The drafted policies are open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

As mandated by House Bill 4, 87th Legislature, Regular Session, 2021, the Health and Human Services Commission (HHSC) is performing a targeted review of the following behavioral health Medicaid medical policies to add language to allow the delivery of services by telemedicine or telehealth for Medicaid clients:

* Health and Behavior Assessment and Intervention (HBAI) Services
* Screening, Brief Intervention and Referral to Treatment (SBIRT) Services
* Outpatient Mental Health Services
* Peer Specialist Services
* Substance Use Disorder Services
* Physician and Evaluation Management Services - Office or Other Outpatient Services
* Mental Health Targeted Case Management Services
* Mental Health Rehabilitation Services

In addition, as mandated by Senate Bill 1921, 87th Legislature, Regular Session, 2021, HHSC is performing a targeted review of the following behavioral health Medicaid medical policies to update language to allow non-Local Mental Health Authorities (LMHAs) to provide the services to clients in fee-for-service (FFS) Medicaid.

* Mental Health Targeted Case Management (MHTCM) Services
* Mental Health Rehabilitation (MHR) Services

The following is a summary of changes in scope for this policy review:

* Added telemedicine or telehealth language to each Medicaid medical policy under this targeted review to allow the use of telemedicine or telehealth when appropriate.
* Removed any references to ‘in person’ delivery of services from the Medicaid medical polices under this targeted review to allow the use of telemedicine or telehealth when appropriate and as indicated in the individual policies.
* Added non-LMHAs as a provider type for persons in FFS Medicaid for MHTCM and MHR services.
* Added prior authorization information for non-LMHAs that provide MHTCM and MHR services to persons in FFS Medicaid.

Some policy language that is out of scope for this review is included in this document for context. New policy language has been underlined and deleted language has been struck-through to highlight proposed policy changes.

Note: The current language regarding behavioral health benefits can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Behavioral Health and Case Management Services Handbook and the Children’s Services Handbook (Vol. 2, Provider Handbooks).

**Texas Medicaid**

# Health and Behavior Assessment and Intervention Services (HBAI)

## Statement of Benefits

Health and behavior assessment and intervention (HBAI) services are a benefit of Texas Medicaid for persons who are 20 years of age and younger when provided by a licensed practitioner of the healing arts (LPHA) who is co-located in the same office or building complex as the physician, physician assistant (PA), or advanced practice registered nurse (APRN) who is treating the person. Co-location is defined as the provision of services in the same office or building complex in which the person’s physician, PA, or APRN has their practice. HBAI services are designed to identify the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms.

### Telemedicine and Telehealth

1. 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.
2. Providers must provide HBAI 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, HBAI services in full accordance with all applicable licensure and certification requirements.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. HBAI 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. HBAI services provided by synchronous audiovisual technology must be billed using modifier 95.

#### Synchronous Telephone (Audio-Only) Technology

1. HBAI 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. HBAI services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

## Documentation Requirements

1. For the initial assessment, documentation must support the medical necessity of the assessment, and must include the following information:
	1. The date of initial diagnosis of physical illness;
	2. A clear rationale for assessment;
	3. Outcome of assessment, which includes mental status and the person’s or caregiver’s ability to understand and respond meaningfully; and
	4. Goals and expected duration of specifically recommended psychological intervention(s).
2. For reassessment, documentation must support the reassessment is necessary and include the following information:
	1. The date of change in mental or physical status; and
	2. Rationale for reassessment with a clear indication of precipitating events.
3. For the intervention, documentation must support the necessity of the intervention and include the following information:
	1. Evidence that the person receiving services or caregiver has the capacity to understand and respond meaningfully;
	2. Clear outline of planned psychological intervention;
	3. Goals of the psychological intervention identifying expected improvement in compliance with the medical treatment plan;
	4. The person’s response to the intervention; and
	5. Rationale for frequency and duration of acute care services.

### Telemedicine and Telehealth

1. 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.

# SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

## Statement of Benefits

Screening Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons 10 years of age and older with alcohol or substance use disorders, as well as those who are at risk of developing these disorders. 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). SBIRT can be performed in the office, home, outpatient hospital, skilled nursing facility or intermediate care facility, extended care facility and other location settings.

