g., person in hospital, person with friend and scheduled to see doctor at 9:00 a.m. the following day)
- All actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented
- The response of the person, and if appropriate, the response of the LAR and family members
- Any pertinent event or behavior relating to the person's treatment that occurs during the provision of the service
- Follow up activities that may include referral to another provider

Documentation for day programs for acute needs must be made daily. Documentation must be made after each face-to-face contact occurs to provide the mental health rehabilitative service for all other services.

An LPHA must, within two business days after crisis intervention services are provided, determine whether the crisis intervention services met the definition of medical necessity. If medical necessity is met then the LPHA must document the medical necessity.

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

A provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

5.2.3.12 Exclusions

Persons receiving psychosocial rehabilitation services are not eligible to simultaneously receive skills training and development or MHTCM services.

Mental health rehabilitative services do not include any of the following services that must be billed to Texas Medicaid:

- Rehabilitative services provided:
 - Before the establishment of a diagnosis of mental illness and authorization of services
 - To persons who reside in an institution for mental diseases
 - To general acute care hospital inpatients
- Services to residents of institutions that furnish food, shelter, and treatment to four or more unrelated persons

- Services to nursing facility residents who have not been identified through the PASSR process as needing specialized mental health services
- Services to inmates of public institutions
- Job task-specific vocational services
- Educational services
- Room and board residential costs
- Services that are an integral and inseparable part of another Medicaid-reimbursable service, including MHTCM services, residential rehabilitative behavioral health services, institutional and waiver services
- Services that are covered elsewhere in the state Medicaid plan
- Services to persons with a single diagnosis of intellectual or developmental disability or substance use disorder who do not have a co-occurring diagnosis of mental illness in adults or SED in children
- Inpatient hospital services
- Respite services
- Family support services

5.2.3.13 Non-reimbursable Activities

A Medicaid provider will not be reimbursed for a mental health rehabilitative service:

- That is not included in the person's treatment plan (except for crisis intervention services and psychosocial rehabilitative services provided in a crisis situation).
- That is not authorized, except for crisis intervention services.
- Provided in excess of the amount authorized.
- Provided outside of the duration authorized.
- Provided to a person receiving MHTCM services.
- That is not documented.
- Provided to a person who does not meet the eligibility criteria.
- Provided to a person who does not have a current uniform assessment (except for crisis intervention services).
- Provided to a person who is not present, awake, and participating during such service.

A Medicaid provider will not be reimbursed for a crisis service provided to a person who does not have an SMI.

The cost of the following activities is included in the Medicaid mental health rehabilitative services reimbursement rate(s) and may not be directly billed by the Medicaid provider:

- Developing and revising the treatment plan and interventions that are appropriate to a person's needs.
- Staffing and team meetings to discuss the provision of mental health rehabilitative services to a specific person.
- Monitoring and evaluating outcomes of interventions, including contacts with a person other than the person receiving services.
- Documenting the provision of mental health rehabilitative services.
- A staff member's travel time to and from a location to provide mental health rehabilitative services.

- All services provided within a day program for acute needs that are delivered by a staff member, including services delivered in response to a crisis or an episode of acute psychiatric symptoms.
- Administering the uniform assessment to persons who are receiving mental health rehabilitative services.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including MH and IDD services.

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

5.4 Claims Filing and Reimbursement

IDD service coordination, MHTCM, and mental health 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 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 paper 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.

Services 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.

5.4.1 Managed Care Clients

Claims for persons in managed care must be submitted to the client's MCO. Mental health targeted case management and mental health rehabilitative services that are funded by a criminal justice agency (submitted with modifier HZ) are carved out and must be submitted to TMHP.

5.4.2 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper 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, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement and the federal matching percentage.

6 Peer Specialist Services

6.1 Services, Benefits, Limitations, and Prior Authorization

Peer specialist services (procedure code H0038) for a mental health or substance use condition, or both, are a benefit of Texas Medicaid for persons who are 21 years of age and older, and who have peer specialist services included as a component of their person-centered recovery plan.

Peer specialist services are recovery-oriented, person-centered, relationship-focused, voluntary, and trauma-informed.

Peer specialist services include the following:

- Recovery and wellness support services, which include providing information and support for recovery planning.
- Mentoring, which includes serving as a role model and helping to find needed community resources and services.
- Advocacy, which includes providing support during stressful or urgent situations and helping to ensure that the person's rights are respected. Advocacy may also include encouraging the person to advocate for him or herself to obtain services.

Peer specialist services are based on a mutual relationship between the peer specialist and the Medicaid eligible person. A peer specialist uses his or her lived experience to support the person with the following:

- Achieving the goals and objectives of the person's individualized recovery plan
- Skill development
- Problem solving strategies
- Coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder

Peer specialist services can be delivered individually or in a group setting.

6.1.1 Telehealth Service

Providers of peer specialist services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide peer specialist services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, peer specialist services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

6.1.1.1 Synchronous Audiovisual Technology

Peer specialist services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the person-centered recovery plan of the person receiving services. Peer specialist services provided by synchronous audiovisual technology must be billed using modifier 95.

6.1.1.2 Synchronous Telephone (Audio-Only) Technology

Peer specialist services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the person-centered recovery plan of the person receiving services.

Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of peer specialist services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. Peer specialist services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service from the same billing provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service from the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: “Same billing provider” refers to providers that are within the same entity or organization, as identified by the entity's or organization's NPI number or numbers, if the entity or organization has multiple locations (i.e., the same LMHA/LBHA, comprehensive provider agency of mental health targeted case management or rehabilitative services, clinic/group practice, FQHC, rural health clinic, or chemical dependency treatment facility, or opioid treatment provider) presuming all other applicable state and federal laws and regulations are followed.

Note: The required in-person or synchronous audiovisual delivered peer specialist, MHTCM, or MHR service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.

The billing provider is required to conduct at least one in-person or synchronous audiovisual peer specialist, MHTCM, or MHR service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.

- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person's condition.

Note: *The required in-person or synchronous audiovisual delivered peer specialist, MHTCM, or MHR service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

6.2 Peer Specialist Requirements

Peer specialist services may be delivered as part of a coordinated, comprehensive, and individualized approach to treating a person's mental health or substance use condition, or both, if the peer specialist is employed by one of the following Medicaid-enrolled provider types:

- Clinic/group practices that treat behavioral health conditions
- Physicians (M.D.s), osteopaths (D.O.s), and nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) that treat behavioral health conditions
- Psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of targeted case management and mental health rehabilitative services
- Local mental and behavioral health authorities
- Chemical dependency treatment facilities
- Federally qualified health clinics (FQHCs)
- Rural health clinics (RHCs)
- Opioid Treatment Providers (OTPs)

Only clinic/group practices or behavioral health care individual providers (M.D., D.O., NP, CNS, and PA) with a behavioral health focus may be reimbursed for peer specialist services.

Peer specialists coordinate with all behavioral health service providers involved in the person's care and utilize a person-centered, recovery-oriented approach to treatment planning and service delivery.

Non-Medicaid enrolled providers that employ peer specialists can contract with one of the listed Medicaid-enrolled provider types to furnish peer specialist services as part of a continuum of comprehensive treatment services. Subcontracted peer specialist services must also be part of the coordinated, comprehensive, and individualized person-centered recovery plan.

