# OUTPATIENT BEHAVIORAL HEALTH

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**NOVEMBER 2026**

TEXAS
Health and Human
Services

# OUTPATIENT BEHAVIORAL HEALTH

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## 29.1 Enrollment

To enroll in the CSHCN Services Program, outpatient behavioral health providers are required to be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state outpatient behavioral health providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

The CSHCN Services Program enrolls the following types of providers of outpatient behavioral health services:

- Licensed marriage and family therapist (LMFT)
- Licensed clinical social worker (LCSW, formerly LMSW-ACP)
- Licensed professional counselor (LPC)
- Licensed psychologist or neuropsychologist (PhD)
- Psychiatrist (doctor of medicine [MD] or doctor of osteopathy [DO])

***Important:*** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

***Refer to:*** Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

### 29.1.1 Provisionally Licensed Psychologist (PLP)

The Texas State Board of Examiners of Psychologist (TSBEP) requires the provisionally licensed psychologist (PLP) to work under the direct supervision of a licensed psychologist and does not allow a PLP to engage in independent practice. Therefore, a PLP will not be independently enrolled in the CSHCN Services Program and must provide services under the delegating psychologist's National Provider Identifier (NPI).

## 29.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program does not provide outpatient behavioral health services to clients who are also enrolled in Texas Medicaid, Comprehensive Care Program (CCP), or Children's Health Insurance Program (CHIP).

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Outpatient behavioral health services are limited to no more than 30 encounters by all practitioners per client, per calendar year. Benefits include, but are not limited to, psychological testing, neuropsychological testing, psychotherapy, and counseling.

Laboratory and radiology services do not count toward the 30 outpatient encounters per client, per calendar year limitation. Pharmacological management does not count toward the 30 encounters per client, per calendar year limitation.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects. Pharmacological management represents a skilled aspect of client care and is intended for use by clients who are being managed primarily by psychotropics or other types of psychopharmacologic medications that are part of the billable E/M visit.

The focus of a pharmacological management encounter is the use of medication for relief of a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness, which necessitates a discussion beyond minimal psychotherapy or counseling in a given day, the focus of the service is broader and is considered outpatient psychotherapy or counseling rather than pharmacological management.

Visits for the sole purpose of pharmacological management should be billed as a regular physician visit, not as a behavioral health visit using the appropriate E/M procedure code. Pharmacological management visits should be conducted on the basis of medical necessity.

### 29.2.1 Authorization Requirements

Authorization is not required for outpatient behavioral health services. The CSHCN Services Program may reimburse a maximum of 30 outpatient behavioral health services encounters by any practitioner per client, per calendar year.

### 29.2.2 Documentation Requirements

Services not supported by documentation in the client's medical record are subject to recoupment. All entries must be clear and concise, legible to individuals other than the author, and dated (month/date/year) and signed by the performing provider.

Documentation must include all of the following:

- Beginning and ending times for each counseling session or test administered
- Diagnosis
- Support for the medical necessity of the chosen treatment
- All pertinent information about the client's condition that substantiates the need for services, including, but not limited to, the following:
    - Reason for referral or the presenting problem
    - Prior history, including prior treatment
    - Other pertinent medical, social, and family history
    - Clinical observations and mental status examinations
    - The name of each test (e.g., WAIS-R, Rorschach, MMPI) administered
    - The scoring of the test
    - Narrative descriptions of the test findings
    - An explanation to substantiate the necessity of retesting, if testing is repeated
    - Background, symptoms, impression
    - Narrative description of the assessment

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- Behavioral observations during the counseling session
- Narrative description of the counseling session
- Treatment plan and recommendations, including expected long-term and short-term benefits

The original testing material must be maintained by the provider and readily available for retrospective review by the Department of State Health Services (DSHS) or its designee.

### 29.2.3 Pharmacological Management Services Documentation

Documentation for pharmacological management services must include the following:

- Complete diagnosis
- Medication history
- Current psychiatric symptoms and problems (including the presenting mental status or physical symptoms) that indicate the client requires a medication adjustment
- Problems, reactions, and side effects (if any) to medications or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Reasons for medication adjustments, changes, or continuation with anticipated outcomes
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Treatment goals

### 29.2.4 Reimbursement—The 12-Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day for inpatient or outpatient behavioral health services:

- Psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)

Each hour of testing counts towards the 12 hour limit. Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services and, as a result, may submit claims in excess of 12 hours per day.

Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services, and, as a result, may submit claims in excess of 12 hours per day. Additionally, because a psychologist can delegate to multiple PLPs and may submit claims for PLP services in excess of 12 hours per day, PLPs are not subject to the 12-hour system limitation. PLPs who perform delegated psychology services under the delegating psychologist's NPI are subject to retrospective review.