### Telemedicine and Telehealth

1. 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.
2. 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.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. 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.

#### Synchronous Telephone (Audio-Only) Technology

1. 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.

## Documentation Requirements

1. The person’s medical record documentation must support medical necessity for the SBIRT services provided. The record must be maintained by the SBIRT provider and be readily available for review whenever requested by HHSC or its designee.
2. SBIRT documentation for screening must include:
	1. The provider who performed the SBIRT screening; and
	2. Screening results from a standardized screening tool or laboratory results such as BAC, toxicology screen, or other measures showing risk for alcohol and/or substance use and the specific screening tool used.
3. 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 1-99408. The plan must include the following:
	1. The provider who performed the SBIRT brief intervention, if different from the provider who screened the person;
	2. Start and stop time of the session, or the total time spent providing SBIRT services to the person must be documented;
	3. Goal(s) established;
	4. Specific strategies to achieve the goal(s);
	5. The person’s support system, such as family members, a legal guardian, or friends, 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; and
	6. The name, address, and phone number of the provider to that the person has been referred for substance use disorder treatment.
4. All services outlined in this policy are subject to retrospective review, to include services delivered by telemedicine or telehealth, to ensure that the documentation in the person’s medical record supports the medical necessity of the service(s) provided.

### Telemedicine and Telehealth

1. 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.

# OUTPATIENT MENTAL HEALTH SERVICES

## Statement of Benefits

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 (individual, family or group ), psychological, neurobehavioral or neuropsychological testing, pharmacological management and electroconvulsive therapy (ECT).

### Telemedicine and Telehealth

1. 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.
2. 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.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. The following outpatient mental health 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. Outpatient mental health services provided by synchronous audiovisual technology must be billed using modifier 95.
	1. Psychiatric diagnostic evaluation services with and without medical services (procedure codes 1-90791 and 1-90792)
	2. Psychotherapy (individual, family, or group) services (procedure codes 1-90832, 1-90833, 1-90834, 1-90836, 1-90837, 1-90838, 1-90846, 1-90847, 1-90853, 1-99354 and 1-99355)
	3. Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only
	4. Neurobehavioral services (procedure codes 1-96116 and 1-96121).
	5. Psychological testing services (procedure codes 1-96130, 1-96131, 1-96136 and 1-96137) if the following conditions are met:
		1. The psychometric test must be available in an online format;
		2. The provider, or test administrator, must observe the person, in real-time, for the duration of the test; and
		3. The provider must adhere to professional guidelines for delivering psychometric tests by telehealth established by The American Psychological Association, American Board of Professional Psychology and The National Register of Health Service Psychologists.

#### Synchronous Telephone (Audio-Only) Technology

1. The following outpatient mental health services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an ‘existing clinical relationship’ and 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. Outpatient mental health services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.
	1. Psychiatric diagnostic evaluation services with and without medical services (procedure codes 1-90791 and 1-90792)
	2. Psychotherapy (individual, family, or group) services (procedure codes 1-90832, 1-90833, 1-90834, 1-90836, 1-90837, 1-90838, 1-90846, 1-90847, 1-90853, 1-99354 and 1-99355)
	3. Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only
2. An ‘existing clinical relationship’ occurs when a person has received at least one in-person or synchronous audiovisual outpatient mental health service from the same provider within the 6 months prior to the initial service delivered by synchronous telephone (audio-only) technology. The 6-month requirement for at least one in-person or synchronous audiovisual service prior to the initial synchronous telephone (audio-only) service may not be waived.
3. The provider is required to conduct at least one in-person or synchronous audiovisual outpatient mental health 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 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:
	1. 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
	2. 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)