A peer specialist must meet all of the following criteria:

- Be at least 18 years of age.
- Have lived experience with a mental health or substance use condition, or both.
- Have a high school diploma or General Equivalency Diploma (GED).
- Be willing to appropriately share his or her own recovery story with the person receiving services.
- Demonstrate current self-directed recovery.
- Pass criminal history and registry checks as described in 1 TAC §354.3201.

A peer specialist must not:

- Practice psychotherapy.
- Make clinical or diagnostic assessments.
- Dispense expert opinions.
- Engage in any service that requires a license.
- Falsify any documentation related to application, training, testing, certification, or services provided.

6.2.1 Certification

A peer specialist must complete all required training and certification before providing services. To be certified as a peer specialist as specified in 1 TAC §354.3155, a candidate must complete the following training:

- Required orientation
- Self-assessment activities
- Core training delivered by a certified training entity
- Supplemental training in one of two specialty areas:
 - Mental health peer specialist
 - Recovery support peer specialist

The candidate can apply for initial certification after successful completion of core and one supplemental training and a knowledge assessment.

A peer specialist who is initially certified may begin to deliver Medicaid billable services, if participating in a supervised internship at their place of employment. The internship consists of 250 hours of supervised work experience to be completed within a 6-month period. An extension may be granted by the certification entity should a peer be unable to complete the required hours within the 6-month time frame.

Independent study, such as reading or watching instructional videos, does not count toward the required supervised work experience hours. Time spent receiving supervision, other than the observation of the peer specialist providing services, does not count toward the required hours.

After completing the required internship hours, certified peer specialists can apply for renewed certification through the approved certification entity. Peer specialists must renew their certification every two years, which requires continuing education hours.

Certified peer specialists should only deliver services in their specialty area.

6.2.2 Supervision

As defined in 1 TAC §354.3003, providers may be reimbursed for peer specialist services rendered under the supervision of one of the following:

- Qualified credentialed counselor (QCC)
- Licensed practitioner of the healing arts (LPHA)
- Qualified mental health professional (QMHP), with a QCC or LPHA supervising the QMHP
- Qualified peer supervisor (QPS), with a QCC or LPHA supervising the QPS

Supervision must focus on a peer specialist's provision of services, including:

- Review of cases and activities

- Skill building
- Problem resolution
- Professional growth

Supervision may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

Peer specialist supervision may be provided as follows:

- Individually
- In a group setting
- Face-to-face
- By teleconference
- Through observation of the peer specialist providing services

Supervision must occur at least once weekly for a peer specialist with an initial certification, at least once monthly for a peer specialist with a two-year certification, or more frequently at the request of the peer specialist.

A QCC or LPHA who supervises a QMHP or QPS must provide individual or group supervision at least once monthly and conduct an observation of the QMHP or QPS supervising the peer specialist at a self-determined frequency based on the QMHP's or QPS's skill level.

A supervisor must successfully complete supervisory training for peer specialist services and the recovery model from a certified training entity before supervising a peer specialist. Supervisor training must include instruction about:

- The distinction between peer support and therapy.
- The role of peer support in building and sustaining recovery goals.
- Advocacy for peer specialists and peer specialist services.
- Job performance review, including strengths-based, timely, and respectful feedback.
- Supervisory skills, such as how to work with a variety of personality types and communication styles.

After completing training, each candidate must successfully complete a knowledge assessment before receiving approval to supervise a peer specialist from a certified training entity. Peer specialist supervisor certification must be renewed every two years, which requires continuing education hours.

6.3 Prior Authorization Requirements

Prior authorization is not required for the first 104 units of peer specialist services in a rolling 6-month period. Prior authorization is required once a person exceeds 104 units of individual or group peer specialist services in a rolling 6-month period.

Prior authorization requests for procedure code H0038 must be submitted to TMHP using the Special Medical Prior Authorization (SMPA) Request Form. Providers must retain a copy of the signed and dated prior authorization form in the person's medical record. Requests for continued services must demonstrate all of the following:

- The person continues to meet eligibility criteria as outlined in the statement of benefits above, including current DSM diagnoses
- The current person-centered recovery plan and goals
- The progress made relative to the goals outlined in the person-centered recovery plan

- The need for continued services

Requests must indicate how many additional units of service are being requested (up to 30 units are allowed per request) and the type (individual or group), as well as the expected time frame when services will be delivered.

Note: *The requesting provider may be asked for additional information to clarify or complete a request.*

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the requested service.

Referto: Refer to: “Section 5: Fee-for-Service Prior Authorizations” (*Vol. 1, General Information*) for more information on submitting prior authorization methods.

6.4 Documentation Requirements

The Medicaid-enrolled provider must ensure proper documentation of all peer specialist services that are rendered. Documentation of peer specialist services must:

- Indicate the date, time, and place of service.
- Summarize the purpose and content of the services.
- Include the specific strategies and activities utilized as related to the goals of the person’s plan of care.

Peer specialist supervisors must document all supervisory sessions and maintain the records in the peer specialist’s employee personnel file. Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered.

Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: *The Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

6.4.1 Reimbursement

Reimbursement for procedure code H0038 is limited to substance use disorders and mental health conditions, including, but not limited to:

- Schizophrenia spectrum and other psychotic disorders.
- Bipolar and related disorders.
- Depressive disorders.
- Anxiety disorders.
- Obsessive-compulsive and related disorders.
- Trauma and stressor related disorders.
- Feeding and eating disorders.

Procedure code H0038 is limited to 104 units in a rolling six-month period. This limitation may be exceeded with documentation of medical necessity for the additional services.

Peer specialist services will also be limited as follows:

- Must not be delivered simultaneously with other behavioral health services that are delivered to the person or group of persons receiving services
- Must be delivered in person and not through advanced telecommunications technology

- Limited to 12 total persons per group session

6.4.2 Claim Filing

Procedure code H0038 must be submitted with one of the following specialty modifiers:

- Modifier HE-mental health
- Modifier HF-substance use

If services are provided in a group setting, procedure code H0038 must also be submitted with modifier HQ.

Mental health rehabilitative services must be billed separately from peer specialist services.

FQHCs and RHCs should submit claims using procedure code H0038 for informational purposes only.

| Modifier | Description |
|----------|--|
| 95 | Delivered by synchronous audiovisual technology |
| FQ | Delivered by synchronous telephone (audio-only) technology |
| HE | Mental health program |
| HF | Substance abuse program |
| HQ | Group setting |

6.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Record keeping or documentation activities
- Services that are not provided directly to the person receiving services

7 Inpatient Psychiatric Services

Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service Medicaid or managed care.

Admissions to psychiatric facilities, i.e. Institutions for Mental Disease (IMD), for inpatient psychiatric services are a benefit of Texas Medicaid for:

- Persons 20 years of age and younger and 65 years of age and older in fee-for-service Medicaid.
- Persons 21 through 64 years of age enrolled in managed care as an in lieu of service if the MCO and the person receiving services agree to an IMD as the setting for inpatient psychiatric services. The benefit is for a maximum of 15 calendar days per month, not per stay.

Note: *In lieu of services are services substituted for Medicaid State Plan services or settings, as allowed by 42 CFR §438.3(e).*

Referto: Section 3.4, “Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services” of the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information.

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 persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT is used for intervention directed to a person and not for group intervention.

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

Referto: Section 9, “Substance Use Disorder (SUD) Services” in this handbook for additional information on SUD treatment.