No single behavioral health services provider may be reimbursed for more than 12 hours of behavioral health services per day. As a result, all providers who are not subject to the 12-hour system limitation, and each provider to whom they delegate, are subject to retrospective review and recoupment.

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### 29.2.5 Procedure Codes Included in the 12-Hour System Limitation

The following table lists the outpatient behavioral health procedure codes included in the system limitation. The table also includes the time increments that the system applies based on the billed procedure code. The system uses the "time applied" time increments to determine whether the 12-hour-per-day system limitation has been exceeded.

| Procedure Code | Time Assigned by Procedure Code Description | Time Applied |
|---|---|---|
| 90791 | N/A | 60 minutes |
| 90792 | N/A | 60 minutes |
| 90832 | 30 minutes | 30 minutes |
| 90833 | 30 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 30 minutes |
| 90834 | 45 minutes | 45 minutes |
| 90836 | 45 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 45 minutes |
| 90837 | 60 minutes | 60 minutes |
| 90838 | 60 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 60 minutes |
| 90846 | N/A | 50 minutes |
| 90847 | N/A | 50 minutes |
| 96116 | 60 minutes | 60 minutes |
| 96121* | 60 minutes | 60 minutes |
| 96130 | 60 minutes | 60 minutes |
| 96131* | 60 minutes | 60 minutes |
| 96132 | 60 minutes | 60 minutes |
| 96133* | 60 minutes | 60 minutes |
| 96136 | 60 minutes | 30 minutes |
| 96137* | 60 minutes | 30 minutes |
| **N/A = Not Applicable**<br>***Add-on procedure codes must be billed with their corresponding primary procedure code.** | | |

***Note:*** *Procedure code 90853 is not included in the 12-hour system limitation, so it is not shown in the table.*

LCSWs, LMFTs, or LPCs may use only the following procedure codes when filing claims:

| Procedure Codes | | | | | |
|---|---|---|---|---|---|
| 90832 | 90834 | 90837 | 90846 | 90847 | 90853 |

LMFT services require the U8 modifier.

Only physicians, APRNs, and PAs may use the following procedure codes when filing claims:

| Procedure Codes | | | | |
|---|---|---|---|---|
| 90791 | 90792 | 90833 | 90836 | 90838 |

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Procedure codes 90833, 90836, and 90838 are add on codes and must be billed with a primary E/M code in order to be considered for reimbursement.

Physicians and psychologists may use the following procedure codes when filing claims:

| Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 90791 | 90832 | 90834 | 90837 | 90846 | 90847 | 90853 | 96116 | 96121* | 96130 |
| 96131* | 96132 | 96133* | 96136 | 96137 | | | | | |
| ***Add-on procedure codes must be billed with their corresponding primary procedure code.** | | | | | | | | | |

Clinical psychologist services must be submitted with the AH modifier.

PLP services may be reimbursed using procedure code 90791 with modifier U9.

### 29.2.6 Psychological Testing, Neuropsychological Testing, and Neurobehavioral Status Exams

Psychological testing (procedure codes 96130, 96131*, 96136, and 96137*), neurobehavioral status exams (procedure codes 96116 and 96121*), and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) are limited to a total of 4 hours per day and 8 hours per calendar year, per client, for any provider. Claims submitted for an amount greater than 4 hours per day or 8 hours per year must be submitted with documentation of medical necessity. All supporting documentation must be maintained by the provider in the client's medical record.

***Note:*** **Add-on procedure codes must be billed with their corresponding primary procedure code.*

Reimbursement of psychological testing, neurobehavioral status exams, and neuropsychological testing includes testing, scoring, and interpretation of results.

The number of units on 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.

If the performance, interpretation, and reporting of the testing span more than one day, the date of service on the claim must reflect the date and the time spent for each service performed.

- Providers must submit only one claim for each psychological or neuropsychological testing or neurobehavioral status exam performed, even if the scoring and interpretation cannot be completed on the same date as the testing.
- A claim must not be submitted until testing is complete. Providers can submit one claim with multiple details on separate claims for each date of service.

Psychological testing, neurobehavioral status exams, and neuropsychological testing are not reimbursed to an APRN or physician assistant. Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant, but is not reimbursed separately. The most appropriate office encounter code must be used.

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

Testing procedure codes 96116, 96121*, 96130, 96131, 96132, 96133*, 96136, and 96137* count toward the 30 per calendar year limitation.

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Psychological testing (procedure codes 96130, 96131*, 96136, and 96137*), neurobehavioral testing (procedure codes 96116 and 96121*), and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) will not be reimbursed on the same date of service when performed by the same provider.

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

## 29.2.7 Psychotherapy and Counseling

Reimbursement for outpatient psychotherapy or counseling is limited to no more than 4 hours per client, per day.