## Documentation Requirements

1. In addition to documentation requirements outlined in the “Authorization Requirements” section of this policy, if any, the following requirements apply:
	1. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the person’s medical record supports the medical necessity of the service or services provided.
2. Supporting documentation for individual, family or group psychotherapy services must include:
	1. Start and end time of session
	2. Modality or modalities utilized
	3. Frequency of psychotherapy sessions
	4. Clinical notes for each visit must, including diagnosis, symptoms, functional status, focused mental status examination (if indicated), treatment plan, prognosis and progress, and name, signature and credentials of the individual performing the service or services
3. Supporting documentation for psychiatric diagnostic evaluation services must include:
	1. Reason for referral or presenting problem
	2. Prior diagnoses and any prior treatment
	3. Other pertinent medical, social and family history
	4. Clinical observations and results of mental status examination
	5. Complete diagnosis utilizing diagnostic criteria in the current edition of the DSM
	6. Recommendations, including expected long- and short-term goals
4. Supporting documentation for pharmacological management services must include:
	1. Complete diagnosis utilizing diagnostic criteria in the current edition of the DSM
	2. Current list of medications
	3. Current psychiatric symptoms and problems, including presenting mental status
	4. Problems, reactions and side effects, if any, to medications
	5. Any medication modifications made during a visit and the reasons for medication adjustments, changes or continuation
	6. Desired therapeutic drug levels, if applicable, for medications requiring blood level monitoring, e.g. Lithium
	7. Current laboratory values, if applicable, for medications requiring monitoring for potential side effects, e.g. hyperglycemia caused by anti-psychotic medications
	8. Treatment goals
5. Supporting documentation for psychological, neurobehavioral or neuropsychological testing services must include:
	1. Reason for referral or presenting problem
	2. The name of the tests (e.g., WAIS-R, Rorschach, MMPI) performed
	3. The scoring of the test
	4. Location where the testing is performed
	5. The name and credentials of each provider involved in administering, interpreting and preparing the report
	6. Test interpretations, including narrative descriptions of the test findings
	7. 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
	8. Recommended treatment, including how test results affect the prescribed treatment
	9. Recommendations for further testing, including an explanation to substantiate the necessity for retesting, if applicable
	10. 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
	11. Original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC
	12. When psychological, neurobehavioral or neuropsychological testing is performed in a SNF, ICF or ECF, a copy of the test and the resulting report must be maintained in the person’s medical record at the facility

### Telemedicine and Telehealth

1. 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.

# PEER SPECIALIST SERVICES

## Statement of Benefits

Peer specialist services are a benefit of Texas Medicaid for persons 21 years of age or older with a mental health or substance use condition or both, 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: Recovery and wellness support, which includes providing information on and support with planning for recovery; Mentoring, which includes serving as a role model and aiding in finding needed community resources and services; and Advocacy, which includes providing support in 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.

### Telemedicine and Telehealth

1. 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.
2. 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.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. Peer specialist 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. 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.

#### Synchronous Telephone (Audio-Only) Technology

1. Peer specialist services may be provided by synchronous telephone (audio-only) technology to persons with whom the peer specialist has an ‘existing clinical relationship’ and if clinically appropriate and safe, as determined by the 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 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.
2. An ‘existing clinical relationship’ occurs when a person has received at least one in-person or synchronous audiovisual peer specialist service from the same provider within the 6 months prior to the initial service delivered by synchronous telephone (audio-only) technology. The 6-month requirement for at least one in-person or synchronous audiovisual service prior to the initial synchronous telephone (audio-only) service may not be waived.
3. The provider is required to conduct at least one in-person or synchronous audiovisual 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 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:
	1. 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.
	2. 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.

## Documentation Requirements

1. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the person’s medical record supports the medical necessity of the service(s) provided.
2. The enrolled provider shall ensure proper documentation of all peer specialist services delivered.
3. Documentation of peer specialist services shall indicate the date, time, and place of service, and shall summarize the purpose and content of the services, along with specific strategies and activities utilized as related to the goal(s) in the person’s plan of care.
4. Peer specialist supervisors must document all supervisory sessions and maintain records in the peer specialist’s employee personnel file.

### Telemedicine and Telehealth

1. 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.

# SUBSTANCE USE DISORDER SERVICES

## Statement of Benefits

Substance use disorders (SUD) 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 euphoriants 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) Diagnostic and Statistical Manual of Mental Disorders (DSM).