8.1 SBIRT Training

Providers that perform SBIRT services must be trained in the correct practice of this method and will be required to complete at least four hours of training. Proof of completion of SBIRT training must be maintained in an accessible manner at the provider’s place of service.

Information regarding available trainings and standardized screening tools can be found through the [Substance Abuse and Mental Health Services Administration](#).

8.2 Screening

Screening persons for problems related to alcohol or substance use identifies the person’s level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening 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

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk.

8.3 Brief Intervention

Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivational interviewing techniques (such as the Brief Negotiated Interview) that is focused on raising the person's awareness of his or her alcohol or substance use and its consequences. The session is also focused on motivating the person toward behavioral change.

Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

Note: Providers may choose to schedule multiple screening and brief intervention sessions in a rolling year in order to provide ongoing support to a person at risk for substance use who is receptive to behavior change.

8.4 Referral to Treatment

If the provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment provider.

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

Note: If the person is currently under the care of a behavioral health provider, the person must be referred to that provider.

8.5 Telemedicine and Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Providers must provide SBIRT services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, SBIRT services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

8.5.1 Synchronous Audiovisual Technology

SBIRT services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. SBIRT services provided by synchronous audiovisual technology must be billed using modifier 95.

8.5.2 Synchronous Telephone (Audio-only Technology)

SBIRT services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of

synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers must document in the person’s medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. SBIRT services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

| Modifier | Description |
|----------|--|
| 95 | Delivered by synchronous audiovisual technology |
| FQ | Delivered by synchronous telephone (audio-only) technology |

8.6 Reimbursement and Limitations

SBIRT services are limited to persons who are 10 years of age and older.

SBIRT services are limited to up to two screening sessions per rolling year. A screening that results in a negative result does not require a brief intervention. In these instances procedure code H0049 should be used. A provider may re-screen a person within the same rolling year to determine whether their substance use behavior has changed.

Procedure code 99408 or G2011 should be used when a brief intervention follows an SBIRT screening. Procedure code 99408 is limited to once per day. SBIRT services are limited to four sessions per rolling year when it constitutes a screening followed by a brief intervention.

If a person requires more than four combined screening and brief intervention sessions per rolling year, the person must be referred for substance use disorder treatment.

SBIRT services are not reimbursable to providers (whether licensed or non-licensed) who have not completed the required number of training hours in SBIRT methodology.

Procedure codes 99408, G2011, and H0049 will be denied if billed for the same date of service as any of the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90791 | 90792 | 90832 | 90833 | 90834 | 90836 | 90837 | 90838 | 90847 | 90853 |
| 90865 | 90870 | 96130 | 96131 | 96132 | 96133 | 96136 | 96137 | | |

Procedure codes 99408 and H0049 cannot both be billed on the same date.

Physicians and other qualified health care professionals that bill an Evaluation and Management (E/M) code for a visit where SBIRT occurred must use modifier 25 to identify a significant, separately identifiable E/M service rendered by the same provider on the same date of service.

Note: FQHCs and RHCs should submit claims using SBIRT procedure codes for informational purposes only.

8.7 Documentation Requirements

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

- The provider who performed the SBIRT screening; and

- Screening results from a standardized screening tool or laboratory results such as BAC, toxicology screen, or other measures showing risk for alcohol or substance use and the specific screening tool used.

Documentation for SBIRT brief intervention sessions must include a person-centered plan for the delivery of medically necessary services that supports the use of procedure code 99408. The plan must include the following:

- The provider who performed the SBIRT brief intervention, if different from the provider who screened the person
- Start and stop time of the session, or the total time spent providing SBIRT services to the person
- Goals established
- Specific strategies to achieve the goals
- The person’s support system such as family members, a legal guardian, or friends.

Note: *If subsequent sessions are indicated, the provider who performed the SBIRT session must document that a follow up SBIRT appointment was made and with whom, or document another mechanism established to reassess progress*

- The name, address, and phone number of the provider that the person has been referred to for substance use disorder treatment

Services are subject to retrospective review to ensure that the documentation in the person’s medical record supports the medical necessity of the services provided.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

8.8 Claims Filing and Reimbursement

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

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

Subsection 6.1, “Claims Information” in “Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

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.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8085.

Texas Medicaid rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085.

Texas Medicaid rates for Nurse Practitioners and Clinical Nurse Specialists are calculated in accordance with TAC §355.8281.

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 NPI are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

Note: For more information about Texas Medicaid rates for the provider types above, refer to the [OFL](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

9 Substance Use Disorder (SUD) Services

9.1 Overview

SUDs are chronic, relapsing medical illnesses that require an array of best practice medical and psychosocial interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, "club" drugs, other synthetic euphorants), and other substances that may be identified in the future.

Treatment for SUD is a benefit of Texas Medicaid for persons who meet the criteria for a substance-related disorder, as outlined in the current edition of the American Psychiatric Association's (APA's) Diagnostic Statistical Manual of Mental Disorders (DSM).

SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat a person's problematic use of alcohol or other drugs, including prescription medication.

SUD services include:

- Withdrawal management services.
- Individual and group SUD counseling in an outpatient setting.
- Residential treatment services.
- Medication assisted treatment.
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.

Level of care (e.g., outpatient, residential, inpatient hospital) and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, such as those outlined in the current edition of the American Society of Addiction Medicine's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions, as well as the licensure requirements outlined in 25 TAC §448 pertaining to standards of care.

SUD outpatient or residential treatment services may only be delivered in a licensed chemical dependency treatment facility (CDTF). Medication assisted treatment (MAT) may also be delivered in the office setting by appropriately trained physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) who are recognized by the Texas Board of Nursing as either nurse practitioners (NPs), clinical nurse specialists (CNSs), nurse anesthetists (CRNAs), or nurse midwives (CNMs), provided that the APRN is a qualifying practitioner and possesses the Drug Addiction Treatment Act (DATA) waiver.

SUD withdrawal management in an inpatient hospital setting may be provided for persons who meet hospital level of care requirements as a result of the severity of their withdrawal syndrome or the severity of their co-occurring conditions. These services may be reimbursed as general hospital inpatient services.

The treatment setting and the intensity or level of services will vary depending on the severity of the person's SUD and what is clinically appropriate. The intensity or level of services refers to the number of hours of services per week, as well as the types of services the person receives. Early Intervention services are part of the spectrum of SUD treatment and are a benefit in Texas Medicaid. Early intervention services target persons who are at risk of developing a substance related problem but may not have a diagnosed SUD.

Referto: Subsection 8, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in this handbook for further information on early intervention services.

Upon admission into a treatment setting, a multi-dimensional assessment (procedure code H0001) must be conducted by a qualified credentialed counselor (QCC) or intern as defined in Department of State Health Services (DSHS) TAC §441.101 to determine a course of treatment that is medically necessary and clinically appropriate. The assessment must be signed off by a QCC.

9.2 Evaluation, Treatment, or Referral for Co-Occurring Conditions

CDTFs shall facilitate access to physical health, mental health, and ancillary services if those services are not available through the program and are necessary to meet treatment goals or needs of the person receiving services.

Persons in residential CDTFs commonly require medications unrelated to their SUD treatment for which costs are not covered in the reimbursement for SUD or MAT services. These medications, if included in the Medicaid formulary, may be obtained and reimbursed through the person's Medicaid pharmacy benefit.

