Texas Medicaid

Provider Procedures Manual

November 2026

Volume 2

Provider Handbooks

Behavioral Health and Case Management Services Handbook

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

BEHAVIORAL HEALTH AND CASE MANAGEMENT SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for the Case Management for the Blind Children's Vocational Discovery and Development Program (BCVDDP), Case Management for Children and Pregnant Women, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), psychologist, physician, advanced practice registered nurse (APRN), physician assistant (PA), or providers of intellectual and developmental disability (IDD) case management, mental health targeted case management, and mental health rehabilitative services.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7.1.2, "Reporting Child Abuse or Neglect" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) and subsection 1.7.1.5, "Training" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid eligible persons in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure to deliver, at all times, health-care items and services to Medicaid eligible persons in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

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

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

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

These reimbursement guidelines do not apply in the following circumstances:

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

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

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

2.1 Overview

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

BCVDDP services include the following:

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

2.2 Enrollment

Texas Health and Human Services Commission (HHSC) Blind Children's Vocational Discovery and Development Program (BCVDDP) is the Medicaid provider of case management for persons who are 22 years of age and younger and blind or visually impaired. Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in BCVDDP case management activities.

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

2.3 Services, Benefits, Limitations, and Prior Authorization

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

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

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

2.3.1 Prior Authorization

Prior authorization is not required for BCVDDP case management services.

2.4 Documentation Requirements

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

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

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2.5 Claims Filing and Reimbursement

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

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements. Providers must not submit a claim when or after the person turns 21 years of age.

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

Any child who has a suspected or diagnosed visual impairment may be referred to BCVDDP. HHSC BCVDDP assesses the impact the visual impairment has on the child's development and provides blindness-specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the HHS website at www.hhs.texas.gov/.

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

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

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

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

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

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

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

3 Case Management for Children and Pregnant Women

3.1 Overview

Case management services are provided to help Medicaid eligible persons gain access to necessary medical, social, educational, and other services. Case managers assess a person's need for these services and then develop a service plan to address those needs. Case Management for Children and Pregnant Women (CPW) services are outlined in the Texas Administrative Code (TAC).

3.1.1 Eligibility

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

- Are Medicaid eligible in Texas.

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- Have, or are at risk for, a health condition illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy peers of the same age in the general areas of physical, cognitive, emotional, or social growth and development.
- Are in need of Case Management for Children and Pregnant Women services.
- Choose such services.

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

- Are Medicaid eligible in Texas.
- Are pregnant and have a medical and/or psychosocial condition(s) that places them and their fetus(es) at a greater than average risk for complications, either during pregnancy, delivery, or following birth.
- Are in need of Case Management for Children and Pregnant Women services.
- Choose such services.

Clients that are Medicaid-eligible, but not yet enrolled may have Medicaid coverage assigned retroactively.

Verbal or written consent must be obtained from the client, parent, or legal guardian prior to the initiation of any CPW services. If the client receiving CPW services is a minor, all CPW services and visits must be completed with a parent or legal guardian present.

3.1.2 Referral Process

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

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

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

3.2 Enrollment

Providers must be at least 18 years of age, enrolled in Medicaid, and approved by the Health and Human Services Commission (HHSC) to provide CPW services.

A provider shall not be approved as a provider of CPW services unless they meet one of the following qualifications:

- APRN who holds a license under Texas Occupations Code Chapter 301; or
- Registered nurse (RN) who holds a license under Texas Occupations Code Chapter 301 and has a baccalaureate degree in nursing, or
- RN who holds a license under Texas Occupations Code Chapter 301 and has an associate degree in nursing with:
    - At least 2 years cumulative paid full-time work experience; or two years of supervised, full-time educational internship/practicum experience in the past ten years with children, up to age 21, and/or pregnant women; or

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- Social worker who holds a license, other than a provisional or temporary license, under Texas Occupations Code Chapter 505, appropriate for the individual's practice, including the practice of independent social work in the State of Texas; or
- Community health worker as defined by Section 48.001, Health and Safety Code, who is certified by the Department of State Health Services; or
- Doula who is certified in alignment with nationally recognized standards, and as determined by HHSC, must have:
  - Five years of experience within the last seven years as a doula; and
  - Attendance in three births in the last seven years; and
  - Three written professional letters of recommendation.
- Doula who is certified in alignment with nationally recognized standards, and as determined by HHSC, who is without five years of experience as a doula must have:
  - Attendance in three births; and
  - Three written professional letters of recommendation; and
  - Training in core competencies is required and must include:
    - Childbirth education
    - Lactation support (or proof of being a certified lactation counselor (CLC) or International Board-Certified Lactation Counselor (IBCLC)
    - Nonmedical comfort measures, prenatal support, and labor support techniques
    - Chronic and acute health conditions during the perinatal period
    - Cultural competency training

A Federally Qualified Health Center (FQHC) that has obtained HHSC approval may be eligible to provide CPW case management services. FQHCs must:

- Use the FQHC provider type, specialty code, and taxonomy code to deliver CPW services.
- Use their own individual National Provider Identifier (NPI) to deliver services.

Enrollment for Case Management for Children and Pregnant Women providers is a four-step process. Providers must complete all of the following:

- A pre-planning process with HHSC.
- The HHSC standardized case management training provided by HHSC.
- The Health Insurance Portability and Accountability Act (HIPAA) training.

  Note: *CPW Authorization to Disclose Protected Health Information forms in English or Spanish located on the HHSC CPW website must be completed as necessary to help the client access services.*

- Providers must receive an approval letter from HHSC to enroll as a state Medicaid provider of CPW services.

Providers may be a group, an individual, or perform services under guidance of a FQHC.

Upon approval by HHSC, potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women and submit a copy of their HHSC approval letter. Facility providers must enroll as a Case Management for Children and Pregnant Women group, and each eligible case manager must enroll as a performing provider for the group. Federally Qualified Health Center (FQHC)

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facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.

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

3.3 Services, Benefits, Limitations, and Prior Authorization

Case Management for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day. Prior authorization is not required for case management services.

Procedure code G9012, with required modifiers, may be reimbursed for Case Management for Children and Pregnant Women (CPW) services. Modifiers are used to identify which service component is provided.

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

Modifier	Description
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
TS	Follow-up service
U2	Comprehensive visit
U5	Face to face visit

Comprehensive visits are limited to one service per client, per provider in 12 consecutive months from the intake date.

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

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

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

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

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

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

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

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

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

FQHC's will bill for services using procedure code G9012 with the corresponding modifiers.

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

Note: *Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.*

Reminder: *Billable services are defined in program rule 25 TAC §27.11.*

Case Management for Children and Pregnant Women services are not billable when a person is an inpatient at a hospital or other treatment facility.

Reimbursement will be denied for services rendered by providers who have not been approved by HHSC.

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

Providers and their case managers must operate in accordance with the laws, rules, regulations, and standards of care relating to the practice of their respective license(s) or certifications.

Providers must provide services according to policies and procedures as published.

Providers must cease providing services and notify HHSC if the professional license or certification of a provider is suspended or revoked.

Providers must assure that case managers attend required trainings provided by HHSC.

Providers must provide services convenient to clients, either in their home, an office setting, or other place of the client's preference.

Providers must have knowledge of, and coordinate services with, providers of health and health-related services, non-covered services, and other active community resources.

Providers must develop and maintain a quality management system for the provision of services.

Providers may be disenrolled by HHSC for failure to comply with provisions of the TMHP Provider Agreement or any applicable law, rule, or policy of the program.

Providers must submit claims for rendered case management services. If no claims are submitted for 24 months, the provider will be disenrolled.

Providers may be disenrolled for not providing services for 12 months or longer.

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

Providers are to disseminate accurate information regarding case management services to health, education, and human service professionals, community organizations, and potential clients to generate referrals. Some examples may include:

- Participate in community outreach events such as health fairs.
- Network with community agencies that serve children and pregnant women.
- Participate in community coalition meetings.
- Distribute brochures to medical/mental health professionals, dental providers, community resources, and schools.
- Conduct presentations.
- Develop community resource documents to include:
  - Local resources supporting nonmedical needs.
  - Providers accepting Medicaid clients.
  - Any other information about resources available specific to the provider's population served.

Providers must ensure that outreach activities do not impede a client's freedom to choose a provider.

Providers must refer and adhere to CPW outreach guidance available on the HHSC CPW website when producing outreach materials.

Providers must comply with the requirements outlined in TAC Title 1, Part 15, Chapter 371, Rule §371.1669, concerning Self-Dealing.

3.3.1 Initial Intake

CPW providers must complete an initial intake with the client, parent, or legal guardian to determine the client's eligibility. The following information must be obtained during the initial intake and must be documented on the CPW Intake and Referral Form located on the HHSC CPW website:

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

If the client to receive services is a minor, then the initial intake must be completed with the person's parent or legal guardian present.

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The CPW initial intake service is not billable for reimbursement but is a required function of case management services. Providers who are unable to accept a referral, based on approved limitations, must re-direct the referral to the Texas Health Steps Hotline (1-877-THSteps or 1-877-847-8377). The approved limitations are:

- The client resides outside the provider service area.
- The provider is not contracted with the managed care organization (MCO) that is responsible for delivering services to the client.
- The provider has disenrolled as a CPW provider from TMHP.
- The provider cannot serve the individual's needs.

Referrals received for clients in STAR Kids must receive an intake to determine if there are needs for coordinating school services. All other services are to be provided by the client's MCO.

If the CPW initial intake indicates the client is eligible for services and a need for CPW services is identified, then the provider must complete a comprehensive visit within 30 business days of the intake date in which eligibility was determined.

If the CPW initial intake indicates the client is eligible for services and a need for CPW services is identified, but the client is not yet enrolled in Medicaid, then the case manager must complete a comprehensive visit within thirty (30) business days after the client's enrollment period is established.

3.3.2 Comprehensive Visits

The comprehensive visit (procedure code G9012 with the appropriate modifier combination) is a reimbursable service.

The comprehensive visit must include the completion of all the following:

- Family Needs Assessment
- Service Plan
- Service Plan Consent

The comprehensive visit must be completed within 30 business days of the intake date on which eligibility was determined or retroactive eligibility is established. If the client receiving CPW services is a minor, the comprehensive visit must be completed with the person's parent or legal guardian present. The comprehensive visit may be completed in-person or through the use of synchronous audiovisual technology. Comprehensive visits using synchronous audiovisual technology should only be provided if agreed to by the client, parent or legal guardian.

The FNA is completed to determine the need for any medical, educational, social, or other services required to address the client's short- and long-term health and the overall well-being of the client. The FNA must include the following documentation using the FNA form located on the HHSC CPW website:

- Completing a personal and family medical, mental health, and medication history.
- Identifying the client's needs, including any non medical health-related needs.
- Assessing and providing a referral for personal and family issues that impact the client's health condition, health risk, high-risk condition, or non-medical needs and completing related documentation.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the client.

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The Service Plan (SP) is part of the comprehensive visit and must be completed and documented during the comprehensive visit using the Service Plan form on the HHSC CPW website. The Service Plan Consent is completed to authorize the provider to share information as necessary for referrals and for services to be provided. The Service Plan Consent form is located on the HHSC CPW website.

The SP is completed to determine a planned course of action. The service plan must include:

- Activities and goals that are developed in consultation with the client, parent, or legal guardian, involve the participation of the client, and address the medical, social, educational, and other services that are needed by the client receiving CPW services.
- Identify a course of action to respond to the assessed needs of the client, including identifying the individual responsible for contacting the appropriate service providers, and designating the time frame within which the client should access services.

The Service Plan may also include:

- Referral and related activities to help the client obtain needed services, including activities that help link the client with third parties such as medical, social, and educational providers.
- Case management may include collateral contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the client access services and managing the client's care.
- Participating in meetings.
- Providing resource information.
- Problem solving and advocating for the client.

The service plan must be translated or interpreted in the client's preferred language.

The Service Plan and Service Plan Consent forms must have verbal or written consent by the client, parent, or legal guardian and kept in the client's record, to be made available upon request.

3.3.3 Follow-up Visits

Follow-up visits (procedure code G9012 with the appropriate modifier combination) are reimbursable services, and may only be completed after the comprehensive visit has been completed. The follow-up visit and comprehensive visit cannot occur on the same day.

Follow-up visits by a case manager are necessary to ensure the Service Plan is implemented and adequately addresses the client's needs.

Follow-up visits shall be conducted as frequently as necessary. At least one annual follow-up is required for clients who are eligible for case management lasting longer than 12 consecutive months. For reimbursement, follow-up visits must be documented and must include the following:

- The current service plan to include the client's needs and status
- Services are being furnished in accordance with the client's service plan
- How services are addressing the client's needs as outlined in the Service Plan
- Service is maintained and modified when the client's needs or status changes

If the client receiving CPW services is a minor, the follow-up visit must be completed with the client's parent or legal guardian present.

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

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

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

Activities during the follow-up visit must be documented on the Follow-up form found on the HHSC CPW website and must include:

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

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

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

- Phone calls to the client, parent, or legal guardian between billable follow-up visits.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators on behalf of the client, parent, or legal guardian.

Follow-up visits by the case manager for clients who are pregnant with a high-risk condition or non-medical needs shall occur as needed during the 12-month postpartum period. When all needs related to the health condition, health risk, high-risk pregnancy, or non-medical needs have been addressed, then CPW services must no longer be provided.

