Outpatient Mental Health Services

Summary of proposed changes being made to the Outpatient Mental Health Services Policy:

- Allow pre-doctoral psychology interns to perform psychological services when delegated by a Medicaid enrolled clinical psychologist
- Revise the 30 visit per year limit in FFS to only include psychotherapy visits; psychological testing, psychiatric evaluations, electroconvulsive therapy, and office visits billed as Evaluation & Management services no longer count toward this annual limit
- Allow psychological and neuropsychological testing to be conducted at nursing facilities, extended care facilities and intermediate care facilities by community-based providers (aligns with policy for all other outpatient mental health services)
- Make family psychotherapy without the child present a payable benefit
- Remove narcosynthesis as a payable benefit
- Streamline the prior authorization request process by creating one multi-purpose form for all outpatient mental health services (with the exception of 90899 which still requires a separate request form)
- Rename the policy Outpatient Mental Health Services (currently Outpatient Behavioral Health Services) to more clearly distinguish it from the Substance Use Disorder policy (TMPPM handbook continues to be called Behavioral Health as it addresses both sets of services under one umbrella)

IMPORTANT:
The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in this policy are subject to National Correct Coding Initiative (NCCI) guidelines. According to federal law, Texas Medicaid and the CSHCN Services Program may impose stricter limitations than are imposed by the Centers for Medicare and Medicaid Services (CMS). Additional restrictions made by Texas Medicaid and the CSHCN Services Program may be outlined in the Texas Medicaid and CSHCN Services Program medical policies. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.cms.gov/MedicaidNCCICoding/ for correct coding guidelines and specific applicable code combinations. In instances when Texas Medicaid or CSHCN Services Program medical policy is more restrictive than NCCI MUE guidance, Texas Medicaid or CSHCN Services Program medical policy prevails.

Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid covered services to eligible clients. Administrative procedures such as prior authorization, precertification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee for service) and from MCO to MCO. Providers should contact the client’s specific MCO for details.

Statement of Benefits

1 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 client and, utilizing therapeutic interventions, attempts to alleviate the symptoms of mental illness or emotional disturbance, and reverse, change or ameliorate maladaptive patterns of behavior.

Policy Overview/Scope

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

- Individual psychotherapy is defined as therapy that focuses on the client but may include others in the session with the goals of treatment focused on the client versus others in attendance.
- 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. Family psychotherapy may include a certain number of sessions with the parent or parents only to address topics that would not be appropriate to discuss with a child present.
- Group psychotherapy is a type of psychotherapy that involves one or more therapists working with several clients at the same time.
- Psychological or Neuropsychological Testing involves the use of formal tests and other assessment tools to measure and assess a client’s emotional, and cognitive functioning in order to arrive at a diagnosis and guide treatment.
- Pharmacological Management is the in-depth management of psychopharmacological agents to treat a member’s mental health symptoms.
- Electroconvulsive therapy is the induction of convulsions by the passage of an electric current through the brain used in the treatment of certain psychiatric disorders.
- Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. Psychiatric diagnostic evaluation with medical service also includes a medical assessment, other physical examination elements as indicated, and may also include prescription of medications, and laboratory or other diagnostic studies.

3 Outpatient mental health services are benefits of Texas Medicaid when provided to clients who are experiencing a mental health issue that is causing distress, dysfunction and/or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the current edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Note that claims will require the corresponding diagnosis code(s) from the most current edition of the International Classification of Diseases (ICD).