Persons in residential CDTFs also commonly require other services that are benefits of Texas Medicaid, but not included in the CDTF rate. Claims for these services can be submitted by the appropriate providers.

CDTFs should screen each person for risk for contracting tuberculosis, Hepatitis B and C, HIV antibody, and sexually transmitted infections, and if appropriate, provide access to testing and follow up. Testing may be performed on site and billed by the ordering provider if appropriate testing facilities are available that are compliant with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

9.3 Withdrawal Management Services

Withdrawal management, formerly known as detoxification, is the medical and behavioral treatment of persons experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use.

Withdrawal management involving opioids, alcohol, sedatives, hypnotics, or anxiolytics will vary depending on the severity of the withdrawal symptoms experienced but will typically involve medications to treat symptoms in addition to supportive care, observation, and monitoring. Withdrawal management involving stimulants, inhalants, and cannabis typically involves supportive care, observation and monitoring, and medications to treat withdrawal symptoms as required.

Withdrawal management may be performed in an outpatient setting for persons experiencing mild to moderate withdrawal symptoms that can be successfully, as well as safely, managed outside of a residential setting or an inpatient hospital. Withdrawal management in a residential setting may be required for persons whose multidimensional assessment indicates one or more of the following circumstances that would make outpatient withdrawal management unsafe or unsuccessful:

- A level of severity of withdrawal, medical, or mental health complication
- Sufficient challenges with readiness to change, ability to stop using, or social support

Withdrawal management in an inpatient hospital setting may be required for persons whose severity of medical withdrawal (e.g., impending delirium tremens, severe withdrawal seizures), comorbid medical conditions (e.g., severe liver impairment, acute pneumonia, endocarditis, dementia), or comorbid psychiatric conditions (e.g., severe suicidality, acute and unstable psychosis or mania) requires a hospital level of care.

9.4 Individual and Group SUD Counseling Services in an Outpatient Setting

Counseling for SUDs is designed to assist persons in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist persons in accordance with the plan. The overall intent of the service is to assist persons in understanding their SUD and developing the skills and supports needed to address their SUD over time. Counseling may be done individually or in a group setting with multiple members. Group counseling sessions are limited to a total of 16 persons per session.

Outpatient counseling services are appropriate for the following:

- Persons with less severe disorders
- Persons who are in the early stages of change
- As a step down from more intensive services
- Persons who are stable but for whom ongoing monitoring is appropriate

Note: For persons unable or unwilling to access SUD treatment services at a CDTF, psychotherapy delivered by a licensed practitioner of the healing arts (LPHA) may be an alternative treatment option to address a person's SUD.

Outpatient services may be appropriate at the start of treatment, throughout treatment, or after an episode of residential or inpatient treatment, depending on the person's acuity, severity, comorbidity, needs, or preferences. Outpatient services can address active symptoms as well as provide ongoing treatment for persons in partial or full remission who need continuing help to maintain progress.

Abstinence should not necessarily be a requirement for participation in outpatient services.

9.5 Residential Treatment Services

Residential treatment programs provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate. The frequency and duration of services should be based on meeting the person's needs and achieving the person's treatment goals.

Residential services are appropriate for persons who require a structured therapeutic environment to stabilize SUD and develop coping and recovery skills. Residential treatment programs may specialize in the unique needs of a specific population such as adolescents, or pregnant or parenting women with children.

Episodes of residential treatment may be required for persons with more severe SUD, more significant medical or psychiatric comorbidities, more significant challenges with sustaining motivation, maintaining control in an outpatient setting, or a living environment that jeopardizes their current ability to be successful in outpatient treatment.

Residential SUD treatment services may only be provided by a licensed CDTF.

9.6 Outpatient Treatment Services

Outpatient treatment services must be billed with procedure codes H0004 or H0005.

Procedure codes H0004 and H0005 are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F1010 | F1011 | F10120 | F10121 | F10129 | F10130 | F10131 | F10132 |
| F10139 | F1014 | F10150 | F10151 | F10159 | F10180 | F10181 | F10182 |
| F10188 | F1019 | F1020 | F1021 | F10220 | F10221 | F10229 | F10230 |
| F10231 | F10232 | F10239 | F1024 | F10250 | F10251 | F10259 | F1026 |
| F1027 | F10280 | F10281 | F10282 | F10288 | F1029 | F1090 | F1091 |
| F10920 | F10921 | F10929 | F10930 | F10931 | F10932 | F10939 | F1094 |
| F10950 | F10951 | F10959 | F1096 | F1097 | F10980 | F10981 | F10982 |
| F10988 | F1099 | F1110 | F1111 | F11120 | F11121 | F11122 | F11129 |
| F1113 | F1114 | F11150 | F11151 | F11159 | F11181 | F11182 | F11188 |
| F1119 | F1120 | F1121 | F11220 | F11221 | F11222 | F11229 | F1123 |
| F1124 | F11250 | F11251 | F11259 | F11281 | F11282 | F11288 | F1129 |
| F1190 | F1191 | F11920 | F11921 | F11922 | F11929 | F1193 | F1194 |
| F11950 | F11951 | F11959 | F11981 | F11982 | F11988 | F1199 | F1210 |
| F1211 | F12120 | F12121 | F12122 | F12129 | F1213 | F12150 | F12151 |
| F12159 | F12180 | F12188 | F1219 | F1220 | F1221 | F12220 | F12221 |
| F12222 | F12229 | F1223 | F12250 | F12251 | F12259 | F12280 | F12288 |
| F1229 | F1290 | F1291 | F1293 | F12920 | F12921 | F12922 | F12929 |
| F12950 | F12951 | F12959 | F12980 | F12988 | F1299 | F1310 | F1311 |
| F13120 | F13121 | F13129 | F13130 | F13131 | F13132 | F13139 | F1314 |
| F13150 | F13151 | F13159 | F13180 | F13181 | F13182 | F13188 | F1319 |
| F1320 | F1321 | F13220 | F13221 | F13229 | F13230 | F13231 | F13232 |
| F13239 | F1324 | F13250 | F13251 | F13259 | F1326 | F1327 | F13280 |
| F13281 | F13282 | F13288 | F1329 | F1390 | F1391 | F13920 | F13921 |
| F13929 | F13930 | F13931 | F13932 | F13939 | F1394 | F13950 | F13951 |
| F13959 | F1396 | F1397 | F13980 | F13981 | F13982 | F13988 | F1399 |
| F1410 | F1411 | F14120 | F14121 | F14122 | F14129 | F1413 | F1414 |
| F14150 | F14151 | F14159 | F14180 | F14181 | F14182 | F14188 | F1419 |
| F1420 | F1421 | F14220 | F14221 | F14222 | F14229 | F1423 | F1424 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|---------|
| F14250 | F14251 | F14259 | F14280 | F14281 | F14282 | F14288 | F1429 |
| F1490 | F1491 | F14920 | F14921 | F14922 | F14929 | F1493 | F1494 |
| F14950 | F14951 | F14959 | F14980 | F14981 | F14982 | F14988 | F1499 |
| F1510 | F1511 | F15120 | F15121 | F15122 | F15129 | F1513 | F1514 |
| F15150 | F15151 | F15159 | F15180 | F15181 | F15182 | F15188 | F1519 |
| F1520 | F1521 | F15220 | F15221 | F15222 | F15229 | F1523 | F1524 |
| F15250 | F15251 | F15259 | F15280 | F15281 | F15282 | F15288 | F1529 |
| F1590 | F1591 | F15920 | F15921 | F15922 | F15929 | F1593 | F1594 |
| F15950 | F15951 | F15959 | F15980 | F15981 | F15982 | F15988 | F1599 |
| F1610 | F1611 | F16120 | F16121 | F16122 | F16129 | F1614 | F16150 |
| F16151 | F16159 | F16180 | F16183 | F16188 | F1619 | F1620 | F1621 |
| F16220 | F16221 | F16229 | F1624 | F16250 | F16251 | F16259 | F16280 |
| F16283 | F16288 | F1629 | F1690 | F1691 | F16920 | F16921 | F16929 |
| F1694 | F16950 | F16951 | F16959 | F16980 | F16983 | F16988 | F1699 |
| F1810 | F1811 | F18120 | F18121 | F18129 | F1814 | F18150 | F18151 |
| F18159 | F1817 | F18180 | F18188 | F1819 | F1820 | F1821 | F18220 |
| F18221 | F18229 | F1824 | F18250 | F18251 | F18259 | F1827 | F18280 |
| F18288 | F1829 | F1890 | F1891 | F18920 | F18921 | F18929 | F1894 |
| F18950 | F18951 | F18959 | F1897 | F18980 | F18988 | F1899 | F1910 |
| F1911 | F19120 | F19121 | F19122 | F19129 | F19130 | F19131 | F19132 |
| F19139 | F1914 | F19150 | F19151 | F19159 | F1916 | F1917 | F19180 |
| F19181 | F19182 | F19188 | F1919 | F1920 | F1921 | F19220 | F192221 |
| F19222 | F19229 | F19230 | F19231 | F19232 | F19239 | F1924 | F19250 |
| F19251 | F19259 | F1926 | F1927 | F19280 | F19281 | F19282 | F19288 |
| F1929 | F1990 | F1991 | F19920 | F19221 | F19922 | F19929 | F19930 |
| F19931 | F19932 | F19939 | F1994 | F19950 | F19951 | F19959 | F1996 |
| F1997 | F19980 | F19981 | F19982 | F19988 | F1999 | F551 | F553 |