The client status is to be documented on the Case Closure Form available on the HHSC CPW website, to identify the outcome of the case when the following apply:

- All eligible needs have been addressed or resolved.
- The client is no longer eligible for case management due to an improvement in their health condition, health risk, or high-risk condition.
- The child reaches 21 years of age and does not meet other eligibility requirements for CPW services.
- The client is no longer eligible for Medicaid and does not anticipate obtaining Medicaid in the near future.
- The client no longer chooses to receive services.
- The client is denied additional visits because documentation does not support continued eligibility.
- The client is lost to follow-up when provider has made three attempts on different dates to contact client, parent, or legal guardian.
- The client relocates or transfers to a new provider.

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- The provider is unable to render services due to the disruptive, unruly, threatening, or uncooperative behavior of the client, parent, or legal guardian.

  Note: *Providers may choose to close a case if the client, parent, or legal guardian is disruptive, unruly, threatening, or uncooperative to the extent the client, parent, or legal guardian seriously impairs the provider's ability to render services or if the client, parent, or legal guardian's behavior jeopardizes the client's own safety, or the providers. The provider should also contact the appropriate authority when necessary.*

3.3.4 Case Transfers

Prior authorization is not required for CPW case management services.

Case transfers must be documented on the Case Transfer form available on the HHSC CPW website. The Case Transfer form is completed if the client continues to meet eligibility criteria, but the case needs to be transferred. Transfers may occur for the following reasons:

- The client requests a transfer.
- The client relocates.
- The provider's service area changes.
- The provider disenrolls as an active CPW provider.
- There is a need to change to another case manager.

The provider must assist a client with a transfer to case management services to another area of Texas.

A client must give approval to a provider to transfer the case management record to the new provider.

Providers must appropriately link clients of a family member that is a migrant worker to resources in the geographic areas in which they live and to which they migrate. This case transfer process is to be documented on the Migrant Information Form available on the HHSC CPW website. Providers are to:

- Determine the family members that migrate.
- Identify the source(s) of payment for medical care if family migrates outside of Texas.
- Determine the location and timeframe for each migrating location.
- Document each new location address, contact persons, medical providers, and school attendance, if needed.

3.4 Technical Assistance

Providers may contact HHSC program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns. Regional DSHS staff make routine contact with providers to ensure providers are delivering services as required.

3.4.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure may contact HHSC program staff at *askcm@hhs.texas.gov*.

3.5 Documentation Requirements

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

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Providers must maintain accurate demographic information on their provider record with TMHP. Changing significant provider information must be updated on the Provider Enrollment Management System (PEMS) within seven calendar days of the change including:

- Group Name or Doing Business As (DBA)
- Location Address
- Telephone Number
- Fax Number
- Email Address

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

CPW forms including the Family Needs Assessment, Service Plan, Follow-Up form, follow-up documentation, and progress notes must be completed and maintained in the client's record. The documentation maintained must meet the requirements as outlined in this handbook. CPW documentation forms are available on the HHSC CPW website at hhs.texas.gov/providers/health-services-providers/case-management-providers-children-pregnant-women.

Signatures, or documentation confirming verbal consent was received, must be included on all forms and documents that require signatures. All forms and documents completed in relation to CPW services must be maintained in the client's record.

All contacts with or on behalf of the client, parent, or legal guardian must be documented and maintained in the client's record. Documentation of activities, not otherwise documented on CPW required forms, must be recorded on the Progress Notes form available on the HHSC CPW website. Progress notes may include the following information:

- Phone calls to the client, parent, or legal guardian between billable follow-up visits
- Gathering information from other sources, such as family members, medical providers, social workers, and educators on behalf of the client, parent, or legal guardian

Documentation in the client's record must include the reason(s) a CPW service was not provided or completed. This can be documented on the Referral and Intake form during the initial eligibility determination or on the Case Closure form available on the HHSC CPW website.

Records are subject to review by HHSC or its designee.

3.6 Claims Filing and Reimbursement

3.6.1 Claims Information

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

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

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

- Phone calls to the client, parent, or legal guardian between billable follow-up visits.
- Collateral contacts on behalf of a client, parent, or legal guardian.

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Claims for a client who receives retroactive eligibility must be submitted within 95 days of the date that the client's eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service (DOS).

Claims for a client who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the eligibility is added to the TMHP eligibility file.

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

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

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

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

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

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

3.6.1.1 Exclusions

CPW services are not billable for clients who have already received another case management service on the same day from any billing provider.

CPW services are not billable when a client is in an inpatient at a hospital or other treatment facility.

CPW services are not billable when the exact services are duplicated within the client's managed care organization.

3.6.2 Managed Care Clients

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

4 Outpatient Mental Health Services

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

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

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

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

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

4.1 Provider Enrollment

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

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

4.1.1 Physicians

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

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

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

4.1.2 Physician Assistants (PAs)

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

4.1.3 Advanced Practice Registered Nurses (APRNs)

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

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

4.1.4 Licensed Clinical Social Workers (LCSWs)

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare.

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

4.1.5 Licensed Marriage and Family Therapists (LMFTs)

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

4.1.6 Licensed Professional Counselors (LPCs)

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

4.1.7 Psychologists

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

4.1.8 Licensed Psychological Associates (LPAs)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scope and standards of practice.

Services performed by an LPA are a Medicaid-covered benefit when the following conditions are met:

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

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

4.1.9 Provisionally Licensed Psychologists (PLPs)

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

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

- The services must be performed under the required supervision of a licensed psychologist in accordance with the TSBEP guidelines.

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- The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
- The PLP who is performing the service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

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

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

4.1.10 Post-Doctoral Fellows

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

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

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

4.1.11 Pre-doctoral Psychology Interns

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

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

4.2 * Services, Benefits, Limitations

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

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90846	90847
90853	90870	90899	96116	96121+	96130	96131+	96132	96133+	96136
96137+									
+ Add-on procedure code must be billed with the appropriate primary code									

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

Procedure Codes									
90832	90833+	90834	90836+	90837	90838+	90846	90847	90853	
+ Add-on procedure code must be billed with the appropriate primary code									

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

[Revised] Diagnosis Codes							
F0390	F03911	F03918	F0392	F0393	F0394	F03A0	F03A11

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[Revised] Diagnosis Codes							
F03A18	F03A2	F03A3	F03A4	F03B0	F03B11	F03B18	F03B2
F03B3	F03B4	F03C0	F03C11	F03C18	F03C2	F03C3	F03C4
F04	F05	F060	F061	F062	F0630	F0631	F0632
F0633	F0634	F064	F0670	F0671	F068	F070	F0781
F0789	F09	F1010	F1011	F10120	F10121	F10130	F10131
F10132	F10139	F1014	F10150	F10151	F10159	F10180	F10181
F10182	F10188	F1019	F1020	F1021	F10220	F10221	F10230
F10231	F10232	F10239	F1024	F10250	F10251	F10259	F1026
F1027	F10280	F10281	F10282	F10288	F1029	F1090	F1091
F10921	F10930	F10931	F10932	F10939	F1094	F10950	F10951
F10959	F1096	F10980	F10981	F10982	F10988	F1099	F1110
F1111	F11120	F11121	F11122	F11129	F1113	F1114	F11150
F11151	F11159	F11181	F11182	F11188	F1119	F1120	F1121
F11220	F11221	F11222	F11229	F1123	F1124	F11250	F11251
F11259	F11281	F11282	F11288	F1129	F1191	F11920	F11921
F11922	F11929	F1193	F1194	F11950	F11951	F11959	F11981
F11982	F11988	F1199	F1210	F1211	F12120	F12121	F12122
F12129	F1213	F12150	F12151	F12159	F12180	F12188	F1219
F1220	F1221	F12220	F12221	F12222	F12229	F1223	F12250
F12251	F12259	F12280	F12288	F1229	F1291	F12920	F12921
F12922	F12929	F1293	F12950	F12951	F12959	F12980	F12988
F1299	F1310	F1311	F13120	F13121	F13129	F13130	F13131
F13132	F13139	F1314	F13150	F13151	F13159	F13180	F13181
F13182	F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259	F1326
F1327	F13280	F13281	F13282	F13288	F1391	F13920	F13921
F13929	F13930	F13931	F13932	F13939	F1394	F13950	F13951
F13959	F1396	F1397	F13980	F13981	F13982	F13988	F1399
F1410	F1411	F14120	F14121	F14122	F14129	F1413	F1414
F14150	F14151	F14159	F14180	F14181	F14182	F14188	F1419
F1420	F1421	F14220	F14221	F14222	F14229	F1423	F1424
F14250	F14251	F14259	F14280	F14281	F14282	F14288	F1429
F1491	F14920	F14921	F14922	F14929	F1493	F1494	F14950
F14951	F14959	F14980	F14981	F14982	F14988	F1499	F1510
F1511	F15120	F15121	F15122	F15129	F1513	F1514	F15150
F15151	F15159	F15180	F15181	F15182	F15188	F1519	F1520
F1521	F15220	F15221	F15222	F15229	F1523	F1524	F15250
F15251	F15259	F15280	F15281	F15282	F15288	F1529	F1591
F15920	F15921	F15922	F15929	F1593	F1594	F15950	F15951
F15959	F15980	F15981	F15982	F15988	F1599	F1610	F1611

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[Revised] Diagnosis Codes							
F16120	F16121	F16122	F16129	F1614	F16150	F16151	F16159
F16180	F16183	F16188	F1619	F1620	F1621	F16220	F16221
F16229	F1624	F16250	F16251	F16259	F16280	F16283	F16288
F1629	F1691	F16920	F16921	F16929	F1694	F16950	F16951
F16959	F16980	F16983	F16988	F1699	F1810	F1811	F18120
F18121	F18129	F1814	F18150	F18151	F18159	F1817	F18180
F18188	F1819	F1820	F1821	F18220	F18221	F18229	F1824
F18250	F18251	F18259	F1827	F18280	F18288	F1829	F1890
F1891	F18920	F18921	F18929	F1894	F18950	F18951	F18959
F1897	F18980	F18988	F1899	F1910	F1911	F19120	F19121
F19122	F19129	F19130	F19131	F19132	F19139	F1914	F19150
F19151	F19159	F1916	F1917	F19180	F19181	F19182	F19188
F1919	F1920	F1921	F19220	F19221	F19222	F19229	F19230
F19231	F19232	F19239	F1924	F19250	F19251	F19259	F1926
F1927	F19280	F19281	F19282	F19288	F1929	F1991	F19920
F19921	F19922	F19930	F19931	F19932	F19939	F1994	F19950
F19951	F19959	F1996	F1997	F19980	F19981	F19982	F19988
F1999	F200	F201	F202	F203	F205	F2081	F2089
F209	F21	F22	F23	F24	F250	F251	F258
F259	F28	F29	F3010	F3011	F3012	F3013	F302
F303	F304	F308	F309	F310	F3110	F3111	F3112
F3113	F312	F3130	F3131	F3132	F314	F315	F3160
F3161	F3162	F3163	F3164	F3171	F3172	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F3189	F319	F320
F321	F322	F323	F324	F325	F3281	F3289	F329
F32A	F330	F331	F332	F333	F338	F3341	F3342
F339	F340	F341	F3481	F3489	F349	F39	F4001
F4002	F4010	F4011	F40210	F40218	F40220	F40228	F40230
F40231	F40232	F40233	F40240	F40241	F40242	F40243	F40248
F40290	F40291	F40298	F408	F409	F410	F411	F413
F418	F419	F422	F423	F424	F428	F429	F430
F4310	F4311	F4312	F4320	F4321	F4322	F4323	F4324
F4325	F4329	F4381	F4389	F439	F440	F441	F442
F444	F445	F446	F447	F4481	F4489	F449	F450
F451	F4520	F4521	F4522	F4529	F4541	F4542	F458
F459	F481	F482	F488	F489	F5000	F50010	F50011
F50012	F50013	F50014	F50019	F50020	F50021	F50022	F50023
F50024	F50029	F5020	F5021	F5022	F5023	F5024	F5025
F50810	F50811	F50812	F50813	F50814	F50819	F5082	F5083
F5084	F5089	F509	F5101	F5102	F5103	F5104	F5105