4 Outpatient mental health services performed by the following providers are a benefit to clients of any age with the diagnoses listed in the Appendix, when provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations:
- Physician/psychiatrist (M.D. or D.O.)
- Advanced Practice Registered Nurse (APRN)
• Licensed Clinical Social Worker (LCSW)
• Physician Assistant (PA)
• Licensed Professional Counselor (LPC)
• Licensed Marriage and Family Therapist (LMFT)
• Licensed psychologist
• Licensed Psychological Associate (LPA) under the direct supervision of a psychologist in accordance with the Texas State Board of Examiners of Psychologists (TSBEP)
• Provisionally Licensed Psychologist (PLP) under the direct supervision of a psychologist in accordance with the TSBEP
• Pre-doctoral Psychology Interns enrolled in a formal internship under the direct supervision of a psychologist in accordance with the TSBEP

5 Psychotherapy for clients with Alzheimer’s disease or dementia may be a benefit of Texas Medicaid for clients with very mild or mild cognitive decline.

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

Authorization Requirements

7 Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the electronic Signatures in Prior Authorizations medical policy.

8 All providers are required to adhere to prior authorization requirements.

9 Prior authorization is not required for the following services:
  • One psychiatric diagnostic evaluation (procedure code 90791 or 90792) per client, per year, per provider (same provider)
  • 30 psychotherapy visits per client per year
  • 4 hours of mental health services per client per day
  • 8 hours of psychological or neuropsychological testing per client per year
  • Electroconvulsive therapy

10 Psychotherapy services (individual, family or group) exceeding 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization requests in increments of up to 10 additional encounters/visits may be considered. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:
• Identifying client information
• Provider name and identifier
• 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 DFPS-directed services

11 Providers with established clients must request prior authorization when they determine the client is approaching 30 encounters or visits for the calendar year. If the client changes providers during the year and the new provider is unable to obtain complete information on the client’s encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

12 Additional psychiatric diagnostic interviews 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 Department of Family and Protective Services (DFPS) directive
• If a major change of status occurs

13 Psychological testing (procedure code 96101) or neuropsychological testing (procedure code 96118) require prior authorization if more than 4 hours of testing per day, or more than 8 hours of testing per calendar year are medically necessary. The request must be submitted on an Outpatient Mental Health Services Request Form and include the following information:
• Identifying client information
• Provider name and identifier
• Current DSM diagnosis(es)
• Indication of court-ordered or DFPS-directed services
• Type of testing requested (psychological or neuropsychological) including specific procedure code(s)
• Rationale for requested testing
• Previous history and testing results

14 Requests for prior authorization for procedure code 90899 (Unlisted psychiatric service or procedure) must be submitted by the provider to the Special Medical Prior Authorization (SMPA) department using the SMPA
request form with documentation supporting medical necessity including:

- Client's diagnosis(es)
- Prior treatment for this diagnosis(es) 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

Reimbursement/Billing Guidelines

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

Table A: Procedure Codes for Outpatient Mental Health Services

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>90791</td>
</tr>
<tr>
<td>90792</td>
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<tr>
<td>90832</td>
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<tr>
<td>90833</td>
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<tr>
<td>90834</td>
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<tr>
<td>90836</td>
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<tr>
<td>90837</td>
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<tr>
<td>90838</td>
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<tr>
<td>90846</td>
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<tr>
<td>90847</td>
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<tr>
<td>90853</td>
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<tr>
<td>90870</td>
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<tr>
<td>90899</td>
</tr>
<tr>
<td>96101</td>
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<tr>
<td>96118</td>
</tr>
</tbody>
</table>
The following procedure codes are subject to a 30 visit per year limitation:

Table B: Procedure Codes for Outpatient Mental Health Services

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
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<tr>
<td>90833</td>
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<tr>
<td>90834</td>
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<tr>
<td>90836</td>
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<tr>
<td>90837</td>
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<tr>
<td>90838</td>
</tr>
<tr>
<td>90846</td>
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<tr>
<td>90847</td>
</tr>
<tr>
<td>90853</td>
</tr>
</tbody>
</table>

Telemedicine and Telehealth

 Certain outpatient mental health services may be provided by distant site providers through telemedicine or telehealth when billed with the GT modifier. See the Telemedicine and Telehealth Services policies for additional information.

Mental health services delivered through telemedicine or telehealth do not require a patient site presenter unless the patient is experiencing a mental health emergency.