### Telemedicine and Telehealth

1. 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.
2. 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.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. The following SUD 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. SUD services provided by synchronous audiovisual technology must be billed using modifier 95.
	1. Comprehensive assessment (procedure code1-H0001)
	2. Individual and group counseling (procedure codes 9-H0004 and 9-H0005)

#### Synchronous Telephone (Audio-Only) Technology

1. The following SUD services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an ‘existing clinical relationship’ and 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. SUD services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.
	1. Comprehensive assessment (procedure code1-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.
	2. Individual and group counseling (procedure codes 9-H0004 and 9-H0005)
2. An ‘existing clinical relationship’ occurs when a person has received at least one in-person or synchronous audiovisual SUD service from the same provider within the 6 months prior to the initial service delivered by synchronous telephone (audio-only) technology. The 6-month requirement for at least one in-person or synchronous audiovisual service prior to the initial synchronous telephone (audio-only) service may not be waived.
3. The provider is required to conduct at least one in-person or synchronous audiovisual SUD 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 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:
	1. 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
	2. 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)

## Documentation Requirements

1. In addition to documentation requirements outlined in the “Prior Authorization Requirements” section of this policy, the following requirements apply:
	1. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the person’s medical record supports the medical necessity of the service(s) provided.

### Telemedicine and Telehealth

1. 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.

# PHYSICIAN EVALUATION AND MANAGEMENT SERVICES

## Statement of Benefits

Evaluation and management (E/M) services are a benefit of Texas Medicaid. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS when selecting the level of service provided.

### Office or Other Outpatient Services

1. Outpatient services are defined as services rendered in an outpatient setting such as a physician’s office, ambulatory facility, and/or other outpatient setting.

#### New Patient Services

1. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
2. A new patient visit will be limited to one every three years, per patient, per provider.
3. Providers must utilize one of the following procedure codes for new patient services provided in the office setting, or in an outpatient or other ambulatory facility.

#### Established Patient Services

1. An established patient is one who has received professional services from the physician or another physician of the exact same specialty who belongs to the same group practice, within the past three years.
2. Established E/M services are limited to once per day, same provider.
3. Providers must utilize one of the following procedure codes for established patient services provided in the office setting, or in an outpatient or other ambulatory facility.

### Office or Other Outpatient Services by Telemedicine

1. 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.
2. Providers must provide 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, services in full accordance with all applicable licensure and certification requirements.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. The following office and outpatient 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. New patient and established patient services provided by synchronous audiovisual technology must be billed using modifier 95.
	1. New and established patient services (procedure codes 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214 and 1-99215)

#### Synchronous Telephone (Audio-Only) Technology

1. For the diagnosis, evaluation and treatment of a mental health or substance use condition, the following office and other outpatient 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. Established patient services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.
	1. Established patient services (procedure codes 1-99212, 1-99213, 1-99214 and 1-99215)
	2. Established patient service (procedure code 1-99211) – Only during certain public health emergencies.

## Documentation Requirements

1. In addition to documentation requirements outlined in the “Authorization Requirements” section of this policy, if any, the following requirements apply.
	1. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the client’s medical record supports the medical necessity of the service(s) provided.

### Telemedicine and Telehealth

1. 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.

# MENTAL HEALTH TARGETED CASE MANAGEMENT

## Statement of Benefits

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 (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), and who have been determined via a uniform assessment process to need MHTCM services. Excluded from this benefit are 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). MHTCM services are services furnished to assist persons in gaining access to needed medical, social, behavioral, educational, and other services and supports.

### Telemedicine and Telehealth

1. 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.
2. 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 requirements.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. MHTCM 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 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.

#### Synchronous Telephone (Audio-Only) Technology

1. MHTCM services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an ‘existing clinical relationship’ and if clinically appropriate and safe, as determined by the 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.
2. An ‘existing clinical relationship’ occurs when a person has received at least one in-person or synchronous audiovisual MHTCM service from the same provider within the 6 months prior to the initial service delivered by synchronous telephone (audio-only) technology. The 6-month requirement for at least one in-person or synchronous audiovisual service prior to the initial synchronous telephone (audio-only) service may not be waived.
3. The provider is required to conduct at least one in-person or synchronous audiovisual MHTCM 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 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:
	1. 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.
	2. 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).