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[Revised] Diagnosis Codes							
F5109	F5111	F5112	F5113	F5119	F513	F514	F515
F518	F519	F520	F521	F5221	F5222	F5231	F5232
F524	F525	F526	F528	F529	F530	F531	F54
F550	F551	F552	F553	F554	F558	F600	F601
F602	F603	F604	F605	F606	F607	F6081	F6089
F609	F630	F631	F632	F633	F6381	F6389	F639
F640	F641	F642	F648	F649	F64A	F650	F651
F652	F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F68A	F69	F70
F800	F801	F802	F804	F8082	F809	F8181	F819
F82	F840	F842	F843	F845	F849	F900	F901
F902	F908	F909	F910	F911	F912	F913	F918
F919	F930	F938	F939	F940	F941	F942	F948
F949	F950	F951	F952	F959	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	G300	G301
G308	G309	G3101	G3109	G3184	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	I69212	O906
R413	R41840	R41841	R41842	R41843	R41844	R4189	R45850
R45851	R4588	T5892XD	T5892XS	T7401XA	T7401XD	T7401XS	T7402XA
T7412XD	T7412XS	T7421XA	T7421XD	T7421XS	T7422XA	T7422XD	T7422XS
T7431XA	T7431XD	T7431XS	T7432XA	T7432XD	T7432XS	T7451XA	T7451XD
T7451XS	T7452XA	T7452XD	T7452XS	T7461XA	T7461XD	T7461XS	T7462XA
T7462XD	T7462XS	T7601XA	T7601XD	T7601XS	T7602XA	T7602XD	T7602XS
T7611XA	T7611XD	T7611XS	T7612XA	T7612XD	T7612XS	T7621XA	T7621XD
T7621XS	T7622XA	T7622XD	T7622XS	T7631XA	T7631XD	T7631XS	T7632XA
T7632XD	T7632XS	T7651XA	T7651XD	T7651XS	T7652XA	T7652XD	T7652XS
T7661XA	T7661XD	T7661XS	T7662XA	T7662XD	T7662XS	Z0389	Z600
Z608	Z609	Z620	Z621	Z6221	Z6222	Z6223	Z6224
Z62810	Z62811	Z62812	Z62813	Z62820	Z62821	Z62822	Z62823
Z62831	Z62832	Z62833	Z62890	Z62892	Z6331	Z6332	Z634
Z635	Z6372	Z638	Z644	Z654	Z655	Z658	Z69010
Z69011	Z69020	Z69021	Z6912	Z6982	Z72810	Z72811	Z736
Z781	Z818	Z8651	Z9151	Z9152	Z9183		

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

Diagnosis Codes							
F71	F72	F73	F78A1	F78A9	F79		

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

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[Revised] Diagnosis Codes							
A8100	A8101	A8109	A8181	A8183	B1001	B1009	B451
D8681	E7500	E7501	E7502	E7509	E7510	E7511	E7519
E7523	E7525	E7526	E7529	E754	F0150	F01511	F01518
F0152	F0153	F0154	F01A0	F01A11	F01A18	F01A2	F01A3
F01A4	F01B0	F01B11	F01B18	F01B2	F01B3	F01B4	F01C0
F01C11	F01C18	F01C2	F01C3	F01C4	F0280	F02811	F02818
F0282	F0283	F0284	F02A0	F02A11	F02A18	F02A2	F02A3
F02A4	F02B0	F02B11	F02B18	F02B2	F02B3	F02B4	F02C0
F02C11	F02C18	F02C2	F02C3	F02C4	F0390	F03911	F03918
F0392	F0393	F0394	F03A0	F03A11	F03A18	F03A2	F03A3
F03A4	F03B0	F03B11	F03B18	F03B2	F03B3	F03B4	F03C0
F03C11	F03C18	F03C2	F03C3	F03C4	F04	F05	F060
F061	F062	F0630	F0631	F0632	F0633	F0634	F064
F0670	F0671	F068	F070	F0781	F0789	F09	F1010
F10120	F10121	F10129	F10130	F10131	F10132	F10139	F1014
F10150	F10151	F10159	F10180	F10181	F10182	F10188	F1019
F1020	F1021	F10220	F10221	F10229	F10230	F10231	F10232
F10239	F1024	F10250	F10251	F10259	F1026	F1027	F10280
F10281	F10282	F10288	F1029	F1090	F1091	F10920	F10921
F10929	F10930	F10931	F10932	F10939	F1094	F10950	F10951
F10959	F1096	F1097	F10980	F10981	F10982	F10988	F1099
F11120	F11121	F11122	F11129	F1113	F1114	F11150	F11151
F11159	F11181	F11182	F11188	F1119	F1120	F1121	F11220
F11221	F11222	F11229	F1123	F1124	F11250	F11251	F11259
F11281	F11282	F11288	F1129	F1191	F11920	F11921	F11922
F11929	F1193	F1194	F11950	F11951	F11959	F11981	F11982
F1199	F1210	F1211	F12120	F12121	F12122	F12129	F1213
F12150	F12151	F12159	F12180	F12188	F1219	F1220	F1221
F12220	F12221	F12222	F12229	F1223	F12250	F12251	F12259
F12280	F12288	F1229	F1290	F1291	F12920	F12921	F12922
F12929	F1293	F12950	F12951	F12959	F12980	F12988	F1299
F1311	F1314	F13120	F13121	F13129	F13130	F13131	F13132
F13139	F13150	F13151	F13159	F13180	F13181	F13182	F13188
F1320	F1321	F13220	F13221	F13229	F13230	F13231	F13232
F13239	F1324	F13250	F13251	F13259	F1326	F1327	F13280
F13281	F13282	F13288	F1391	F13920	F13921	F13929	F13930
F13931	F13932	F13939	F1394	F13950	F13951	F13959	F1396
F13980	F13981	F13982	F13988	F1399	F1410	F1411	F14120
F14121	F14122	F14129	F1413	F1414	F14150	F14151	F14159
F14180	F14181	F14182	F14188	F1419	F1420	F1421	F14220

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[Revised] Diagnosis Codes							
F14221	F14222	F14229	F1423	F1424	F14250	F14251	F14259
F14280	F14281	F14282	F14288	F1429	F1491	F14920	F14921
F14922	F14929	F1493	F1494	F14950	F14951	F14959	F14980
F14982	F14988	F1499	F1510	F1511	F15120	F15121	F15122
F15129	F1513	F1514	F15150	F15151	F15159	F15180	F15181
F15182	F15188	F1519	F1520	F1521	F15220	F15221	F15222
F15229	F1523	F1524	F15250	F15251	F15259	F15280	F15281
F15282	F15288	F1529	F1591	F15920	F15921	F15922	F15929
F1594	F15950	F15951	F15959	F15980	F15981	F15982	F15988
F1599	F1610	F1611	F16120	F16121	F16122	F16129	F1614
F16150	F16151	F16159	F16180	F16183	F16188	F1619	F1620
F1621	F16220	F16221	F16229	F1624	F16250	F16251	F16259
F16280	F16283	F16288	F1629	F1691	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F1811	F18120	F18121	F18129	F1814	F18150	F18151	F18159
F1817	F18180	F18188	F1819	F1820	F1821	F18220	F18221
F18229	F1824	F18250	F18251	F18259	F1827	F18280	F18288
F1829	F1890	F1891	F18920	F18921	F18929	F18950	F18951
F1897	F18980	F18988	F1894	F1899	F1910	F1911	F19120
F19121	F19122	F19129	F19130	F19131	F19132	F19139	F1914
F19150	F19151	F19159	F1916	F1917	F19180	F19181	F19182
F19188	F1919	F1920	F1921	F19220	F19221	F19222	F19229
F19230	F19231	F19232	F19239	F1924	F19250	F19251	F19259
F1926	F1927	F19280	F19281	F19282	F19288	F1929	F1991
F19920	F19921	F19922	F19929	F19930	F19931	F19932	F19939
F19950	F19951	F19959	F1996	F1997	F19980	F19981	F19982
F19988	F1999	F200	F201	F202	F203	F205	F2081
F2089	F209	F21	F22	F23	F24	F250	F251
F258	F259	F28	F29	F3010	F3011	F3012	F3013
F302	F303	F304	F308	F309	F310	F3110	F3111
F3112	F3113	F312	F3130	F3131	F3132	F314	F315
F3160	F3161	F3162	F3163	F3164	F3170	F3171	F3172
F3173	F3174	F3175	F3176	F3177	F3178	F3181	F3189
F319	F320	F321	F322	F323	F324	F325	F3281
F3289	F329	F32A	F330	F331	F332	F333	F3341
F3342	F338	F339	F340	F341	F3481	F3489	F349
F39	F4001	F4002	F4010	F4011	F40210	F40218	F40220
F40228	F40230	F40231	F40232	F40233	F40240	F40241	F40242
F40243	F40248	F40290	F40291	F40298	F408	F409	F410
F411	F413	F418	F419	F422	F423	F424	F428

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[Revised] Diagnosis Codes							
F429	F430	F4310	F4311	F4312	F4320	F4321	F4322
F4323	F4324	F4325	F4329	F4381	F4389	F439	F440
F441	F442	F444	F445	F446	F447	F4481	F4489
F449	F450	F451	F4520	F4521	F4522	F4529	F4541
F4542	F458	F459	F481	F482	F488	F489	F5000
F50010	F50011	F50012	F50013	F50014	F50019	F50020	F50021
F50022	F50023	F50024	F50029	F5020	F5021	F5022	F5023
F5024	F5025	F50810	F50811	F50812	F50813	F50814	F50819
F5082	F5083	F5084	F5089	F509	F5101	F5102	F5103
F5104	F5105	F5109	F5111	F5112	F5113	F5119	F513
F514	F515	F518	F519	F520	F521	F5221	F5222
F5231	F5232	F524	F525	F526	F528	F529	F530
F531	F54	F550	F551	F552	F553	F554	F558
F600	F601	F602	F603	F604	F605	F606	F607
F6081	F6089	F609	F630	F631	F632	F633	F6381
F6389	F639	F640	F641	F642	F648	F649	F64A
F650	F651	F652	F653	F654	F6551	F6552	F6581
F6589	F659	F66	F6810	F6811	F6812	F6813	F68A
F688	F69	F70	F71	F72	F73	F78A1	F78A9
F79	F800	F801	F802	F804	F8082	F8089	F809
F810	F812	F8181	F819	F82	F840	F842	F843
F845	F848	F849	F88	F89	F900	F901	F902
F908	F909	F910	F911	F912	F913	F918	F919
F930	F938	F939	F940	F941	F942	F948	F949
F950	F951	F952	F958	F959	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	G000	G001
G002	G003	G008	G009	G01	G02	G030	G031
G032	G038	G039	G0400	G0401	G0402	G042	G0430
G0431	G0432	G0439	G0481	G0482	G0489	G0490	G0491
G053	G054	G060	G061	G062	G07	G210	G300
G301	G308	G309	G3101	G3109	G311	G312	G3180
G3181	G3182	G3183	G3184	G3185	G3186	G3187	G3189
G319	G3289	G35A	G35B0	G35B1	G35B2	G35C0	G35C1
G35C2	G35D	G40001	G40009	G40011	G40019	G40B01	G40B09
G40B11	G40B19	G40C01	G40C09	G40C11	G40C19	G40101	G40109
G40111	G40119	G40201	G40209	G40211	G40219	G40301	G40309
G40311	G40319	G40501	G40509	G40801	G40802	G40803	G40804
G40811	G40812	G40813	G40814	G40821	G40822	G40823	G40824
G40841	G40842	G40843	G40844	G4089	G40901	G40909	G40911
G40919	G40A01	G40A09	G40A11	G40A19	G44209	G450	G451

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[Revised] Diagnosis Codes							
G452	G454	G458	G459	G468	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	G910	G911
G912	G928	G929	G930	G931	G9340	G9341	G9342
G9343	G9344	G9345	G9349	G937	G9381	G9389	G939
G94	H93291	H93292	H93293	H93A1	H93A2	H93A3	H93A9
I6000	I6001	I6002	I6010	I6011	I6012	I602	I6030
I6031	I6032	I604	I6050	I6051	I6052	I606	I607
I608	I609	I610	I611	I612	I613	I614	I615
I616	I618	I619	I6200	I6201	I6202	I6203	I621
I629	I6300	I63011	I63012	I63013	I63019	I6302	I63031
I63032	I63033	I63039	I6309	I6310	I63111	I63112	I63113
I63119	I6312	I63131	I63132	I63133	I63139	I6319	I6320
I63211	I63212	I63213	I63219	I6322	I63231	I63232	I63233
I63239	I6329	I6330	I63311	I63312	I63313	I63319	I63321
I63322	I63323	I63329	I63331	I63332	I63333	I63339	I63341
I63342	I63343	I63349	I6339	I6340	I63411	I63412	I63413
I63419	I63421	I63422	I63423	I63429	I63431	I63432	I63433
I63439	I63441	I63442	I63443	I63449	I6349	I6350	I63511
I63512	I63513	I63519	I63521	I63522	I63523	I63529	I63531
I63532	I63533	I63539	I63541	I63542	I63543	I63549	I6359
I6381	I6389	I6501	I6502	I6503	I6509	I651	I6521
I6522	I6523	I6529	I658	I659	I6601	I6602	I6603
I6609	I6611	I6612	I6613	I6619	I6621	I6622	I6623
I6629	I663	I668	I669	I671	I672	I674	I675
I676	I677	I6781	I6782	I67850	I67858	I6789	I679
I680	I682	I688	I6900	I69010	I69011	I69012	I69013
I69014	I69015	I69018	I69019	I69020	I69021	I69022	I69023
I69028	I69031	I69032	I69033	I69034	I69039	I69041	I69042
I69043	I69044	I69049	I69051	I69052	I69053	I69054	I69059
I69061	I69062	I69063	I69064	I69065	I69069	I69090	I69091
I69092	I69093	I69098	I6910	I69110	I69111	I69112	I69113
I69114	I69115	I69118	I69119	I69120	I69121	I69122	I69123
I69128	I69131	I69132	I69133	I69134	I69139	I69141	I69142
I69143	I69144	I69149	I69151	I69152	I69153	I69154	I69159
I69161	I69162	I69163	I69164	I69165	I69169	I69190	I69191
I69192	I69193	I69198	I6920	I69210	I69211	I69212	I69213
I69214	I69215	I69218	I69219	I69220	I69221	I69222	I69223
I69228	I69231	I69232	I69233	I69234	I69239	I69241	I69242
I69243	I69244	I69249	I69251	I69252	I69253	I69254	I69259
I69261	I69262	I69263	I69264	I69265	I69269	I69290	I69291