Psychotherapy

 Providers must bill with modifier 59 when performing individual psychotherapy (procedure codes 90832, 90834, or 90837) and family psychotherapy (procedure code 90847) on the same day for the same client. When billing for these services, providers must append modifier 59 to the family psychotherapy procedure code 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 client. Documentation that supports the provision of distinct or independent services must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Table C: Billing individual psychotherapy and family psychotherapy on the same day

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most appropriate Procedure code</td>
<td>59</td>
</tr>
</tbody>
</table>

Procedure codes 90833, 90836, and 90838 are add on codes and must be billed with the appropriate primary E/M code.

When billing for psychotherapy using the Prolonged Services E/M codes 99354 and 99355, providers
must also include the appropriate psychotherapy add on code (90833, 90836, 90838) to indicate the prolonged service is psychotherapy related.

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

23 LMFTs must bill with modifier U8 to differentiate from Licensed Professional Counselors.

Table D: Billing for LMFTs

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most appropriate</td>
<td>U8</td>
</tr>
</tbody>
</table>

Family Psychotherapy

24 Regardless of the number of family members present per session, family psychotherapy is reimbursable for only one Medicaid eligible client per session.

25 Family psychotherapy may be provided for Medicaid recipients of any age using procedure code 90847.

26 Family psychotherapy for Medicaid recipients under the age of 21 may be provided to the child's parent(s), foster parent(s) or legal guardian without the child present (using procedure code 90846) when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

Table E: Family Psychotherapy Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>For Medicaid recipient under the age of 21</td>
</tr>
<tr>
<td>90847</td>
<td>For Medicaid recipients of any age</td>
</tr>
</tbody>
</table>

27 Only specific relatives are allowed to participate in family psychotherapy services. The following relatives may be included in family therapy 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

Twelve Hour System Limitation
The following provider types are limited in reimbursement to a maximum combined total of 12 hours per provider, per day, regardless of number of patients seen, for outpatient mental health services:

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

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

Table F: Procedure Codes Included in the 12-hour System Limitation

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90792</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90832</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90833</td>
<td>30 minutes with patient and/or family member when performed with an Evaluation and Management service. (List separately in addition to the code for primary procedure.)</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>45 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>90836</td>
<td>45 minutes with patient and/or family member when performed with an Evaluation and Management service. (List separately in addition to the code for primary procedure.)</td>
<td>45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90838</td>
<td>60 minutes with patient and/or family member when performed with an Evaluation and Management service. (List separately in addition to the code for primary procedure.)</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90846</td>
<td>N/A</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>N/A</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96101</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96118</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

Court-ordered and DFPS directed services are not subject to the 12-hour per provider, per day system limitation when billed with modifier H9.
31 M.D.s and D.O.s can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

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

Delegated Services
33 Delegated psychological services provided by LPAs or PLPs must be performed within the scope of practice of their respective licensure and under the direct supervision of a licensed psychologist.

34 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.

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

36 Services provided by a psychologist, LPA, PLP, or psychology intern must be billed with a modifier. Any claim submitted without a modifier will be denied. Psychological services provided by an LPA, PLP or psychology intern must be billed under the supervising psychologist’s Medicaid identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.

37 Services performed by the LPA, PLP or psychology intern will be reduced to 70 percent of the psychologist reimbursement fee schedule rate. A psychologist’s services must be billed with modifier AH; LPA services must be billed with modifier UC; PLP services must be billed with modifier Ug; psychology intern services must be billed with modifier UB. Claims submitted without a modifier or with two of these modifiers on the same detail will be denied.

Table G: Modifiers used with Procedure Codes for Licensed Psychologist Services

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>UB</td>
<td>Identifies service provided by a psychology intern</td>
</tr>
<tr>
<td>UC</td>
<td>Identifies service provided by an LPA</td>
</tr>
<tr>
<td>Ug</td>
<td>Identifies service provided by a PLP</td>
</tr>
</tbody>
</table>

39 Only the LCSW, LMFT, LPC, APRN, or PA actually 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.

Pharmacological Management
40 Pharmacological management is a physician service and cannot be provided by a non-physician or
"incident to" a physician service, with the exception of APRNs and PAs whose scope of license in this state permits them to prescribe.