9.7 * Medication Assisted Treatment Services

MAT is the use of FDA-approved medications in combination with psychosocial treatment to treat SUDs, particularly alcohol and opioid use disorders (OUD).

MAT is a recognized best practice for alcohol use disorder (AUD) and OUD. All persons with AUD and OUD should be educated about the availability of MAT and the evidence supporting MAT, and have the opportunity to receive MAT regardless of where they are receiving SUD services. This could be accomplished on site or through a written agreement with a collaborating opioid treatment program (OTP) or office-based opioid treatment (OBOT) program.

Initiation or induction of MAT can appropriately occur in lieu of withdrawal management for OUDs, may begin early in withdrawal management for either AUD or OUD, and can be initiated as appropriate at any point in time during the course of treatment. Duration of MAT is determined on an person basis, depending on the person’s unique needs and treatment goals.

Determination of which MAT medication to use is also an individualized treatment decision based on provider assessment and the person’s needs and treatment goals. Providers are encouraged to offer as many treatment options as possible (within the parameters of their licensing and scope of practice) to maximize the person’s choice and access to care.

MAT may be utilized as appropriate, as part of the service array delivered by outpatient providers or residential treatment services programs at CDTFs.

Opioid treatment programs (also referred to as narcotic treatment programs) are the only settings permitted by law to provide methadone for OUD and must comply with additional federal and state requirements, rules on licensure and scope of practice, including physician delegation, supervision, and prescriptive authority. Opioid treatment programs can also provide or administer other forms of MAT.

CDTFs, physicians, NPs, and PAs may prescribe and provide for the administration of long-acting injectable naltrexone (Vivitrol) to treat cravings associated with either OUD or AUD.

Physicians, PAs, and APRNs who are recognized by the Texas Board of Nursing as either NPs, CNSs, APRNs, or CNMs who have received a federal waiver to dispense buprenorphine may choose to incorporate this form of MAT into their medical practice while also providing or referring for other types of treatment services (also referred to as OBOT).

Certain MAT medications to treat alcohol and opioid use disorders (such as buprenorphine, disulfiram, acamprosate, and naltrexone), are available as a pharmacy benefit and may be prescribed to a person by their physician or other qualified health care professional. Providers may refer to the Vendor Drug Program Formulary for additional information on covered medications.

A prescription for an opioid antagonist (e.g., naloxone) should be given to all persons receiving treatment for OUD, and instruction should be provided on how to administer if needed.

Claims for urinalysis drug screens ordered by a physician, NP, or CNS to monitor compliance with MAT may be submitted by the individually-enrolled physician or APRN.

The following MAT procedure codes may be separately reimbursed from withdrawal management and treatment services in the outpatient or residential setting:

| [Revised] Procedure Codes | | | | | |
|---------------------------|-------|-------|-------|-------|-------|
| H0020 | H0033 | J0570 | J0576 | J2315 | Q9991 |
| Q9992 | | | | | |

9.7.1 * Opioid Treatment Providers

Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) opioid treatment providers (OTPs) that are also licensed as narcotic treatment programs in Texas are required to enroll in Medicare before enrolling with Texas Medicaid as OTPs. Providers billing claims for persons who have dual eligibility for Medicaid and Medicare must first submit their claims to Medicare.

The following procedure codes may be reimbursed to Opioid Treatment Providers:

| [Revised] Procedure Codes | | | | |
|---------------------------|-------|-------|-------|-------|
| H0001 | H0004 | H0005 | H0020 | H0033 |
| J0570 | J0576 | J2315 | Q9991 | Q9992 |

Important: CDTFs cannot bill for OTP services through Medicare, as CDTFs are not Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) OTPs.

A comprehensive assessment (procedure code H0001) is limited to once per day, any provider. An assessment is also limited to once per episode of care and should be performed at the start of each new episode of care.

9.8 Telemedicine and Telehealth Services

Providers of SUD services must defer to the needs of the person receiving the services, allowing the mode of service delivery to be accessible, person- and family-centered and primarily driven by the person's choice and not provider convenience.

Providers must provide SUD services to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, SUD services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

9.8.1 Synchronous Audiovisual Technology

The following SUD services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. SUD services provided by synchronous audiovisual technology must be billed using modifier 95.

- Comprehensive assessment (procedure code H0001)
- Individual and group counseling (procedure codes H0004 and H0005)
- MAT services - Prescribing of certain MAT medications may be done via telemedicine presuming all other applicable state and federal laws and regulations are followed.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about prescriptions generated from a telemedicine medical service.

9.8.2 Synchronous Telephone (Audio-only) Technology

The following SUD services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology of telemedicine and telehealth services. Therefore, providers of SUD services must document in the person's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. SUD services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- Comprehensive assessment (procedure code H0001) - Only during certain public health emergencies or natural disasters; to the extent allowed by federal law (assessments for withdrawal management services are excluded); and the existing clinical relationship requirement is waived.
- Individual and group counseling (procedure codes H0004 and H0005)

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) from the same provider within the six months prior to the initial service delivered by synchronous telephone

(audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

Note: “Same billing provider” refers to providers within the same entity or organization, as identified by the entity’s or organization’s NPI number or numbers, if the entity or organization has multiple locations (i.e., CDTF, OTP or clinic, or group practice).