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[Revised] Diagnosis Codes							
I69292	I69293	I69298	I6930	I69310	I69311	I69312	I69313
I69314	I69315	I69318	I69319	I69320	I69321	I69322	I69323
I69328	I69331	I69332	I69333	I69334	I69339	I69341	I69342
I69343	I69344	I69349	I69351	I69352	I69353	I69354	I69359
I69361	I69362	I69363	I69364	I69365	I69369	I69390	I69391
I69392	I69393	I69398	I6980	I69810	I69811	I69812	I69813
I69814	I69815	I69818	I69819	I69820	I69821	I69822	I69823
I69828	I69831	I69832	I69833	I69834	I69839	I69841	I69842
I69843	I69844	I69849	I69851	I69852	I69853	I69854	I69859
I69861	I69862	I69863	I69864	I69865	I69869	I69890	I69891
I69892	I69893	I69898	I6990	I69910	I69911	I69912	I69913
I69914	I69915	I69918	I69919	I69920	I69921	I69922	I69923
I69928	I69931	I69932	I69933	I69934	I69939	I69941	I69942
I69943	I69944	I69949	I69951	I69952	I69953	I69954	I69959
I69961	I69962	I69963	I69964	I69965	I69969	I69990	I69991
I69992	I69993	I69998	O906	P102	P103	P520	P521
P5221	P5222	P523	P525	P84	P90	P9160	P9161
P9162	P9163	R0901	R0902	R413	R41840	R41841	R41842
R41843	R41844	R4189	R450	R453	R454	R457	R45850
R45851	R4586	R4587	R4588	R4589	R5600	R5601	R569
S060X0A	S060X0D	S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D
S060X9S	S060XAA	S060XAD	S060XAS	S06306A	S06306D	S06306S	S0630AA
S0630AD	S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S
S06312A	S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D
S06314S	S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06319A
S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A	S06320D	S06320S
S06321A	S06321D	S06321S	S06322A	S06322D	S06322S	S06323A	S06323D
S06323S	S06324A	S06324D	S06324S	S06325A	S06325D	S06325S	S06326A
S06326D	S06326S	S06329A	S06329D	S06329S	S0632AA	S0632AD	S0632AS
S06330A	S06330D	S06330S	S06331A	S06331D	S06331S	S06332A	S06332D
S06332S	S06333A	S06333D	S06333S	S06334A	S06334D	S06334S	S06335A
S06335D	S06335S	S06336A	S06336D	S06336S	S06339A	S06339D	S06339S
S0633AA	S0633AD	S0633AS	S06340A	S06340D	S06340S	S06341A	S06341D
S06341S	S06342A	S06342D	S06342S	S06343A	S06343D	S06343S	S06344A
S06344D	S06344S	S06345A	S06345D	S06345S	S06346A	S06346D	S06346S
S06349A	S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D
S06350S	S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A
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S06356A	S06356D	S06356S	S06359A	S06359D	S06359S	S0635AA	S0635AD
S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D	S06361S	S06362A

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[Revised] Diagnosis Codes							
S06362D	S06362S	S06363A	S06363D	S06363S	S06364A	S06364D	S06364S
S06365A	S06365D	S06365S	S06366A	S06366D	S06366S	S06369A	S06369D
S06369S	S0636AA	S0636AD	S0636AS	S06370A	S06370D	S06370S	S06371A
S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D	S06373S
S06374A	S06374D	S06374S	S06375A	S06375D	S06375S	S06376A	S06376D
S06376S	S06379A	S06379D	S06379S	S0637AA	S0637AD	S0637AS	S06380A
S06380D	S06380S	S06381A	S06381D	S06381S	S06382A	S06382D	S06382S
S06383A	S06383D	S06383S	S06384A	S06384D	S06384S	S06385A	S06385D
S06385S	S06386A	S06386D	S06386S	S06389A	S06389D	S06389S	S0638AA
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S064X2A	S064X2D	S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D
S064X4S	S064X5A	S064X5D	S064X5S	S064X6A	S064X6D	S064X6S	S064X9A
S064X9D	S064X9S	S064XAA	S064XAD	S064XAS	S065X0A	S065X0D	S065X0S
S065X1A	S065X1D	S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D
S065X3S	S065X4A	S065X4D	S065X4S	S065X5A	S065X5D	S065X5S	S065X6A
S065X6D	S065X6S	S065X7A	S065X8A	S065X9A	S065X9D	S065X9S	S065XAA
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S06896D	S06896S	S06897A	S06899A	S06899D	S06899S	S0689AA	S0689AD
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T40412D	T40412S	T40413A	T40413D	T40413S	T40414A	T40414D	T40414S
T40415A	T40415D	T40415S	T40416A	T40416D	T40416S	T40421A	T40421D
T40421S	T40422A	T40422D	T40422S	T40423A	T40423D	T40423S	T40424A
T40424D	T40424S	T40425A	T40425D	T40425S	T40426A	T40426D	T40426S
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T40493S	T40494A	T40494D	T40494S	T40495A	T40495D	T40495S	T40496A
T40496D	T40496S	T40711A	T40711D	T40711S	T40712A	T40712D	T40712S
T40713A	T40713D	T40713S	T40714A	T40714D	T40714S	T40715A	T40715D
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T40725A	T40725D	T40725S	T40726A	T40726D	T40726S	T50912A	T50912D
T50912S	T50914A	T50914D	T50914S	T5801XA	T5801XD	T5801XS	T5802XA
T5802XD	T5802XS	T5803XA	T5803XD	T5803XS	T5804XA	T5804XD	T5804XS

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[Revised] Diagnosis Codes							
T5811XA	T5811XD	T5811XS	T5812XA	T5812XD	T5812XS	T5813XA	T5813XD
T5813XS	T5814XA	T5814XD	T5814XS	T582X1A	T582X1D	T582X1S	T582X2A
T582X2D	T582X2S	T582X3A	T582X3D	T582X3S	T582X4A	T582X4D	T582X4S
T588X1A	T588X1D	T588X1S	T588X2A	T588X2D	T588X2S	T588X3A	T588X3D
T588X3S	T588X4A	T588X4D	T588X4S	T5891XA	T5891XD	T5891XS	T5892XA
T5892XD	T5892XS	T5893XA	T5893XD	T5893XS	T5894XA	T5894XD	T5894XS
T71111A	T71111D	T71111S	T71112A	T71112D	T71112S	T71113A	T71113D
T71113S	T71114A	T71114D	T71114S	T71121A	T71121D	T71121S	T71122A
T71122D	T71122S	T71123A	T71123D	T71123S	T71124A	T71124D	T71124S
T71131A	T71131D	T71131S	T71132A	T71132D	T71132S	T71133A	T71133D
T71133S	T71134A	T71134D	T71134S	T71141A	T71141D	T71141S	T71143A
T71143D	T71143S	T71144A	T71144D	T71144S	T71151A	T71151D	T71151S
T71152A	T71152D	T71152S	T71153A	T71153D	T71153S	T71154A	T71154D
T71154S	T71161A	T71161D	T71161S	T71162A	T71162D	T71162S	T71163A
T71163D	T71163S	T71164A	T71164D	T71164S	T71191A	T71191D	T71191S
T71192A	T71192D	T71192S	T71193A	T71193D	T71193S	T71194A	T71194D
T71194S	T7120XA	T7120XD	T7120XS	T7121XA	T7121XD	T7121XS	T71221A
T71221D	T71221S	T71222A	T71222D	T71222S	T71223A	T71223D	T71223S
T71224A	T71224D	T71224S	T71231A	T71231D	T71231S	T71232A	T71232D
T71232S	T71233A	T71233D	T71233S	T71234A	T71234D	T71234S	T7129XA
T7129XD	T7129XS	T719XXA	T719XXD	T719XXS	T7401XA	T7401XD	T7401XS
T7402XA	T7402XD	T7402XS	T7411XA	T7411XD	T7411XS	T7412XA	T7412XD
T7412XS	T7421XA	T7421XD	T7421XS	T7422XA	T7422XD	T7422XS	T7431XA
T7431XD	T7431XS	T7432XA	T7432XD	T7432XS	T7451XA	T7451XD	T7451XS
T7452XA	T7452XD	T7452XS	T7461XA	T7461XD	T7461XS	T7462XA	T7462XD
T7462XS	T751XXA	T751XXD	T751XXS	T7601XA	T7601XD	T7601XS	T7602XA
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T7631XS	T7632XA	T7632XD	T7632XS	T7651XA	T7651XD	T7651XS	T7652XA
T7652XD	T7652XS	T7661XA	T7661XD	T7661XS	T7662XA	T7662XD	T7662XS
Z608	Z634	Z644	Z658	Z72810	Z72811	Z736	Z73810
Z73811	Z73812	Z73819	Z781	Z818	Z8651	Z8659	Z87820
Z878901	Z878902	Z878903	Z878904	Z878909	Z87893	Z9151	Z9152
Z9183							

4.2.1 Telemedicine and Telehealth Services

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

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

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

4.2.1.1 Synchronous Audiovisual Technology

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

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)
- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only
- Neurobehavioral services (procedure codes 96116 and 96121).
- Neuropsychological and psychological testing services (procedure codes 96130, 96131, 96132, 96133, 96136 and 96137) if the following conditions are met:
  - The psychometric test must be available in an online format, except for tests that are administered and responded to orally;
  - The provider, or test administrator, must observe the person, in real-time, for the duration of the test; and
  - The provider delivers the psychometric test in accordance with their licensing board and professional guidelines.

4.2.1.2 Synchronous Telephone (audio-only) Technology

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

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

- Psychiatric diagnostic evaluation services with and without medical services (procedure codes 90791 and 90792)

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- Psychotherapy (individual, family, or group) services (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853)
- Pharmacological management services (most appropriate E/M code with modifier UD) for psychiatric care only

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

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

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

The billing provider is required to conduct at least one in-person or synchronous audiovisual outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological] or ECT) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

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

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

Note: *The required in-person or synchronous audiovisual-delivered outpatient mental health service (psychiatric diagnostic evaluation, psychotherapy [individual, family, or group], pharmacological management, testing [neurobehavioral, psychological, or neuropsychological], or ECT) may be delivered by another authorized professional or paraprofessional of*

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the same billing provider (see note above for the definition of same billing provider) as the professional, or paraprofessional, who delivers the service by synchronous telephone (audio-only) technology.

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

4.2.2 Psychotherapy Services

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

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

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

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

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

Refer to: Subsection 9.2.60.6, "Prolonged Physician Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about prolonged physician services.

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

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

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

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

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

LMFTs must bill with modifier U8 to differentiate from LPCs.

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

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

4.2.2.1 Family Psychotherapy

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

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

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

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

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

4.2.2.2 Treatment for Alzheimer's Disease and Dementia

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

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

4.2.3 Delegated Services

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

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

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

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

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

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

4.2.4 Pharmacological Management Services

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

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

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

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

Supporting documentation for pharmacological management services must include:

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

4.2.5 Electroconvulsive Therapy

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

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

4.2.6 Psychiatric Diagnostic Evaluation Services

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

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

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

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

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

Supporting documentation for psychiatric diagnostic evaluation services must include:

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

4.2.7 Psychological, Neurobehavioral, and Neuropsychological Testing Services

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

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

- Identifying information for the person receiving services
- Provider name and NPI
- Current DSM diagnoses
- Indication of court-ordered or DFPS-directed services

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- Type of testing requested (psychological, neurobehavioral, or neuropsychological) including specific procedure codes
- Rationale for requested testing, to include the current symptoms of the person receiving services
- Previous history and testing results

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

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

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

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

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

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

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

4.2.7.1 Testing in Facilities

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

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

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

- Reason for referral or presenting problem
- The name of the tests (e.g.,WAIS-R, Rorschach, MMPI) performed
- The scoring of the test
- Location where the testing is performed
- The name and credentials of each provider involved in administering, interpreting, and preparing the report

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- Test interpretations, including narrative descriptions of the test findings
- Length of time spent by each provider, as applicable, in administration, interpretation, integrating the test interpretation, and documenting the comprehensive report based on the integrated data
- Recommended treatment, including how test results affect the prescribed treatment
- Recommendations for further testing, including an explanation to substantiate the necessity for retesting, if applicable
- Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the person's condition requires testing over two days and the person does not return, or the person's condition precludes completion of the testing.

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

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

4.3 Prior Authorization

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

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

All providers must adhere to prior authorization requirements.

4.3.1 Services Requiring Prior Authorization

Prior Authorization is required for the following services:

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

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

- Diagnosis(es)
- Prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the evidence-based service or procedure to be performed, and the intended fee for the service or procedure
- The reason for recommending this particular service or procedure

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- A procedure code that is comparable to the service or procedure being requested
- Documentation that this service or procedure is not investigational or experimental

4.3.2 Prior Authorization Not Required

Prior authorization is not required for the following services:

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

4.4 Documentation Requirements

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

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

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

4.5 Twelve Hour System Limitation

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

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

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

Procedure Code	Time Applied
90791	60 minutes
+ Add-on procedure codes to be billed with the most appropriate E/M procedure code.	