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

42 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 client's condition, along with modifier UD to designate the visit as primarily focused on pharmacological management.

Table H: Procedure Code for Pharmacological Management

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most appropriate E/M code</td>
<td>UD</td>
</tr>
</tbody>
</table>

Electroconvulsive Therapy

43 ECT is limited to one service per day, per client, by any provider in any setting.

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

Psychiatric Diagnostic Evaluation

45 A psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) may be reimbursed to psychiatrists, psychologists, APRNs, PAs, LCSWs, LPCs, LMFTs, LPAs, PLPs, and psychology interns.

46 A psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792) may be reimbursed to psychiatrists, APRNs, and PAs.

47 A psychiatric diagnostic evaluation (procedure code 90791 or 90792) is limited to the following:

- Once per client, per day, any provider, regardless of the number of professionals involved in the interview.
- Once per client, per year, per provider (same provider) in the office, home, outpatient hospital, or other settings.

Testing

48 Psychological and neuropsychological testing will not be reimbursed to an APRN or a PA. The most appropriate office encounter/visit code must be billed.

49 Mental health screening may be performed during an assessment by an APRN or a PA, but will not be reimbursed separately.

50 Psychological testing (procedure code 96101) or neuropsychological testing (procedure code 96118) may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (procedure code 90791 or 90792).
Psychological testing (procedure code 96101) done on the same date of service as neuropsychological testing (procedure code 96118) will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

The reimbursement for procedure codes 96101 and 96118 includes the face-to-face testing and the scoring and interpretation of the results. The number of units in the claim must reflect the time spent face-to-face testing with the client plus the time spent scoring and interpreting the results in one hour increments.

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

Testing in Facilities

Psychological testing (procedure code 96101) or neuropsychological testing (procedure code 96118) may be reimbursed when provided in a SNF, ICF or ECF as clinically indicated. Testing may be indicated, for example, when a resident has experienced a significant change in mental status requiring specialized testing, or to evaluate a patient's competency to return to a community-based setting. Patients with well-established mental or cognitive issues do not require additional testing.

Psychological 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).

Documentation Requirements

In addition to documentation requirements outlined in the "Authorization Requirements" section of this policy, if any, the following requirements apply:

- 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.

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

- Start and end time of session
- Modality or modalities utilized
- Frequency of psychotherapy sessions
- Clinical notes for each encounter must include: diagnosis; symptoms; functional status; focused mental status examination if indicated; treatment plan, prognosis, and progress; name, signature and credentials of person performing the service

Supporting documentation for psychiatric diagnostic evaluations must include:

- Reason for referral and/or presenting problem
- Prior diagnoses and any prior treatment
Supporting documentation for pharmacological management must include:

- A complete diagnosis utilizing diagnostic criteria from the current edition of the DSM
- Current list of medication(s)
- Current psychiatric symptoms and problems, to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment
- Problems, reactions and side effects, if any, to medications
- Any medication modifications made during visit and the reasons for medication adjustments, changes or continuation
- 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 goal(s)

Supporting documentation for psychological or neuropsychological testing must include:

- The name of the tests(s) (e.g., WAIS-R, Rorschach, MMPI) performed
- The scoring of the test
- Location the testing is performed
- The name and credentials of each provider involved in administering, interpreting and preparing the report
- Interpretation of the test to include narrative descriptions of the test findings
- Length of time spent by each provider, as applicable, in face-to-face 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 to include 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 client’s condition requires testing over two days and client does not return, or the client’s condition precludes completion of the testing
- The original testing material must be maintained by the provider and
must be readily available for retrospective review by HHSC.

- When psychological 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 patient’s medical record at the facility.

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