Note: The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed.

The billing provider is required to conduct at least 1 in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person’s medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

- The person receiving services is located at a qualifying originating site in an eligible geographic area, e.g., a practitioner office in a rural Health Professional Shortage Area.
- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the person’s condition(s).

Note: The required in-person or synchronous audiovisual-delivered SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) may be delivered by another authorized professional, or paraprofessional, of the same billing provider as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology, presuming all other applicable state and federal laws and regulations are followed.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth requirements to include informed consent and privacy and security requirements.

| Modifier | Description |
|----------|--|
| 95 | Delivered by synchronous audiovisual technology |
| FQ | Delivered by synchronous telephone (audio-only) technology |

9.9 Exclusions

SUD treatment services for tobacco use disorder as the primary diagnosis are not a covered benefit, although a comprehensive SUD treatment approach should address tobacco use if reducing or eliminating this substance is part of the person’s treatment goal.

9.10 Prior Authorization

The following services do not require prior authorization:

- Assessment
- Outpatient treatment services
- MAT

Exception: *Outpatient treatment services require prior authorization if the calendar year hours/units are exceeded. Those limits are 135 units of group services and 26 hours of individual services per calendar year.*

The following services require prior authorization:

- Outpatient withdrawal management services
- Outpatient treatment for persons who exceed the benefit limitation
- Residential withdrawal management services
- Residential treatment services

Providers must submit the appropriate prior authorization request form for the initial or continuation of outpatient or residential withdrawal management treatment and residential treatment services. A QCC (as defined by the DSHS licensure standard) must complete and sign the prior authorization request forms.

Providers must submit one of the following forms to obtain prior authorization:

- Outpatient Withdrawal Management Authorization Request Form
- Outpatient Substance Use Disorder Counseling Extension Request Form
- Residential Withdrawal Management Authorization Request Form
- Residential Substance Use Disorder Treatment Request Form

Prior authorization will be considered for the least restrictive environment appropriate to the person's medical need as determined in the person's plan of care (POC), based on national standards.

Prior authorization requests for services beyond the limitations outlined in this section, may be considered with documentation supporting the medical necessity for continuation of the treatment.

9.10.1 Prior Authorization to Persons with Fee-For-Service Benefits

Prior authorization requests for persons with fee-for-service benefits may be submitted to the TMHP Prior Authorization Unit online at www.tmhp.com, by fax at 512-514-4211, or by mail to:

Texas Medicaid & Healthcare Partnership
TMHP Prior Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods. Providers must retain a copy of the signed and dated prior authorization form in the person's medical record.

Providers may contact the TMHP Prior Authorization Unit by telephone at 800-213-8877, Option 2, to obtain information about substance use disorder benefits, the prior authorization process, or the status of a prior authorization request. Prior authorization for substance use disorder services cannot be obtained through this line.

Prior authorization for outpatient withdrawal management, residential treatment, or residential withdrawal management services will be considered when requested within three business days after the date of admission.

Prior authorization may be considered for persons who are enrolled in a Medicaid MCO when they are admitted to SUD services and whose eligibility changes to fee-for-service during treatment. Requests must be submitted within three business days of the date on which the fee-for-service eligibility started.

9.10.2 Prior Authorization for Outpatient Withdrawal Management Treatment Services

Outpatient withdrawal management services may be prior authorized for up to 21 days. The level of service and number of days that are prior authorized will be based on the substances that are used, level of intoxication and withdrawal potential, and the person's medical needs. Providers may submit requests for services using the Outpatient Withdrawal Management Authorization Request Form.

9.10.2.1 Admission Criteria for Outpatient Withdrawal Management Treatment Services

The admission criteria for outpatient withdrawal management treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001–§3.8030.

To be considered eligible for treatment for outpatient withdrawal management services, the person must meet the following conditions:

- **Chemical Substance Withdrawal**—The person must meet all of the following criteria with regard to chemical substance withdrawal:
 - The person is expected to have a stable withdrawal from alcohol or drugs.
 - The diagnosis must meet the criteria for the definition of SUD or the most current revision of the APA's DSM accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
- **Medical Functioning**—The person must meet all of the following criteria with regard to medical functioning:
 - No history of recent seizures or past history of seizures during withdrawal.
 - No clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinically significant obtundation, stupor, or coma).
 - The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
 - Stable vital signs as interpreted by a physician. The person must also be without a previous history of complications from acute chemical substance withdrawal and judged to be free of a health risk as determined by a physician.
 - No evidence of a coexisting serious injury or systemic illness either newly discovered or progressive in nature.
 - Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
 - Clinical condition that allows for a comprehensive and satisfactory assessment.

- **Family, Social, or Academic Dysfunction**—The person must meet at least one of the following criteria with regard to family, social, or academic dysfunction:
 - The person’s social system and significant others are supportive of recovery to the extent that the person can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the person’s SUD.
 - The person’s family or significant others are willing to participate in the outpatient withdrawal management treatment program.
 - The person may or may not have a primary or social support system to assist with immediate recovery, but the person has the social skills to obtain such a support system or to become involved in a self-help fellowship.
 - The person does not live in an environment where licit or illicit mood-altering substances are being used. A person living in an environment where licit or illicit mood-altering substances are being used may not be a candidate for this level of care.
- **Emotional and Behavioral Status**—The person must meet all of the following criteria with regard to emotional and behavioral status:
 - The person is coherent, rational, and oriented for treatment.
 - The mental state of the person does not preclude the person’s ability to comprehend and understand the materials presented, and the person is able to participate in the outpatient withdrawal management treatment process.
 - Documentation exists in the medical record that the person expresses an interest to work toward outpatient withdrawal management treatment goals.
 - The person has no neuropsychiatric condition that places the person at imminent risk of harming self or others (e.g. pathological intoxication or alcohol idiosyncratic intoxication).
 - The person has no neurological, psychological, or uncontrolled behavior that places the person at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety).
 - The person has no documented DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
 - The person has no mental confusion or fluctuating orientation.
- **Chemical Substance Use**—The person must meet the criteria in at least one of the following conditions with regard to recent chemical substance use:
 - The person’s chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
 - The person is motivated to stop using alcohol or drugs and is in need of a supportive, structured treatment program to facilitate withdrawal from chemical substances.

9.10.2.2 Continued Stay Criteria for Outpatient Withdrawal Management Treatment Services

A person is considered eligible for continued stay in the outpatient withdrawal management treatment service when the person meets at least one of the conditions for either chemical substance withdrawal or psychiatric or medical complications. Requests for extension of services must be received on or before the last date authorized or denied. The prior authorization unit will notify the provider by fax or electronic portal. If the date of the prior authorization unit determination letter is on or after the last date

authorized or denied or if the last date falls on a holiday or weekend, the request for extension of services is due by 5 p.m. of the next business day. Documentation in the person's medical record must support either Chemical Substance Withdrawal or Psychiatric or Medical Complications.

Chemical Substance Withdrawal

The person must meet at least one of the following conditions with regard to chemical substance withdrawal complications:

- The person, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by psychological and physical cravings.
- The person, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by significant drug levels.

Psychiatric or Medical Complications

The person must meet both of the following psychiatric or medical complication conditions:

- The intervening medical or psychiatric event was serious enough to interrupt the outpatient withdrawal management treatment.
- Evidence that the person is progressing in treatment again.