## Documentation Requirements

1. 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.
2. MHTCM services, including attempts to provide MHTCM services, must be documented in the person’s medical record.
3. 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.
4. 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 the assigned case manager must document steps taken to meet the child’s or youth’s goals and needs in the child’s or youth’s progress notes.
5. As a result of the meetings, 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.
6. The case manager must document the following for all services provided:
	1. The event or behavior that occurs while providing the MHTCM service or the reason for the specific case management encounter
	2. The person, persons, or entity, including other case managers, with whom the encounter or contact occurred
	3. 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
	4. The recovery plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goals
	5. The timeline for obtaining the needed services
	6. The specific intervention that is being provided
	7. The date the MHTCM service was provided
	8. The start and end time of the MHTCM service
	9. The mode of delivery used to provide the MHTCM service
	10. The name of the provider agency and the signature of the employee providing the MHTCM service, including their credentials
	11. The timeline for reevaluating the needed services
7. 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.
8. The provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules, and regulations.

### Telemedicine and Telehealth

1. 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.

## Prior Authorization Requirements

### Initial Authorization Requirements

1. 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.
2. 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:
	1. 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;
	2. An LPHA determines the diagnosis which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
	3. 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
	4. An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.
3. 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.
4. 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:
	1. 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
	2. 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).
5. For persons enrolled in managed care, Local Mental Health Authorities (LMHAs) 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.
6. For persons in fee-for-service (FFS) Medicaid, LMHAs 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:
	1. Section A – Client information
		1. Complete as indicated in the form.
	2. Section B – Requested procedure or service information
		1. The type of request is ‘Other’
		2. The expected dates of service are the start and end dates provided by CMBHS
		3. The procedure related CPT code is the code for MHTCM and the appropriate modifier(s)
		4. The comments text box must indicate if the prior authorization request is an ‘initial assessment’ or ‘reassessment’
	3. Section C – To be completed by requesting physician or requesting provider
		1. The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
		2. 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:
			1. 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;
			2. 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
			3. If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
		3. Complete provider information as indicated in the form
			1. The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.
7. All plans of care are subject to retrospective review by the state.

### Reauthorization Requirements

1. 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:
	1. every 90 calendar days for persons 20 years of age and younger; or
	2. 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).

## Reimbursement/Billing Guidelines

MHTCM claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA 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.

# MENTAL HEALTH REHABILITATIVE SERVICES

## Statement of Benefits

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 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 community integration, community tenure and behaviors resulting from serious mental illness or serious emotional disturbance 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, and day programs for acute needs.

### Telemedicine and Telehealth

1. 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.
2. Providers must provide mental health rehabilitation 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, mental health rehabilitation services in full accordance with all applicable licensure and certification requirements.
3. During a Declaration of State of Disaster, 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. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

#### Synchronous Audiovisual Technology

1. The following mental health rehabilitation 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 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. Mental health rehabilitation services provided by synchronous audiovisual technology must be billed using modifier 95.
	1. Medication training and support (procedure code 1-H0034).
	2. Skills training and development (procedure code 1-H2014).
	3. Psychosocial rehabilitation services (procedure code 1-H2017)
	4. Crisis intervention services (procedure code 1-H2011).
		1. 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.

#### Synchronous Telephone (Audio-Only) Technology

1. The following mental health rehabilitation services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an ‘existing clinical relationship’ and if clinically appropriate and safe, as determined by the 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 must document in the person’s medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. Mental health rehabilitation services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.
	1. Medication training and support (procedure code 1-H0034).
	2. Skills training and development (procedure code 1-H2014).
	3. Psychosocial rehabilitation services (procedure code 1-H2017).
	4. Crisis intervention services (procedure code 1-H2011)
		1. 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 treating 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.
		2. 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.
	5. An ‘existing clinical relationship’ occurs when a person has received at least one in-person or synchronous audiovisual mental health rehabilitation service from the same provider within the 6 months prior to the initial service delivered by synchronous telephone (audio-only) technology. The 6-month requirement for at least one in-person or synchronous audiovisual service prior to the initial synchronous telephone (audio-only) service may not be waived.
	6. The provider is required to conduct at least one in-person or synchronous audiovisual mental health rehabilitation 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 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:
		1. 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.
		2. 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).