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Procedure Code	Time Applied
90792	60 minutes
90832	30 minutes
90833+	30 minutes
90834	45 minutes
90836+	45 minutes
90837	60 minutes
90838+	60 minutes
90846	50 minutes
90847	50 minutes
96116	60 minutes
96121+	60 minutes
96130	60 minutes
96131+	60 minutes
96132	60 minutes
96133+	60 minutes
96136	30 minutes
96137+	30 minutes
+ Add-on procedure codes to be billed with the most appropriate E/M procedure code.	

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

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

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

4.6 Court-Ordered Services

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

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

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

- A person who is currently residing in a criminal justice facility and receiving treatment through a program at the criminal justice facility.
- A person who is committed under Title 1 Texas Code of Criminal Procedure §46(B), which addresses persons ages 18 and older who have been ordered to receive competency restoration.

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- A person who is committed under Title 3 Texas Family Code §§55.01-55.45. These sections refer to persons committed to inpatient psychiatric care because they are deemed unfit to proceed.

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

- Emergency detention ordered by a judge or magistrate under Title 7 Texas Health and Safety Code §§573. 011-573.026.
- Mental health services ordered under Title 7 Texas Health and Safety Code §§574.01-574.110. Mental health services may include:
  - A mental health examination.
  - Inpatient or outpatient treatment.
  - Detention under protective custody and temporary mental health services.
- Treatment of persons who are found not guilty based on lack of responsibility under Title 3 Texas Family Code §55.
- Treatment that is a condition of probation.
- Treatment of persons with chemical dependencies ordered under Title 6 Texas Health and Safety Code §462.042.

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

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

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

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

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

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

4.7 Exclusions

The following services are not benefits of Texas Medicaid:

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

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4.8 Claims Filing and Reimbursement

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

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

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

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

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

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

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

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

According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Under 1 TAC §355.8261, an FQHC is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

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

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

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

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

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

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4.9 NCCI and MUE Guidelines

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

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

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

5.1 Enrollment

5.1.1 Local Intellectual and Developmental Disability Authority (LIDDA) Providers

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

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

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

5.1.2 Local Mental Health Authority (LMHA) Providers

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

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

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

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

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

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

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

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5.1.4.1 Community Services Specialist (CSSP)

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

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

A CSSP performing MHTCM and MH rehabilitative services must:

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

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

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

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

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

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

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

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

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5.1.4.3 Peer Provider

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

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

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

5.1.4.4 Family Partner

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

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

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

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

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

5.1.4.5 Certifications for Mental Health Rehabilitative Services

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

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

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Service	Provider Types					
	QMHP-CS	CSSP	Peer Provider	Licensed Medical Personnel	Family Partner	RN
Day Program for Acute Needs - Psychiatric Nursing services				X		X

5.2 Services, Benefits, Limitations, and Prior Authorization

5.2.1 Intellectual and Developmental Disabilities Service Coordination

Texas Medicaid provides the following:

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

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

There are two types of encounters:

- *Comprehensive encounter (Type A):* A face-to-face contact with a person to provide service coordination. The comprehensive encounter is limited to one billable encounter per person per calendar month. HHSC will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per person per calendar month.
- *Supportive encounter (Type B):* A face-to-face, telephone, or telemedicine contact with a person or with a collateral on the person's behalf to provide service coordination.

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

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

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

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

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

Prior authorization is not required for IDD coordination services.

5.2.2 * Mental Health Targeted Case Management (MHTCM)

Mental health targeted case management (MHTCM) services are case management services to persons within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are persons, regardless of age, with a diagnosis or diagnoses of mental illness or serious emotional disturbance (SED) as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to need MHTCM services.

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Persons of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for MHTCM services.

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

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

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

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

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

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

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

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

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

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

Procedure code T1017 is limited to the following diagnosis codes:

[Revised] Diagnosis Codes							
F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0789	F09	F200	F201	F202
F203	F205	F2081	F2089	F209	F21	F22	F23
F24	F250	F251	F258	F259	F28	F29	F3010
F3011	F3012	F3013	F302	F303	F304	F309	F310
F3110	F3111	F3112	F3113	F312	F3130	F3131	F3132
F314	F315	F3160	F3161	F3162	F3163	F3164	F3170
F3171	F3172	F3173	F3174	F3175	F3176	F3177	F3178
F3181	F3189	F319	F320	F321	F322	F323	F324
F325	F3281	F3289	F329	F32A	F330	F331	F332
F333	F3340	F3341	F3342	F338	F339	F340	F341
F3481	F348	F349	F39	F4000	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F409	F410	F411	F413	F418	F419
F422	F423	F424	F428	F429	F430	F4310	F4311
F4312	F4320	F4321	F4322	F4323	F4324	F4325	F4329
F4381	F4389	F439	F440	F441	F442	F444	F445
F446	F447	F4481	F4489	F449	F450	F451	F4520
F4521	F4522	F4529	F4541	F4542	F458	F459	F481
F482	F488	F489	F5000	F50010	F50011	F50012	F50013
F50014	F50019	F50020	F50021	F50022	F50023	F50024	F50029
F5020	F5021	F5022	F5023	F5024	F5025	F50810	F50811
F50812	F50813	F50814	F50819	F5082	F5083	F5084	F5089
F509	F5101	F5102	F5103	F5104	F5105	F5109	F5111
F5112	F5113	F5119	F513	F514	F515	F518	F519

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[Revised] Diagnosis Codes							
F530	F531	F54	F600	F601	F602	F603	F604
F605	F606	F607	F6081	F6089	F609	F630	F631
F632	F633	F6381	F6389	F639	F640	F641	F642
F648	F649	F64A	F6810	F6811	F6812	F6813	F68A
F69	F8082	F900	F901	F902	F908	F909	F910
F911	F912	F913	F918	F919	F930	F938	F939
F940	F941	F942	F948	F949	F980	F981	F9821
F9829	F983	F984	F985	F988	F989	F99	O906
T7402XA	T7402XD	T7402XS	T7412XA	T7412XD	T7412XS	T7422XA	T7422XD
T7422XS	T7452XA	T7452XD	T7452XS	T7462XA	T7462XD	T7462XS	T7602XA
T7602XD	T7602XS	T7612XA	T7612XD	T7612XS	T7622XA	T7622XD	T7622XS
T7652XD	T7652XS	T7662XA	T7662XD	T7662XS			

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

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

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

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

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

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

5.2.2.1 Telemedicine and Telehealth

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

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

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

5.2.2.1.1 Synchronous Audiovisual Technology

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

5.2.2.1.2 Synchronous Telephone (Audio-Only Technology)

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

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

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

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

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

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

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

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

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

5.2.2.2 Collateral Contacts

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

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

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

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

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

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

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

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

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

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

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

- Making referrals to potential service providers.
- Initiating contact with potential service providers.
- Arranging, and if necessary to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments.

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- Arranging transportation to ensure the child or youth attendance.
- Advocating with service providers.
- Providing relevant information to service providers.
- Monitoring the child's or youth's progress toward the goals set forth in the plan.

5.2.2.3.1 Prior Authorization Requirements

Initial Authorization Requirements

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

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

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

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

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

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

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

- Section A – Client information

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

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

Reauthorization Requirements

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

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

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

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

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

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

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

Functioning is assessed using one of the following tools:

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

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

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

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

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

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

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

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

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

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

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

5.2.2.6 Documentation Requirements

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

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

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

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

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

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

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

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

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

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

5.2.2.7 Exclusions

The following services are not covered by MHTCM:

- Case management activities that are an integral component of another covered Medicaid service

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

5.2.3 * Mental Health Rehabilitative Services

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

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

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

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

Mental health rehabilitative services may include:

- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention services

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- Day programs for acute needs

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

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

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

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

Service Category	Procedure Codes	Modifiers
Day Program for Acute Needs	H2012	
Medication Training and Support	H0034	HQ: group services for adults HA/HQ: group services for child/youth
Crisis Intervention	H2011	HA: child/youth
Skills Training and Development	H2014	HQ: group services for adults HA: individual services for child/youth HA/HQ: group services for child/youth
Psychosocial Rehabilitation Services	H2017	TD: individual services provided by RN HQ: group services HQ/TD: group services provided by RN ET: individual crisis services

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

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

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

[Revised] Diagnosis Codes							
F060	F061	F062	F0630	F0631	F0632	F0633	F0634
F064	F068	F070	F0789	F09	F200	F201	F202
F203	F205	F2081	F2089	F209	F21	F22	F23

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[Revised] Diagnosis Codes							
F24	F250	F251	F258	F259	F28	F29	F3010
F3011	F3012	F3013	F302	F303	F304	F309	F310
F3110	F3111	F3112	F3113	F312	F3130	F3131	F3132
F314	F315	F3160	F3161	F3162	F3163	F3164	F3170
F3171	F3172	F3173	F3174	F3175	F3176	F3177	F3178
F3181	F3189	F319	F320	F321	F322	F323	F324
F325	F3281	F3289	F329	F32A	F330	F331	F332
F333	F3340	F3341	F3342	F338	F339	F340	F341
F3481	F3489	F349	F39	F4000	F4001	F4002	F4010
F4011	F40210	F40218	F40220	F40228	F40230	F40231	F40232
F40233	F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F409	F410	F411	F413	F418	F419
F422	F423	F424	F428	F429	F430	F4310	F4311
F4312	F4320	F4321	F4322	F4323	F4324	F4325	F4329
F4381	F4389	F439	F440	F441	F442	F444	F445
F446	F447	F4481	F4489	F449	F450	F451	F4520
F4521	F4522	F4529	F4541	F4542	F458	F459	F481
F482	F488	F489	F5000	F50010	F50011	F50012	F50013
F50014	F50019	F50020	F50021	F50022	F50023	F50024	F50029
F5020	F5021	F5022	F5023	F5024	F5025	F5020	F5021
F5022	F5023	F5024	F5025	F50810	F50811	F50812	F50813
F50814	F50819	F5082	F5083	F5084	F5089	F509	F5101
F5102	F5103	F5104	F5105	F5109	F5111	F5112	F5113
F5119	F513	F514	F515	F518	F519	F530	F531
F54	F600	F601	F602	F603	F604	F605	F606
F607	F6081	F6089	F609	F630	F631	F632	F633
F6381	F6389	F639	F640	F641	F642	F648	F649
F64A	F6810	F6811	F6812	F6813	F68A	F69	F8082
F900	F901	F902	F908	F909	F910	F911	F912
F913	F918	F919	F930	F938	F939	F940	F941
F942	F948	F949	F980	F981	F9821	F9829	F983
F984	F985	F988	F989	F99	O906	T7402XA	T7402XD
T7402XS	T7412XA	T7412XD	T7412XS	T7422XA	T7422XD	T7422XS	T7452XA
T7452XD	T7452XS	T7462XA	T7462XD	T7462XS	T7602XA	T7602XD	T7602XS
T7612XA	T7612XD	T7612XS	T7622XA	T7622XD	T7622XS	T7652XD	T7652XS
T7662XA	T7662XD	T7662XS					

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

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

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

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

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

5.2.3.1 Telemedicine and Telehealth

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

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

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

5.2.3.1.1 Synchronous Audiovisual Technology

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

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

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5.2.3.1.2 Synchronous Telephone (Audio-Only) Technology

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

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

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

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

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

The billing provider is required to conduct at least one in-person or synchronous audiovisual MHR, MHTCM, or peer specialist service every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving services and the billing provider agree that an in-person or synchronous audiovisual service is clinically contraindicated, or the risks or burdens of an in-person or synchronous audiovisual service outweigh the benefits. The decision to waive the 12-month requirement applies to that particular rolling 12-month period and the basis for

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the decision must be documented in the person's medical record. Examples of when a synchronous telephone (audio-only) service may be more clinically appropriate or beneficial than an in-person or synchronous audiovisual service include, but are not limited to, the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2.3.4 Treatment Planning

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

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

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

5.2.3.5 Medication Training and Support

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

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Medication training and support includes:

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

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

5.2.3.6 Psychosocial Rehabilitative Services

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

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

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

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

5.2.3.6.1 Independent Living Services

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

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

Training for independent living includes skills related to:

- Personal hygiene.
- Transportation utilization.
- Money management.
- The development of natural supports.

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

5.2.3.6.2 Coordination Services

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

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

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

5.2.3.6.3 Employment-Related Services

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

Included in employment-related services are activities such as:

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

5.2.3.6.4 Housing-Related Services

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

Included in housing-related services are activities such as:

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

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5.2.3.6.5 Medication-Related Services

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

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

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

5.2.3.7 Skills Training and Development

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

The training addresses:

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

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

Skills training and development may include:

- Skills related to personal hygiene.
- Pro-social skills.
- Assertiveness skills.
- Anger management skills.
- Stress reduction techniques.
- Communication skills.
- Transportation utilization.
- Money management.
- The development of natural supports.
- Access to needed services in the community, e.g., medical care, substance use services, legal services, living accommodations.
- Social skills (e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time).