9.10.3 Prior Authorization for Residential Withdrawal Management Treatment Services

Withdrawal management services may be prior authorized for up to 21 days. The level of service and number of prior authorized days will be based on the substances that are used, level of intoxication and withdrawal potential, and the person's medical needs. Providers may submit requests for services using the Residential Withdrawal Management Authorization Request form.

Requests for withdrawal management services for persons who need more than 21 days of residential withdrawal management require review of documentation of medical necessity from a provider who is familiar with the person.

9.10.3.1 Admission Criteria for Residential Withdrawal Management Treatment Services

The admission criteria for residential withdrawal management treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001–§3.8030.

A person is eligible for admission to a residential withdrawal management service when they have failed two previous individual treatment episodes of outpatient withdrawal management or when they have a diagnosis that meets the criteria for the definition of SUD in the most current revision of the APA's DSM.

The person must also meet at least one of the following criteria for admission to residential withdrawal management treatment:

- Chemical Substance Withdrawal—The person must have impaired neurological functions as evidenced by:
 - Extreme depression (e.g., suicidal).
 - Altered mental state with or without delirium as manifested by disorientation to self; alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.
 - History of recent seizures or past history of seizures on withdrawal.

- The presence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).
- Unstable vital signs combined with a history of past acute withdrawal syndromes that are interpreted by a physician to be indication of acute alcohol or drug withdrawal.
- Evidence of coexisting serious injury or systemic illness, newly discovered or progressive.
- Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions and indicates placement in residential withdrawal management service may be justified.
- Neuropsychiatric changes of such severity and nature that they put the person at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication).
- Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
- Major Medical Complications—The person must present a documented condition or disorder that, in combination with alcohol or drug use, presents a determined health risk (e.g., gastrointestinal bleeding, gastritis, severe anemia, uncontrolled diabetes mellitus, hepatitis, malnutrition, cardiac disease, hypertension).
- Major Psychiatric Illness—The person must meet at least one of the following conditions with regard to major psychiatric illness:
 - Documented APA DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
 - Severe neurological and psychological symptoms: (e.g., anguish, mood fluctuations, overreactions to stress, lowered stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, extreme negative emotions, or extreme anxiety).
 - Danger to others or homicidal.
 - Uncontrolled behavior that endangers self or others, or documented neuropsychiatric changes of a severity and nature that place the person at imminent risk of harming self or others.
 - Mental confusion or fluctuating orientation.

9.10.3.2 Continued Stay Criteria for Residential Withdrawal Management Treatment Services

Eligibility for continued stay for residential withdrawal management services is based on the person meeting at least one of the criteria for chemical substance withdrawal, major medical complications, or major psychiatric complications.

Chemical Substance Withdrawal

The person must exhibit one of the following conditions with regard to chemical substance withdrawal complications:

- Incomplete medically stable withdrawal from alcohol or drugs, as evidenced by documentation of at least one of the following conditions:
 - Unstable vital signs
 - Continued disorientation
 - Abnormal laboratory findings related to chemical dependency

- Continued cognitive deficit related to withdrawal so that the person is unable to recognize alcohol or drug use as a problem
- Laboratory finding that, based on the judgment of a physician, indicates that a drug has not sufficiently cleared the person's system

Major Medical Complications

For major medical complications, the person must have documentation in the medical record that indicates that a medical condition or disorder (e.g., uncontrolled diabetes mellitus) continues to present a health risk and is being actively treated.

Major Psychiatric Complications

The person must meet at least one of the following with regard to major psychiatric complications:

- Documentation in the medical record that a psychiatric condition or disorder that, in combination with alcohol or drug use, continues to present a major health risk, is actively being treated.
- Documentation in the medical record that severe neurological or psychological symptoms have not been satisfactorily reduced but are actively being treated.

9.10.4 Prior Authorization for Residential Treatment Services

Residential treatment may be prior authorized for up to 35 days per episode of care, with a maximum of two episodes of care per rolling six-month period and four episodes of care per rolling year.

Providers can use the Residential Substance Use Disorder Treatment Request form to submit authorization requests for persons who require additional episodes within the 6- or 12-month time frame.

9.10.4.1 Admission Criteria for Residential Treatment Services

The admission criteria for residential treatment services follow the existing Texas Department of Insurance licensure requirements and standards that are specified in 28 TAC §3.8001-§3.8030.

The diagnosis must meet the criteria for the definition of an SUD in the most current version of the APA's DSM.

All persons must meet the following conditions to receive treatment in a residential treatment service program:

- **Medical Functioning**—The following must be present with regard to medical functioning:
 - Documented medical assessment following admission (except in instances where the person is being referred from an inpatient service) indicates that the person is medically stable and not in acute withdrawal.
 - The person is not bed-confined and has no medical complications that would hamper participation in the residential service.
- **Family, Social, or Academic Dysfunction and Logistic Impairments**—At least one of the following must be present with regard to family, social, or academic dysfunction and logistic impairments:
 - The person manifests severe social isolation or withdrawal from social contacts.
 - The person lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines person's efforts to change).
 - The person's family or significant others are opposed to the person's treatment efforts and are not willing to participate in the treatment process.
 - Family members or significant others living with the person manifest current SUDs and are likely to undermine treatment.

- Logistic impairments (e.g., distance from treatment facility or mobility limitations) preclude participation in an outpatient treatment setting.
- Emotional and Behavioral Status—The person must meet all three of the following criteria with regard to emotional and behavioral status:
 - The person is coherent, rational, and oriented for treatment.
 - Mental state of the person does not preclude the person’s ability to comprehend and understand the materials presented and participate in rehabilitation or the treatment process.
 - The medical record contains documentation that with continued treatment the person will be able to improve or internalize the person’s motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol or drug related issues). Interventions, treatment goals, or contracts are in place to help the person deal with or confront the blocks to treatment (e.g., family intervention or employee counseling confrontation).
- Chemical Substance Use—The person must meet at least one of the following criteria with regard to chemical substance use:
 - The person’s chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
 - Virtually all of the person’s daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances, and the person requires a secured environment to control the person’s access to chemical substances.

9.10.4.2 Residential Treatment Services for Adolescents

Adolescents who are 13 through 17 years of age must meet all above conditions and the following conditions to receive treatment in an adolescent residential treatment service program:

- At the maturation level, the adolescent must meet both of the following criteria:
 - The adolescent is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post-pubescent).
 - The history of the adolescent reflects cognitive development of at least 11 years of age.
- The adolescent must display at least one of the following with regard to developmental status:
 - Documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, or other criminal charges).
 - A recent history of moderate to severe conduct disorder, as defined in the APA’s DSM, or impulsive disregard for social norms and rights of others.
 - Documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent that interferes with the capacity to remain behaviorally stable.

9.10.4.3 Continued Stay Criteria for Residential Treatment Services

At least one of the following conditions must be present for continued stay in a residential treatment program:

- Chemical Dependency Rehabilitation or Treatment Complications:
 - The person recognizes or identifies with the severity of the alcohol or drug problem but demonstrates minimal insight into the person’s defeating the use of alcohol or drugs. However, documentation in the medical record indicates that the person is progressing in treatment.

- The person identifies with the severity of the alcohol or drug problem and manifests insight into the person's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate the development of problem-solving skills that are necessary to cope with the problem.
- The person would predictably relapse if moved to a lesser level of care.
- Psychiatric or Medical Complications:
 - Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt rehabilitation or treatment, but the person is again progressing in treatment.
 - Documentation in the medical record indicates that the person is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient withdrawal management alcohol or drug service.