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

When more than one type of session (individual, group, or family outpatient psychotherapy or counseling) is provided by any provider on the same date of service, each session type will be reimbursed individually. Services are reimbursed only for clients who are eligible for the CSHCN Services Program.

Only the LMFT, LCSW, LPC, APRN, or PA provider actually performing the behavioral health service may bill the CSHCN Services Program. These providers must not bill for services performed by individuals under their supervision. A psychiatrist may bill for services performed by individuals under their supervision.

A psychologist may also bill for services performed by a PLP under their direct supervision.

Interpretation and documentation time is not reimbursed separately for psychotherapy or counseling procedures.

Psychotherapy and counseling services count toward the 30 per calendar year limitation.

Psychotherapy services must not be continued if no longer beneficial to the client.

Professional services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Hospitals are reimbursed 80 percent of the rate allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital's Medicaid interim rate.

### 29.2.7.1 Treatment for Alzheimer's and Dementia

Treatment for CSHCN Services Program clients with Stage 1, 2, or 3 Alzheimer's disease or dementia may be reimbursed with prior authorization as follows:

**Stage 1- No impairment (normal function)**

The person does not experience any memory problems. An interview with a medical professional does not show any evidence of symptoms of dementia

**Stage 2- Very mild cognitive decline (may be normal age-related changes or earliest signs of Alzheimer's disease)**

The person may feel as if he or she is having memory lapses - forgetting familiarwords or the location of everyday objects. But no symptoms of dementia can bedetected during a medical examination or by friends, family or co-workers

**Stage 3- Mild cognitive decline (early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms)**

Friends, family or co-workers begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common stage 3 difficulties include:

- Noticeable problems coming up with the right word or name
- Trouble remembering names when introduced to new people

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- Having noticeably greater difficulty performing tasks in social or work settings.
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing

Psychotherapy services must not be continued if no longer beneficial to the client.

Psychotherapy for clients with Alzheimer's disease or dementia is limited to the diagnoses listed below and must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

The following psychotherapy procedure codes for clients with Alzheimer's disease or dementia may be reimbursed for clients who meet one of the stages listed above and are diagnosed with one of the diagnosis codes listed below:

| Procedure Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 90832 | 90833 | 90834 | 90836 | 90837 | 90838 | 90846 | 90847 | 90853 |

| Diagnosis Codes | | | | | | | |
|---|---|---|---|---|---|---|---|
| F0390 | F03911 | F03918 | F0392 | F0393 | F0394 | F03A0 | F03A11 |
| F03A18 | F03A2 | F03A3 | F03A4 | F03B0 | F03B11 | F03B18 | F03B2 |
| F03B3 | F03B4 | F03C0 | F03C11 | F03C18 | F03C2 | F03C3 | F03C4 |
| G3184 | R41841 | | | | | | |

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.

Supporting documentation (certification of need) must be documented in the individual client's record. This documentation must be maintained by each facility, as applicable to state and federal guidelines, and be available upon request.

### 29.2.8 Psychiatric Diagnostic Evaluations

Psychiatric diagnostic evaluations (procedure codes 90791 or 90792) are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview.

Psychiatric diagnostic evaluations count toward the 30 per calendar year limitation.

### 29.2.9 Noncovered Services

The following behavioral health services are not benefits of the CSHCN Services Program:

- Services provided by a psychiatric nurse (registered nurse [RN] or licensed vocational nurse [LVN]), mental health worker, or licensed psychological associate (LPA)
- Thermogenic therapy
- Recreational therapy
- Psychiatric day care
- Psychiatric day treatment
- Psychiatric day hospital
- Partial hospitalization
- Neurofeedback including, but not limited to, electroencephalography (EEG) feedback
- Music therapy

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- Dance therapy
- Hypnosis
- Services provided to clients residing in residential treatment centers
- Services provided to clients in an acute-care hospital
- Educationally related services provided in a school setting
- Multiple family group psychotherapy
- Narcosynthesis
- Psychoanalysis
- Unlisted psychiatric services or procedures
- "Adult activity" or "individual activity" (These services are payable only if guidelines for group therapy are met and termed "group therapy.")

The CSHCN Services Program does not reimburse procedure code 90849.

### 29.2.10 National Correct Coding Initiative (NCCI) Guidelines

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

## 29.3 Claims Information

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

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

***Refer to:*** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 29.4 Reimbursement

Outpatient behavioral health services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRNs and PAs will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for services performed by APRNs is 92 percent of the physician's Texas Medicaid reimbursement for the same service. The reimbursement methodology for these services is contained in the specific policy for each service.

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The PLP, LPC, and LMSW providers will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for PLP, LPC, and LMSW services is 70 percent of the physician's Texas Medicaid reimbursement for the same service.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

## 29.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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