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

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

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5.2.3.8 Crisis Intervention

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

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

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

Crisis intervention services consist of the following interventions:

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

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

5.2.3.9 Day Programs for Acute Needs

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

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

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

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

Day programs for acute needs include:

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

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

- One RN for every 16 persons at the day program's location,

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

5.2.3.10 Prior Authorization Requirements

5.2.3.10.1 Initial Authorization

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

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

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

Providers of mental health rehabilitative services must ensure the following:

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

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

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

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

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

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

- Section A – Client information

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

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

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

5.2.3.10.2 Reauthorization Requirements

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

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

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

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

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

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

5.2.3.11 Documentation Requirements

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

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

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

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

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

- Risk of suicide or homicide
- Substance use
- Trauma, abuse, or neglect
- The outcome of the crisis (e.g., person in hospital, person with friend and scheduled to see doctor at 9:00 a.m. the following day)
- All actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented
- The response of the person, and if appropriate, the response of the LAR and family members

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- Any pertinent event or behavior relating to the person's treatment that occurs during the provision of the service
- Follow up activities that may include referral to another provider

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

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

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

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

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

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

5.2.3.12 Exclusions

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

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

- Rehabilitative services provided:
  - Before the establishment of a diagnosis of mental illness and authorization of services
  - To persons who reside in an institution for mental diseases
  - To general acute care hospital inpatients
- Services to residents of institutions that furnish food, shelter, and treatment to four or more unrelated persons
- Services to nursing facility residents who have not been identified through the PASSR process as needing specialized mental health services
- Services to inmates of public institutions
- Job task-specific vocational services
- Educational services
- Room and board residential costs
- Services that are an integral and inseparable part of another Medicaid-reimbursable service, including MHTCM services, residential rehabilitative behavioral health services, institutional and waiver services
- Services that are covered elsewhere in the state Medicaid plan
- Services to persons with a single diagnosis of intellectual or developmental disability or substance use disorder who do not have a co-occurring diagnosis of mental illness in adults or SED in children

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- Inpatient hospital services
- Respite services
- Family support services

5.2.3.13 Non-reimbursable Activities

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

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

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

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

- Developing and revising the treatment plan and interventions that are appropriate to a person's needs.
- Staffing and team meetings to discuss the provision of mental health rehabilitative services to a specific person.
- Monitoring and evaluating outcomes of interventions, including contacts with a person other than the person receiving services.
- Documenting the provision of mental health rehabilitative services.
- A staff member's travel time to and from a location to provide mental health rehabilitative services.
- All services provided within a day program for acute needs that are delivered by a staff member, including services delivered in response to a crisis or an episode of acute psychiatric symptoms.
- Administering the uniform assessment to persons who are receiving mental health rehabilitative services.

5.3 Documentation Requirements

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

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

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5.4 Claims Filing and Reimbursement

IDD service coordination, MHTCM, and mental health rehabilitative services must be submitted to TMHP in an approved electronic claims format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

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

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

5.4.1 Managed Care Clients

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

5.4.2 Reimbursement Reductions

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

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

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

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

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

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

6 Peer Specialist Services

6.1 Services, Benefits, Limitations, and Prior Authorization

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

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

Peer specialist services include the following:

- Recovery and wellness support services, which include providing information and support for recovery planning.
- Mentoring, which includes serving as a role model and helping to find needed community resources and services.

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- Advocacy, which includes providing support during stressful or urgent situations and helping to ensure that the person's rights are respected. Advocacy may also include encouraging the person to advocate for him or herself to obtain services.

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

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

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

6.1.1 Telehealth Service

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

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

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

6.1.1.1 Synchronous Audiovisual Technology

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

6.1.1.2 Synchronous Telephone (Audio-Only) Technology

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

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

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

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

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

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

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

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

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

6.2 Peer Specialist Requirements

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

- Clinic/group practices that treat behavioral health conditions
- Physicians (M.D.s), osteopaths (D.O.s), and nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) that treat behavioral health conditions
- Psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of targeted case management and mental health rehabilitative services

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- Local mental and behavioral health authorities
- Chemical dependency treatment facilities
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs)
- Opioid Treatment Providers (OTPs)

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

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

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

A peer specialist must meet all of the following criteria:

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

A peer specialist must not:

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

6.2.1 Certification

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

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

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

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

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

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

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

6.2.2 Supervision

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

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

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

- Review of cases and activities
- Skill building
- Problem resolution
- Professional growth

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

Peer specialist supervision may be provided as follows:

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

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

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

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

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

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

6.3 Prior Authorization Requirements

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

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

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

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

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

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

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

6.4 Documentation Requirements

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

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

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

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

6.4.1 Reimbursement

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

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

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

Peer specialist services will also be limited as follows:

- Must not be delivered simultaneously with other behavioral health services that are delivered to the person or group of persons receiving services
- Must be delivered in person and not through advanced telecommunications technology
- Limited to 12 total persons per group session

6.4.2 Claim Filing

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

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

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

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

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

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

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6.5 Exclusions

The following services are not a benefit of Texas Medicaid:

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

7 Certified Family Partners

7.1 Services, Benefits, Limitations, and Prior Authorization

Certified family partner (CFP) services, also referred to as family partner support services or family peer support services, are benefits of Texas Medicaid for parents (birth, adoptive, and foster), legally authorized representatives (LARs), or primary caregivers of a Medicaid eligible child or youth (20 years of age and younger) who is diagnosed with a serious emotional disturbance (SED) or a mental health or substance use condition, as defined in the current edition of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and who has CFP services included as a component in their person-centered and trauma-informed recovery plan (henceforth, referred to as the plan of care).

CFPs provide services directly to the parents, LARs, or primary caregivers, not to the Medicaid eligible child or youth.

CFP services are an array of formal and informal services and supports that include:

- Introducing parents, LARs, or primary caregivers to the mental health and substance use system
- Modeling advocacy skills
- Providing education and information
- Making referrals
- Providing skills training
- Assisting in identifying supports
- Conducting support groups
- Helping with navigating systems, e.g., juvenile justice, child protective services, independent school districts

CFP services may be provided in an office, home, outpatient hospital, other locations, and by telehealth if certain conditions are met.

Refer to: Section 7.1.4, "Telehealth" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*)for more information.

CFP services may be delivered as part of a coordinated, comprehensive, and individualized approach to treating a Medicaid eligible child's or youth's SED or mental health or substance use condition. CFPs may not bill Medicaid directly for family partner support services. CFPs must be employed by one of the following Medicaid enrolled provider types that may submit claims for CFP services rendered:

- Clinic and group practices treating behavioral health conditions
- Physicians, APRNs, and PAs treating behavioral health conditions
- Licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Comprehensive provider agencies of mental health targeted case management and mental health rehabilitative services

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- LMHAs/LBHAs
- Chemical dependency treatment facilities
- FQHCs
- RHCs
- Opioid treatment providers

Providers of CFP services must coordinate with all behavioral health service providers involved in the care of the Medicaid eligible child or youth, and utilize a person and family-centered, recovery-oriented approach to recovery planning and service delivery.

Non-Medicaid enrolled providers who employ CFPs may choose to contract with one of the above Medicaid enrolled providers to furnish the services as part of a continuum of comprehensive treatment services. Subcontracted CFP services must also be part of the coordinated, comprehensive, and individualized plan of care of the Medicaid eligible child or youth.

7.1.1 Certification Requirements

A CFP is a parent (birth, adoptive, or foster), LAR, or primary caregiver with lived experience parenting or raising a child or youth with a SED or mental or substance use condition and who has received specialized training and passed a certification exam to provide CFP services.

A CFP must:

- Be 18 years of age or older.
- Have a high school diploma or high school equivalency certificate issued in accordance with the law of the issuing state.
- Have lived experience navigating a child-service system, such as a mental health, juvenile justice, social security, or special education system, as a parent, LAR, or primary caregiver of a child or youth with a SED or mental health or substance use condition.
- Be willing to appropriately share their own recovery story with recipients of CFP services.
- Have successfully completed and passed the Texas Health and Human Services (HHSC) approved certification process.

A CFP must also:

- Satisfy and complete all staff credentialing, competency, training, and supervision requirements, prior to delivering CFP services, as required by the HHSC approved designated certifying entity in Texas.
- Pass criminal history and registry checks, as described in 1 TAC §354.3201.

A CFP certification is issued for a period of two years. A CFP must renew their certification every two years through the HHSC-approved designated certifying entity in Texas. Recertification requires a minimum number of continuing education hours, as required by the HHSC-approved designated certifying entity in Texas

A CFP may not:

- Deliver family partner support services to a child or youth of whom they are a parent (birth, adoptive, and foster), LAR, or primary caregiver.
- Practice psychotherapy.
- Make clinical or diagnostic assessments or dispense expert opinions.
- Engage in any service that requires a license.

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- Falsify any documentation related to application, training, testing, certification, or services provided.

7.1.2 Supervision Requirements

Providers may be reimbursed for CFP services that are rendered under the supervision of one of the following, as defined in 1 TAC §354.3003:

- Qualified Credential Counselor (QCC)
- Licensed Practitioner of the Healing Arts (LPHA)
- Qualified Mental Health Professional-Community Services (QMHP-CS) with a QCC or LPHA supervising the QMHP
- Qualified Peer Supervisor (QPS) with a QCC or LPHA supervising the QPS

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

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

A supervisor must successfully complete and pass the HHSC-approved certification process for supervision of CFP services and the recovery model from a certified training entity before supervising a CFP. Supervisor training must include instruction about:

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

After completing training, each candidate must successfully complete a knowledge assessment before receiving approval to supervise a CFP from the designated certifying entity in Texas.

Supervision of CFPs must focus on the provision of services to include:

- Review of cases and activities.
- Skill building.
- Problem resolution.
- Professional growth.

Supervision of CFPs may be delivered:

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

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

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7.1.3 Reimbursement

CFP services must be included in the plan of care of the Medical eligible child or youth to be reimbursed. A billable unit of CFP services is 15 minutes of continuous contact.

Procedure code S9482 may be reimbursed for CFP services. The following modifiers may be submitted with procedure code S9482 for CFP services as appropriate:

Modifier	Description
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous audio-only technology
HE	Mental health program
HF	Substance use program
HQ	Group-delivered services

Claims for CFP services using procedure code S9482 must be submitted with modifier HE or HF, as appropriate.

Claims for CFP services delivered in a group setting must also be submitted with modifier HQ. CFP services delivered in a group setting are limited to 12 persons per group session.

CFP services are limited to 104 units in a rolling 6-month period. This limit may be exceeded with prior authorization.

CFP services may not be delivered simultaneous to other behavioral health services being delivered to a person or group of persons receiving services.

Mental health rehabilitative services delivered by family partners must be billed separately from CFP services.

FQHCs and RHCs should submit claims for CFP services using procedure code S9482 for informational purposes only.

Only clinic and group practices or individual health care providers (e.g., physicians, APRNs, and PAs) with a behavioral health focus are eligible for reimbursement of CFP services.

7.1.4 Telehealth

Providers of CFP services must defer to the needs of the parent(s), LAR(s), or primary caregiver(s) receiving the services, allowing the mode of service delivery to be accessible and family-centered, and primarily driven by the parent', LARs', or primary caregivers' choice and not provider convenience.

Providers must provide CFP services to the parent(s), LAR(s), or primary caregiver(s) of the Medicaid eligible child or youth in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 TAC §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, CFP services in full accordance with all applicable licensure and certification requirements.

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

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7.1.4.1 Synchronous Audiovisual Technology

CFP services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the parent(s), LAR(s), or primary caregiver(s) receiving services. In addition, approval to deliver the services by synchronous audiovisual technology must be documented in the plan of care of the Medicaid eligible child or youth receiving services. CFP services provided by synchronous audiovisual technology must be billed using modifier 95.

7.1.4.2 Synchronous Telephone (Audio-Only) Technology

CFP services may be provided by synchronous telephone (audio-only) technology to the parent(s), LAR(s), or primary caregiver(s) of the Medicaid eligible child or youth with whom the billing provider has an 'existing clinical relationship' and if clinically appropriate and safe, as determined by the billing provider, and agreed to by the parent(s), LAR(s), or primary caregiver(s) receiving services. In addition, approval to deliver the services by synchronous telephone (audio-only) technology must be documented in the plan of care of the Medicaid eligible child or youth whose parent(s), LAR(s), or primary caregiver(s) are receiving CFP 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 CFP services must document in the medical record of the Medicaid eligible child or youth the reason(s) for why the services were delivered by synchronous telephone (audio-only) technology. CFP services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

An 'existing clinical relationship' occurs when the parent(s), LAR(s), or primary caregiver(s) have received at least one in-person or synchronous audiovisual CFP service or, on behalf of the Medicaid eligible child or youth, has received a mental health targeted case management (MHTCM) or mental health rehabilitative (MHR) service from the same billing provider within the six months prior to the initial CFP service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual CFP, MHTCM, or MHR service from the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

> ***Note:*** *'Same billing provider' refers to providers within the same entity (i.e., same National Provider Identification (NPI) number), e.g., same LMHA/LBHA, comprehensive provider agency of MHTCM or MHR services, clinic, or group practice, FQHC, RHC, chemical dependency treatment facility, or opioid treatment provider presuming all other applicable state and federal laws and regulations are followed. The required in-person or synchronous audiovisual delivered CFP service may be delivered by another authorized professional or paraprofessional of the same billing provider as the professional or paraprofessional who delivers the service by synchronous telephone (audio-only) technology.*

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

- The parent(s), LAR(s), or caregiver(s) receiving services are located at a qualifying originating site in an eligible geographic area (e.g., a practitioner office in a rural health professional shortage area).