9.10.5 Prior Authorization for Outpatient Treatment Services

Prior authorization for outpatient treatment services beyond the annual limitation of 135 units of group services and 26 hours of individual services per calendar year, may be considered with documentation supporting medical necessity for continued treatment services. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

Requests must be submitted before providing the extended services. The documentation must include the following information:

- The person is meeting treatment goals.
- The person demonstrates insight and understanding into relationship with mood-altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals.
- The person is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the person is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the person will effectively address these issues.
- Although other psychiatric or medical complications exist that affect the person's treatment, there is documentation to support the person continues to show treatment progress and there is evidence to support the benefits of continued treatment.

9.11 Documentation Requirements

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including documentation for medical necessity for the services requested. The provider must maintain documentation of medical necessity in the person's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the means of delivery when provided by telemedicine or telehealth.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for more information about telemedicine and telehealth documentation requirements including requirements for informed consent.

9.12 Reimbursement and Limitations

9.12.1 Withdrawal Management Services

Inpatient hospital-based withdrawal management is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

Residential withdrawal management and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.

Residential withdrawal management services (procedure codes H0012, H0031, S9445, and T1007) are limited to once per day, any provider.

Residential withdrawal management services (procedure codes H0031, H0047, S9445, or T1007) will be denied if billed without lead procedure code H0012 on the same day, same provider.

Room and board for residential withdrawal management and treatment (procedure code H0047) is limited to once per date of service, any provider. Procedure code H0047 is reimbursed for persons who are 21 years of age and older as an access-based fee and as an informational detail for persons who are 20 years of age and younger.

Outpatient withdrawal management (procedure codes H0016, H0050, and S9445) is limited to once per day, any provider and may be reimbursed on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the person's treatment plan.

Outpatient withdrawal management (procedure codes H0050 and S9445) will be denied if billed without lead procedure code H0016 on the same day, same provider.

Separate reimbursement may be provided for physician services during a residential stay.

9.12.1.1 Treatment Services

Outpatient treatment services are limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

Residential treatment services (procedure code H2035) are limited to one per day and are allowed up to a maximum of 35 days.

Outpatient treatment (procedure codes H0004 and H0005) will be denied if billed on the same date of service as residential withdrawal management (procedure codes H0012, H0031, H0047, S9445, and T1007) or residential treatment (procedure code H2035).

Procedure code H0047 will be denied if billed without lead procedure code H2035 or H0012 on the same day, same provider.

Referto: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about NCCI MUE guidelines.

9.12.2 MAT Services

Claims billed for MAT must include the person's substance use disorder diagnosis. MAT billing may include billing for induction as well as maintenance.

Methadone administration (procedure code H0020) for opioid disorder must be submitted with the following modifiers:

- When methadone is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
- When methadone is dispensed without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses

Methadone provided in an outpatient setting (procedure code H0020) is limited to once per date of service, by any provider and is reimbursed at a fixed daily rate. Reimbursement for procedure code H0020 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0020 with modifier U1 for each date of service for which a take-home dose is dispensed. Methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

Methadone administration (procedure code H0020) submitted without a modifier will be denied.

Non-methadone (e.g., buprenorphine) administration (procedure code H0033) for opioid disorder must be submitted with the following modifiers:

- When non-methadone is administered with supervision in a facility the provider must submit claims using the modifier UA to indicate opioid disorder treatment facility doses or claims will be denied
- When non-methadone is dispensed without supervision as a take home dose the provider must submit claims using the modifier U1 to indicate opioid disorder take home doses or claims will be denied

Non-methadone provided in an outpatient setting (procedure code H0033) is limited to once per date of service, by any provider. Reimbursement for procedure code H0033 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0033 with modifier U1 for each date of service for which a take-home dose is dispensed. Non-methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

When non-methadone is administered in a facility for a non-opioid treatment, providers must use procedure code H0033 to indicate non-opioid treatment in a facility.

Non-methadone administration (procedure code H0033) submitted without a modifier will be denied. Physician and physician extenders may be reimbursed separately using the appropriate evaluation and management procedure codes.

Injectable administration is considered part of MAT and is not reimbursed separately. Procedure code 96372 will be denied when billed for the same date of service by any provider as procedure code H0020 or H0033.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

9.13 Claims Filing

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

Referto: “Section 3: TMHP Electronic Data Interchange (EDI)” (*Vol. 1, General Information*) for information about electronic claims submissions.

Subsection 6.1, “Claims Information” in “Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

10 * Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMS) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

CoCM services are benefits of Texas Medicaid for persons of all ages who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a physician, physician assistant, nurse practitioner, or clinic/group practice (henceforth referred to as the primary care provider).

The primary care provider must attest they have an established CoCM program prior to delivering CoCM services using the Attestation Form for the Collaborative Care Model (CoCM) in Texas Medicaid that is available on the [Forms web page](#) of the TMHP website under the Resources menu. The primary care provider must complete an attestation form at the start of every new episode of care for each person receiving CoCM services to ensure adherence to the CoCM core principles and the specific functional requirements of the model, as described in the attestation form and the *Texas Medicaid Provider Procedures Manual*.

The attestation form must be maintained in the medical record of each person receiving CoCM services and made available to Texas Medicaid or its designee upon request.

[Revised] CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility, or other locations.

Referto: Subsection 9.3, “Collaborative Care Model (CoCM)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information.

11 Claims Resources

Refer to the following sections or forms when filing claims:

| Resource | Location |
|--------------------------------|--|
| Acronym Dictionary | “Appendix C: Acronym Dictionary” (<i>Vol. 1, General Information</i>) |
| Automated Inquiry System (AIS) | Subsection A.10, “TMHP Telephone and Fax Communication” in “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>) |

| Resource | Location |
|--|---|
| CMS-1500 Paper Claim Filing Instructions | Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>) |
| State, federal, and TMHP contact information | “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>) |
| TMHP Electronic Data Interchange (EDI) information | “Section 3: TMHP Electronic Data Interchange (EDI)” (<i>Vol. 1, General Information</i>) |

12 Contact TMHP

Providers can call the TMHP Contact Center at 800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.

13 Forms

The following linked forms can also be found on the [Forms](#) page of the Provider section of the TMHP website at www.tmhp.com:

| Forms |
|---|
| Attestation Form for Collaborative Care Model (CoCM) in Texas Medicaid |
| Outpatient Withdrawal Management Authorization Request Form |
| Outpatient Substance Use Disorder Counseling Extension Request Form |
| Outpatient Mental Health Services Request Form |
| Residential Withdrawal Management Authorization Request Form |
| Residential Substance Use Disorder Treatment Request Form |

14 Claim Form Examples

The following linked claim form examples can also be found on the [Claim Form Examples](#) page of the Provider section of the TMHP website at www.tmhp.com:

| Claim Form Examples |
|--|
| Blind Children’s Vocational Discovery and Development Program (BCVDDP) |
| Case Management for Children and Pregnant Women |
| Licensed Clinical Social Worker (LCSW) |
| Licensed Marriage and Family Therapist (LMFT) |
| Licensed Professional Counselor (LPC) |
| Mental Health Case Management |
| Psychologist |
| Psychotherapy with Evaluation and Management (E/M) |