## Documentation Requirements

1. 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.
2. Each person 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.
3. A rehabilitative services provider must document the following for all mental health rehabilitative services:
	1. The name of the person to whom the service was provided
	2. The type of service provided
	3. The specific goal or objective addressed, and the modality and method used to provide the service
	4. The date the service was provided
	5. The start and end time of the service
	6. The location where the service was provided
	7. The signature of the staff member providing the service and a notation of their credential
	8. Any pertinent event or behavior relating to the person’s treatment which occurs during the provision of the service
	9. The outcome or progress in achieving treatment plan goals

### Crisis Services Documentation

1. In addition to the general requirements described above, when providing crisis services, a provider must document the following information:
	1. Risk of suicide and/or homicide
	2. Substance use
	3. Trauma, abuse, or neglect
	4. 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)
	5. All actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented
	6. The response of the person, and if appropriate, the response of the LAR and family members
	7. Any pertinent event or behavior relating to the person’s treatment which occurs during the provision of the service
	8. Follow up activities, which may include referral to another provider

### Medical Necessity Documentation

1. An LPHA must review authorizations and re-authorizations for medical necessity.
2. Day programs for acute needs: the documentation must be made daily.
3. For all other services, the documentation must be made after each face-to-face contact that occurs to provide the mental health rehabilitative service.
4. 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; and, if the crisis intervention services were determined to meet medical necessity, document the medical necessity for such services.
5. Services are subject to retrospective review and recoupment if documentation does not support the service billed.
6. A provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

### Telemedicine and Telehealth

1. 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.

## Prior Authorization Requirements

### Initial Authorization Requirements

1. Except for crisis intervention services, providers of mental health rehabilitation services must not bill Texas Medicaid prior to the authorization or reauthorization of services.
2. 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 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 mental health rehabilitative services must ensure the following:
	1. A QMHP-CS or LPHA performs a screening for eligibility using the uniform assessment;
	2. An LPHA determines the diagnosis which must include an interview with the person conducted either in-person or by telemedicine or telehealth;
	3. 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
	4. An LPHA reviews the recommended LOC and verifies whether the services are medically necessary.
3. 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 following:
	1. 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
	2. The clinical justification for the request that includes 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).
4. For persons enrolled in managed care, Local Mental Health Authorities (LMHAs) 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.
5. For persons in fee-for-service (FFS) Medicaid, LMHAs 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:
	1. Section A – Client information
		1. Complete as indicated in the form.
	2. Section B – Requested procedure or service information
		1. The type of request is ‘Other’
		2. The expected dates of service are the start and end dates provided by CMBHS
		3. 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)
		4. The comments text box must indicate if the prior authorization request is an ‘initial assessment’ or ‘reassessment’
	3. Section C – To be completed by requesting physician or requesting provider
		1. The diagnosis(es) is/are the ICD-10 primary diagnosis and related ICD-10 diagnosis code(s)
		2. 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:
			1. The word ‘Deviation’ with a note that the request is for prior authorization of a LOC that is higher or lower than recommended LOC;
			2. 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
			3. If requested by the TMHP Prior Authorization Department, a copy of the CANS or ANSA functional assessment.
		3. Complete provider information as indicated in the form
			1. The SMPA form must be signed and dated within 30 calendar days of the expected start date of services.
6. 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.
7. All plans of care are subject to retrospective review by the state.

### Reauthorization Requirements

1. 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:
	1. every 90 calendar days for persons 20 years of age and younger; or
	2. 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)*.*

1. Prior to the expiration of the authorization period, or depletion of the amount of services authorized, providers must:
	1. Determine whether the person continues to need mental health rehabilitative services; and
	2. An LPHA must determine whether the continuing need for mental health rehabilitative services meets the definition of medical necessity.
2. If the determination is that the person continues to need mental health rehabilitative services and that such services are medically necessary, the provider must:
	1. Request another authorization for the same type and amount of mental health rehabilitative service previously authorized; or
	2. Submit a request, with documented clinical reasons for such request, to change the type or amount of mental health rehabilitative services previously authorized if:
		1. The provider determines the type or amount of mental health rehabilitative services previously authorized is inappropriate to address the person’s needs; and
		2. The criteria described in the TRR Utilization Management Guidelines for changing the type or amount of mental health rehabilitative services has been met.

## Reimbursement/Billing Guidelines

MHR claims submitted by non-LMHAs for dual-eligible persons will be processed by TMHP in the same manner that dual-eligible LMHA 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.