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- An in-person or synchronous audiovisual service is likely to cause disruption in service delivery or has the potential to worsen the condition of the Medicaid eligible child or youth or the family unit.

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

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

7.1.5 Prior Authorization

Prior authorization is not required for the first 104 units (26 hours) of CFP services in a rolling six-month period. A billable unit of CFP services is 15 minutes of continuous contact. Prior authorization is required once the 104 units (26 hours) of CFP services (individual or group) in a rolling six-month period is exceeded. A billable unit of CFP services is 15 minutes of continuous contact.

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

Prior authorization requests are considered on a case-by-case basis with documentation supporting medical necessity for additional units of CFP services.

Prior authorization requests must include the following documentation:

- The Medicaid-eligible child or youth continues to meet eligibility criteria, as outlined in the Benefits section of this handbook, including current APA DSM diagnosis or diagnoses.
- The current plan of care to include goal(s) and objective(s) for the Medicaid-eligible child or youth.
- The progress made to date relative to the goal(s) and objective(s) outlined in the plan of care of the Medicaid-eligible child or youth.
- The need for continued services.

Prior authorization requests must be submitted to the TMHP Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The form must include the following information:

- Section A - Client Information:
  - Identifying information for the Medicaid eligible child or youth (i.e., name, date of birth, and Medicaid number).
- Section B - Requested Procedure or Service Information:
  - Type of request is 'Other.'
  - Expected dates of service.
  - Procedure code (S9482) and description (CFP services).
  - Identifying information (full name) for the parent(s), LAR(s), or primary caregiver(s) receiving CFP services in the comments text box.
- Section C - Requesting Provider Information:
  - ICD-10 primary diagnosis and related ICD-10 diagnosis code(s) of the Medicaid eligible child or youth.
  - Medical necessity information to include:
    - The number of additional units being requested (up to 30 units allowed per request) and the type of units requested (i.e., individual, group, or both).

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  - The need for continued CFP services.
  - Progress made to the goal(s) and objective(s) that are outlined in the plan of care of the Medicaid eligible child or youth.
- Information about the requesting physician or provider, as indicated on the form (e.g., name, physical address, telephone, etc.).
- Signature of the requesting physician or provider, and the signature date of the request.

Note: *The form must be signed, dated, and submitted within 30 calendar days prior to the expected start date of additional CFP services.*

The requesting physician or provider may be asked for additional information to clarify or complete a request. Retrospective review may be performed to ensure documentation supports the medical necessity of the requested service.

Prior authorization requests must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically signed documents must have an electronic date on the same page as the signature. Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable.

All electronically signed transactions and electronically signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules.

Providers who submit a prior authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted.

To complete the prior authorization process by paper, the provider must fax or mail the completed SMPA Request Form to the TMHP Prior Authorization Department and retain a copy of the signed and dated SMPA Request Form in the medical record of the Medicaid eligible child or youth.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated SMPA Request Form in the medical record of the Medicaid eligible child or youth.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the services requested. The physician must maintain documentation of medical necessity in the medical record of the Medicaid eligible child or youth.

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

7.2 Documentation Requirements

In addition to prior authorization documentation requirements outlined in this handbook, the following requirements apply:

- All services outlined in the Benefits section of this handbook are subject to retrospective review to ensure that the documentation in the medical record of the Medicaid-eligible child or youth supports the medical necessity of the services provided.
- The enrolled provider shall ensure proper documentation of all CFP services delivered.

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- Documentation of CFP services must indicate the date, time, and place of service, and must summarize the purpose and content of the services, along with specific strategies and activities utilized, as related to the goal(s) and objective(s) in the plan of care of the Medicaid-eligible child or youth.
- CFP supervisors must document all supervisory sessions and maintain records in the employee personnel file of the CFP.

Documentation requirements for 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.

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

7.3 Exclusions

The following services are not benefits of the Texas Medicaid program:

- Record-keeping or documentation activities
- Services that are not provided directly to the person receiving services
- Children or youth with a single diagnosis of an intellectual and developmental disability

8 Inpatient Psychiatric Services

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

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

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

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

Refer to: Section 3.4, "Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

9 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SBIRT is used for intervention directed to a person and not for group intervention.

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics

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(RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

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

Refer to: Section 10, "Substance Use Disorder (SUD) Services" in this handbook for additional information on SUD treatment.

9.1 SBIRT Training

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

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

9.2 Screening

Screening persons for problems related to alcohol or substance use identifies the person's level of risk and determines the appropriate level of intervention indicated for the person. Providers must explain the screening results to the person, and if the results are positive, be prepared to subsequently deliver, or delegate to another provider, brief intervention services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, annoyed, guilty, eye-opener (CAGE) questionnaire
- Car, relax, alone, forget, family or friends, trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

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

9.3 Brief Intervention

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

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

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

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9.4 Referral to Treatment

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

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

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

9.5 Telemedicine and Telehealth Services

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

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

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

9.5.1 Synchronous Audiovisual Technology

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

9.5.2 Synchronous Telephone (Audio-only Technology)

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

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

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

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9.6 Reimbursement and Limitations

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

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

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

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

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

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

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

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

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

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

9.7 Documentation Requirements

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

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

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

- The provider who performed the SBIRT brief intervention, if different from the provider who screened the person
- Start and stop time of the session, or the total time spent providing SBIRT services to the person
- Goals established
- Specific strategies to achieve the goals

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- The person's support system such as family members, a legal guardian, or friends.

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

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

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

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

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

9.8 Claims Filing and Reimbursement

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

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

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

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

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

According to 1 TAC §355.8091, the Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

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

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

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

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician's or RHC's NPI are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

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

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

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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.*

10 Substance Use Disorder (SUD) Services

10.1 Overview

SUDs are chronic, relapsing medical illnesses that require an array of best practice medical and psychosocial interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, "club" drugs, other synthetic 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's) Diagnostic Statistical Manual of Mental Disorders (DSM).

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

SUD services include:

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

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

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

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

The treatment setting and the intensity or level of services will vary depending on the severity of the person's SUD and what is clinically appropriate. The intensity or level of services refers to the number of hours of services per week, as well as the types of services the person receives. Early Intervention

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services are part of the spectrum of SUD treatment and are a benefit in Texas Medicaid. Early intervention services target persons who are at risk of developing a substance related problem but may not have a diagnosed SUD.

Refer to: Subsection 9, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" in this handbook for further information on early intervention services.

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

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

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

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

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

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

10.3 Withdrawal Management Services

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

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

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

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

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

10.4 Individual and Group SUD Counseling Services in an Outpatient Setting

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

Outpatient counseling services are appropriate for the following:

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

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

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

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

10.5 Residential Treatment Services

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

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

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

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

10.6 Outpatient Treatment Services

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

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

Diagnosis Codes							
F1010	F1011	F10120	F10121	F10129	F10130	F10131	F10132
F10139	F1014	F10150	F10151	F10159	F10180	F10181	F10182
F10188	F1019	F1020	F1021	F10220	F10221	F10229	F10230
F10231	F10232	F10239	F1024	F10250	F10251	F10259	F1026
F1027	F10280	F10281	F10282	F10288	F1029	F1090	F1091
F10920	F10921	F10929	F10930	F10931	F10932	F10939	F1094
F10950	F10951	F10959	F1096	F1097	F10980	F10981	F10982
F10988	F1099	F1110	F1111	F11120	F11121	F11122	F11129
F1113	F1114	F11150	F11151	F11159	F11181	F11182	F11188
F1119	F1120	F1121	F11220	F11221	F11222	F11229	F1123
F1124	F11250	F11251	F11259	F11281	F11282	F11288	F1129
F1190	F1191	F11920	F11921	F11922	F11929	F1193	F1194
F11950	F11951	F11959	F11981	F11982	F11988	F1199	F1210
F1211	F12120	F12121	F12122	F12129	F1213	F12150	F12151
F12159	F12180	F12188	F1219	F1220	F1221	F12220	F12221
F12222	F12229	F1223	F12250	F12251	F12259	F12280	F12288
F1229	F1290	F1291	F1293	F12920	F12921	F12922	F12929
F12950	F12951	F12959	F12980	F12988	F1299	F1310	F1311
F13120	F13121	F13129	F13130	F13131	F13132	F13139	F1314
F13150	F13151	F13159	F13180	F13181	F13182	F13188	F1319
F1320	F1321	F13220	F13221	F13229	F13230	F13231	F13232
F13239	F1324	F13250	F13251	F13259	F1326	F1327	F13280
F13281	F13282	F13288	F1329	F1390	F1391	F13920	F13921
F13929	F13930	F13931	F13932	F13939	F1394	F13950	F13951
F13959	F1396	F1397	F13980	F13981	F13982	F13988	F1399
F1410	F1411	F14120	F14121	F14122	F14129	F1413	F1414
F14150	F14151	F14159	F14180	F14181	F14182	F14188	F1419
F1420	F1421	F14220	F14221	F14222	F14229	F1423	F1424
F14250	F14251	F14259	F14280	F14281	F14282	F14288	F1429
F1490	F1491	F14920	F14921	F14922	F14929	F1493	F1494
F14950	F14951	F14959	F14980	F14981	F14982	F14988	F1499
F1510	F1511	F15120	F15121	F15122	F15129	F1513	F1514
F15150	F15151	F15159	F15180	F15181	F15182	F15188	F1519
F1520	F1521	F15220	F15221	F15222	F15229	F1523	F1524
F15250	F15251	F15259	F15280	F15281	F15282	F15288	F1529
F1590	F1591	F15920	F15921	F15922	F15929	F1593	F1594
F15950	F15951	F15959	F15980	F15981	F15982	F15988	F1599
F1610	F1611	F16120	F16121	F16122	F16129	F1614	F16150
F16151	F16159	F16180	F16183	F16188	F1619	F1620	F1621

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Diagnosis Codes							
F16220	F16221	F16229	F1624	F16250	F16251	F16259	F16280
F16283	F16288	F1629	F1690	F1691	F16920	F16921	F16929
F1694	F16950	F16951	F16959	F16980	F16983	F16988	F1699
F1810	F1811	F18120	F18121	F18129	F1814	F18150	F18151
F18159	F1817	F18180	F18188	F1819	F1820	F1821	F18220
F18221	F18229	F1824	F18250	F18251	F18259	F1827	F18280
F18288	F1829	F1890	F1891	F18920	F18921	F18929	F1894
F18950	F18951	F18959	F1897	F18980	F18988	F1899	F1910
F1911	F19120	F19121	F19122	F19129	F19130	F19131	F19132
F19139	F1914	F19150	F19151	F19159	F1916	F1917	F19180
F19181	F19182	F19188	F1919	F1920	F1921	F19220	F192221
F19222	F19229	F19230	F19231	F19232	F19239	F1924	F19250
F19251	F19259	F1926	F1927	F19280	F19281	F19282	F19288
F1929	F1990	F1991	F19920	F19221	F19922	F19929	F19930
F19931	F19932	F19939	F1994	F19950	F19951	F19959	F1996
F1997	F19980	F19981	F19982	F19988	F1999	F551	F553

10.7 Medication Assisted Treatment Services

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Codes									
H0020	H0033	J0570	J0577	J0578	J2315	Q9991	Q9992		

10.7.1 Opioid Treatment Providers

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

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

Procedure Codes									
H0001	H0004	H0005	H0020	H0033	J0577	J0578	J2315	Q9991	Q9992

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

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

10.8 Telemedicine and Telehealth Services

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

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

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances

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described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

10.8.1 Synchronous Audiovisual Technology

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

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

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

10.8.2 Synchronous Telephone (Audio-only) Technology

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

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

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) from the same provider within the six months prior to the initial service delivered by synchronous telephone (audio-only) technology. The six-month requirement for at least one in-person or synchronous audiovisual service by the same billing provider prior to the initial synchronous telephone (audio-only) service may not be waived.

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

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

The billing provider is required to conduct at least 1 in-person or synchronous audiovisual SUD service (comprehensive assessment, individual or group counseling, MAT, outpatient or residential withdrawal management, or residential treatment services) every rolling 12 months from the date of the initial service delivered by synchronous telephone (audio-only) technology unless the person receiving

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

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

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

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

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

10.9 Exclusions

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

10.10 Prior Authorization

The following services do not require prior authorization:

- Assessment
- Outpatient treatment services
- MAT

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

The following services require prior authorization:

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

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

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

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

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

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

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

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

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

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

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

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

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

10.10.2 Prior Authorization for Outpatient Withdrawal Management Treatment Services

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

10.10.2.1 Admission Criteria for Outpatient Withdrawal Management Treatment Services

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

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

- Chemical Substance Withdrawal—The person must meet all of the following criteria with regard to chemical substance withdrawal:
  - The person is expected to have a stable withdrawal from alcohol or drugs.
  - The diagnosis must meet the criteria for the definition of SUD or the most current revision of the APA's DSM accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
- Medical Functioning—The person must meet all of the following criteria with regard to medical functioning:
  - No history of recent seizures or past history of seizures during withdrawal.
  - No clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinically significant obtundation, stupor, or coma).
  - The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
  - Stable vital signs as interpreted by a physician. The person must also be without a previous history of complications from acute chemical substance withdrawal and judged to be free of a health risk as determined by a physician.
  - No evidence of a coexisting serious injury or systemic illness either newly discovered or progressive in nature.
  - Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
  - Clinical condition that allows for a comprehensive and satisfactory assessment.
- Family, Social, or Academic Dysfunction—The person must meet at least one of the following criteria with regard to family, social, or academic dysfunction:
  - The person's social system and significant others are supportive of recovery to the extent that the person can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the person's SUD.
  - The person's family or significant others are willing to participate in the outpatient withdrawal management treatment program.
  - The person may or may not have a primary or social support system to assist with immediate recovery, but the person has the social skills to obtain such a support system or to become involved in a self-help fellowship.
  - The person does not live in an environment where licit or illicit mood-altering substances are being used. A person living in an environment where licit or illicit mood-altering substances are being used may not be a candidate for this level of care.
- Emotional and Behavioral Status—The person must meet all of the following criteria with regard to emotional and behavioral status:
  - The person is coherent, rational, and oriented for treatment.

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- The mental state of the person does not preclude the person's ability to comprehend and understand the materials presented, and the person is able to participate in the outpatient withdrawal management treatment process.
- Documentation exists in the medical record that the person expresses an interest to work toward outpatient withdrawal management treatment goals.
- The person has no neuropsychiatric condition that places the person at imminent risk of harming self or others (e.g. pathological intoxication or alcohol idiosyncratic intoxication).
- The person has no neurological, psychological, or uncontrolled behavior that places the person at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety).
- The person has no documented DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
- The person has no mental confusion or fluctuating orientation.

- Chemical Substance Use—The person must meet the criteria in at least one of the following conditions with regard to recent chemical substance use:
  - The person's chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
  - The person is motivated to stop using alcohol or drugs and is in need of a supportive, structured treatment program to facilitate withdrawal from chemical substances.

10.10.2.2 Continued Stay Criteria for Outpatient Withdrawal Management Treatment Services

A person is considered eligible for continued stay in the outpatient withdrawal management treatment service when the person meets at least one of the conditions for either chemical substance withdrawal or psychiatric or medical complications. Requests for extension of services must be received on or before the last date authorized or denied. The prior authorization unit will notify the provider by fax or electronic portal. If the date of the prior authorization unit determination letter is on or after the last date authorized or denied or if the last date falls on a holiday or weekend, the request for extension of services is due by 5 p.m. of the next business day. Documentation in the person's medical record must support either Chemical Substance Withdrawal or Psychiatric or Medical Complications.

Chemical Substance Withdrawal

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

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

Psychiatric or Medical Complications

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

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

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10.10.3 Prior Authorization for Residential Withdrawal Management Treatment Services

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

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

10.10.3.1 Admission Criteria for Residential Withdrawal Management Treatment Services

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

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

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

- Chemical Substance Withdrawal—The person must have impaired neurological functions as evidenced by:
  - Extreme depression (e.g., suicidal).
  - Altered mental state with or without delirium as manifested by disorientation to self; alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.
  - History of recent seizures or past history of seizures on withdrawal.
  - The presence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).
  - Unstable vital signs combined with a history of past acute withdrawal syndromes that are interpreted by a physician to be indication of acute alcohol or drug withdrawal.
  - Evidence of coexisting serious injury or systemic illness, newly discovered or progressive.
  - Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions and indicates placement in residential withdrawal management service may be justified.
  - Neuropsychiatric changes of such severity and nature that they put the person at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication).
  - Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
- Major Medical Complications—The person must present a documented condition or disorder that, in combination with alcohol or drug use, presents a determined health risk (e.g., gastrointestinal bleeding, gastritis, severe anemia, uncontrolled diabetes mellitus, hepatitis, malnutrition, cardiac disease, hypertension).

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- Major Psychiatric Illness—The person must meet at least one of the following conditions with regard to major psychiatric illness:
  - Documented APA DSM condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the person.
  - Severe neurological and psychological symptoms: (e.g., anguish, mood fluctuations, overreactions to stress, lowered stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, extreme negative emotions, or extreme anxiety).
  - Danger to others or homicidal.
  - Uncontrolled behavior that endangers self or others, or documented neuropsychiatric changes of a severity and nature that place the person at imminent risk of harming self or others.
  - Mental confusion or fluctuating orientation.

10.10.3.2 Continued Stay Criteria for Residential Withdrawal Management Treatment Services

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

Chemical Substance Withdrawal

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

- Incomplete medically stable withdrawal from alcohol or drugs, as evidenced by documentation of at least one of the following conditions:
  - Unstable vital signs
  - Continued disorientation
  - Abnormal laboratory findings related to chemical dependency
  - Continued cognitive deficit related to withdrawal so that the person is unable to recognize alcohol or drug use as a problem
- Laboratory finding that, based on the judgment of a physician, indicates that a drug has not sufficiently cleared the person's system

Major Medical Complications

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

Major Psychiatric Complications

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

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

10.10.4 Prior Authorization for Residential Treatment Services

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

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

10.10.4.1 Admission Criteria for Residential Treatment Services

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

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

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

- Medical Functioning—The following must be present with regard to medical functioning:
  - Documented medical assessment following admission (except in instances where the person is being referred from an inpatient service) indicates that the person is medically stable and not in acute withdrawal.
  - The person is not bed-confined and has no medical complications that would hamper participation in the residential service.
- Family, Social, or Academic Dysfunction and Logistic Impairments—At least one of the following must be present with regard to family, social, or academic dysfunction and logistic impairments:
  - The person manifests severe social isolation or withdrawal from social contacts.
  - The person lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines person's efforts to change).
  - The person's family or significant others are opposed to the person's treatment efforts and are not willing to participate in the treatment process.
  - Family members or significant others living with the person manifest current SUDs and are likely to undermine treatment.
  - Logistic impairments (e.g., distance from treatment facility or mobility limitations) preclude participation in an outpatient treatment setting.
- Emotional and Behavioral Status—The person must meet all three of the following criteria with regard to emotional and behavioral status:
  - The person is coherent, rational, and oriented for treatment.
  - Mental state of the person does not preclude the person's ability to comprehend and understand the materials presented and participate in rehabilitation or the treatment process.
  - The medical record contains documentation that with continued treatment the person will be able to improve or internalize the person's motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol or drug related issues). Interventions, treatment goals, or contracts are in place to help the person deal with or confront the blocks to treatment (e.g., family intervention or employee counseling confrontation).
- Chemical Substance Use—The person must meet at least one of the following criteria with regard to chemical substance use:
  - The person's chemical substance use is excessive, and the person has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).

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- Virtually all of the person's daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances, and the person requires a secured environment to control the person's access to chemical substances.

10.10.4.2 Residential Treatment Services for Adolescents

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

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

10.10.4.3 Continued Stay Criteria for Residential Treatment Services

At least one of the following conditions must be present for continued stay in a residential treatment program:

- Chemical Dependency Rehabilitation or Treatment Complications:
  - The person recognizes or identifies with the severity of the alcohol or drug problem but demonstrates minimal insight into the person's defeating the use of alcohol or drugs. However, documentation in the medical record indicates that the person is progressing in treatment.
  - The person identifies with the severity of the alcohol or drug problem and manifests insight into the person's personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate the development of problem-solving skills that are necessary to cope with the problem.
  - The person would predictably relapse if moved to a lesser level of care.
- Psychiatric or Medical Complications:
  - Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt rehabilitation or treatment, but the person is again progressing in treatment.
  - Documentation in the medical record indicates that the person is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient withdrawal management alcohol or drug service.

10.10.5 Prior Authorization for Outpatient Treatment Services

Prior authorization for outpatient treatment services beyond the annual limitation of 135 units of group services and 26 hours of individual services per calendar year, may be considered with documentation supporting medical necessity for continued treatment services. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

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Requests must be submitted before providing the extended services. The documentation must include the following information:

- The person is meeting treatment goals.
- The person demonstrates insight and understanding into relationship with mood-altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals.
- The person is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the person is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the person will effectively address these issues.
- Although other psychiatric or medical complications exist that affect the person's treatment, there is documentation to support the person continues to show treatment progress and there is evidence to support the benefits of continued treatment.

10.11 Documentation Requirements

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including documentation for medical necessity for the services requested. The provider must maintain documentation of medical necessity in the person's medical record.

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

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

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

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

10.12 Reimbursement and Limitations

10.12.1 Withdrawal Management Services

Inpatient hospital-based withdrawal management is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

Residential withdrawal management and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.

Residential withdrawal management services (procedure codes H0012, H0031, S9445, and T1007) are limited to once per day, any provider.

Residential withdrawal management services (procedure codes H0031, H0047, S9445, or T1007) will be denied if billed without lead procedure code H0012 on the same day, same provider.

Room and board for residential withdrawal management and treatment (procedure code H0047) is limited to once per date of service, any provider. Procedure code H0047 is reimbursed for persons who are 21 years of age and older as an access-based fee and as an informational detail for persons who are 20 years of age and younger.

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Outpatient withdrawal management (procedure codes H0016, H0050, and S9445) is limited to once per day, any provider and may be reimbursed on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the person's treatment plan.

Outpatient withdrawal management (procedure codes H0050 and S9445) will be denied if billed without lead procedure code H0016 on the same day, same provider.

Separate reimbursement may be provided for physician services during a residential stay.

10.12.1.1 Treatment Services

Outpatient treatment services are limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF. Providers may submit requests requiring additional services using the Outpatient Substance Use Disorder Counseling Extension request form.

Residential treatment services (procedure code H2035) are limited to one per day and are allowed up to a maximum of 35 days.

Outpatient treatment (procedure codes H0004 and H0005) will be denied if billed on the same date of service as residential withdrawal management (procedure codes H0012, H0031, H0047, S9445, and T1007) or residential treatment (procedure code H2035).

Procedure code H0047 will be denied if billed without lead procedure code H2035 or H0012 on the same day, same provider.

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about NCCI MUE guidelines.

10.12.2 MAT Services

Claims billed for MAT must include the person's substance use disorder diagnosis. MAT billing may include billing for induction as well as maintenance.

Methadone administration (procedure code H0020) for opioid disorder must be submitted with the following modifiers:

- When methadone is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
- When methadone is dispensed without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses

Methadone provided in an outpatient setting (procedure code H0020) is limited to once per date of service, by any provider and is reimbursed at a fixed daily rate. Reimbursement for procedure code H0020 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0020 with modifier U1 for each date of service for which a take-home dose is dispensed. Methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

Methadone administration (procedure code H0020) submitted without a modifier will be denied.

Non-methadone (e.g., buprenorphine) administration (procedure code H0033) for opioid disorder must be submitted with the following modifiers:

- When non-methadone is administered with supervision in a facility the provider must submit claims using the modifier UA to indicate opioid disorder treatment facility doses or claims will be denied
- When non-methadone is dispensed without supervision as a take home dose the provider must submit claims using the modifier U1 to indicate opioid disorder take home doses or claims will be denied

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Non-methadone provided in an outpatient setting (procedure code H0033) is limited to once per date of service, by any provider. Reimbursement for procedure code H0033 with modifier U1 is limited to a quantity of 30 per 30 days, any provider.

Providers that allow take-home doses must submit procedure code H0033 with modifier U1 for each date of service for which a take-home dose is dispensed. Non-methadone that is dispensed for unsupervised take-home use should be dispensed in alignment with the federal opioid treatment standards in Title 42 Code of Federal Regulations (CFR) §8.12.

When non-methadone is administered in a facility for a non-opioid treatment, providers must use procedure code H0033 to indicate non-opioid treatment in a facility.

Non-methadone administration (procedure code H0033) submitted without a modifier will be denied. Physician and physician extenders may be reimbursed separately using the appropriate evaluation and management procedure codes.

Injectable administration is considered part of MAT and is not reimbursed separately. Procedure code 96372 will be denied when billed for the same date of service by any provider as procedure code H0020 or H0033.

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

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

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

10.13 Claims Filing

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

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

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

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

11 Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

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CoCM services are benefits of Texas Medicaid for persons of all ages who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a physician, physician assistant, nurse practitioner, or clinic/group practice, federally qualified health center (FQHC), or rural health clinic (RHC) (henceforth referred to as the primary care provider).

Prior to delivering CoCM services, the primary care provider must attest in the Provider Enrollment and Management System (PEMS) that their practice location has an established CoCM program, as described in this handbook. To ensure continued adherence to the CoCM core principles and the specific functional requirements of the model, the primary care provider must also re-attest in PEMS at the time of enrollment revalidation.

CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility, or other locations.

Refer to: Subsection 9.3, "Collaborative Care Model (CoCM)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

12 Claims Resources

Refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

13 Contact TMHP

Providers can call the TMHP Contact Center at 800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.

14 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Attestation Form for Collaborative Care Model (CoCM) in Texas Medicaid

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Forms
Outpatient Withdrawal Management Authorization Request Form
Outpatient Substance Use Disorder Counseling Extension Request Form
Outpatient Mental Health Services Request Form
Residential Withdrawal Management Authorization Request Form
Residential Substance Use Disorder Treatment Request Form

15 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Blind Children's Vocational Discovery and Development Program (BCVDDP)
Case Management for Children and Pregnant Women
Licensed Clinical Social Worker (LCSW)
Licensed Marriage and Family Therapist (LMFT)
Licensed Professional Counselor (LPC)
Mental Health Case Management
Psychologist
Psychotherapy with Evaluation and Management (E/M)

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