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

HHSC is performing a comprehensive review of the 'Inpatient Behavioral Health' benefit for Medicaid clients.

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

- Renamed title of policy to 'Inpatient Psychiatric Services'.
- Renamed 'Freestanding and State Psychiatric Facilities' to 'Privately- and Publicly-Operated Psychiatric Facilities' and used the general term of 'Psychiatric Facilities' when referring to both.
- Revised the policy to include information about coverage for persons who are 65 years of age and older.
- Deleted all information related to the Outpatient Mental Health Services Medicaid policy, i.e. psychotherapy/counseling, psychiatric diagnostic evaluation, psychological, neuropsychological and neurobehavioral testing, pharmacological management services, and 12-hour system limitation information, to include associated diagnosis codes and modifier/s. Information about outpatient mental health services can be found in Chapter 4 of the Behavioral Health and Case Management Services Handbook of the Texas Medicaid Provider Procedures Manual (TMPPM).
- Added enrollment information for acute care hospitals and psychiatric facilities to the 'Statement of Benefits' section to match information in the Inpatient and Outpatient Hospital Services Handbook of the TMPPM.
- Revised court-ordered services information to include specific court-orders that are covered ('Statement of Benefits' section) and are not covered ('Exclusions' section) in an inpatient setting.
- Moved criteria information for initial and extended inpatient psychiatric services to the 'Statement of Benefits' section.
- Moved information about appeals to the 'Prior Authorization/Authorization' section.
- Moved revenue code and utilization review information to the 'Reimbursement/Billing Guidelines' section.
- Moved information about non-covered benefits to the 'Exclusions' section.
- Eliminated redundancy and duplicative information and corrected inconsistencies.
- Edited policy to person-first language.

New policy language has been underlined and deleted language has been struck-through to highlight proposed policy changes.

Note: The current language regarding the Inpatient Behavioral Health benefit can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Inpatient and Outpatient Hospital Services Handbook, Sections 3.4.

Texas Medicaid

~~INPATIENT BEHAVIORAL HEALTH~~ INPATIENT PSYCHIATRIC SERVICES

Statement of Benefits

Acute Care Hospitals~~, Freestanding and State~~ Publicly- and Privately-Operated Freestanding Psychiatric Facilities

1. Acute care hospitals and publicly-operated psychiatric facilities, i.e. state hospitals, must:

1.1. Be certified by Medicare;

1.2. Have a valid provider agreement with the Texas Health and Human Services Commission (HHSC); and

1.3. Complete the TMHP enrollment process.

2. Privately-operated psychiatric facilities must;

2.1. Be licensed by HHSC

2.1. Providers must be accredited by The Joint Commission (TJC).

3. To be eligible to participate in the Comprehensive Care Program to render services to Texas Health Steps clients, privately- and publicly-operated psychiatric facilities (henceforth, referred to as 'psychiatric facilities') must:

3.1. Be accredited by TJC;

3.2. Have a valid provider agreement with HHSC; and

3.3. Complete the TMHP enrollment process.

4. Psychiatric facilities certified by Medicare must meet TJC accreditation requirements.

~~**5.** Inpatient admissions to acute care hospitals, freestanding psychiatric facilities, and state psychiatric facilities for psychiatric conditions may be a benefit of Texas Medicaid as outlined below.~~

~~**Table A: Coverage Details Specific to Age and Program by Facility**~~

~~Facility~~	~~THSteps Comprehensive Care - Inpatient, Psychiatric (THSteps - CCIP) - program (Persons birth through 20 years of age)~~	~~Medicaid (Persons of any age)~~
~~Acute Care Hospital~~	~~No~~	~~Yes~~
~~Freestanding Psychiatric Facility~~	~~Yes~~	~~No~~
~~State Psychiatric Facility~~	~~Yes~~	~~No~~

6. Admissions to acute care hospitals for inpatient psychiatric services ~~may be~~ are a benefit of Texas Medicaid for persons of all ages.

7. Admissions to psychiatric facilities for inpatient psychiatric services ~~may be~~ are a benefit of Texas Medicaid for:

7.1. Persons 20 years of age and younger and 65 years of age and older in fee-for-service (FFS) Medicaid; and

7.2. Persons 21 through 64 years of age enrolled in managed care. The benefit is for a maximum of 15 calendar days per month.

8. Admissions to acute care hospitals and psychiatric facilities must be medically necessary. ~~Admissions to freestanding and state psychiatric facilities must be medically necessary, except for court-ordered services for mental health commitments or a condition of probation~~. Court orders for inpatient psychiatric services constitute the determination of medical necessity and are not subject to utilization management reviews to include prior authorizations, concurrent reviews or retrospective reviews that have the effect of denying, reducing or controverting the court-ordered service. Court-ordered services include:

8.1. Emergency detention ordered by a judge or magistrate pursuant to Texas Health and Safety Code §§573. 011-573.026.

8.2. Mental health services ordered pursuant to Texas Health and Safety Code Chapter 574 (services may include a mental health examination, inpatient/outpatient treatment, order of protective custody, and temporary mental health services).

8.3. Treatment for persons found not guilty based on lack of responsibility pursuant to Texas Family Code Chapter 55.

8.4. Treatment for persons found not guilty by reason of insanity pursuant to Texas Code of Criminal Procedure Chapter 46C.

8.5. Treatment that is a condition of probation pursuant to Texas Code of Criminal Procedure Chapter 42A, Government Code Chapter 508, or other applicable laws.

~~**9.** Inpatient admissions to acute care hospitals, freestanding, and state psychiatric facilities are subject to the Texas Medicaid retrospective utilization review (UR) requirements. The UR requirements are applicable, regardless of the hospital's designation as a psychiatric unit versus medical/surgical unit.~~

10. ~~When a person requires~~ Upon admission, or once ~~the person~~ a person who is 20 years of age or younger becomes Medicaid eligible while in the facility, a certification of need for services, as required by Title 42 Code of Federal Regulations (CFR) §441.152, must be completed and placed in the person's medical record within 14 days of the admission.

~~**11.** Inpatient psychiatric treatment is a benefit of Texas Medicaid if:~~

~~**11.1.** The person has a psychiatric condition that requires inpatient treatment~~

~~**11.2.** The inpatient treatment is directed by a psychiatrist~~

~~**11.3.** The inpatient treatment is provided in a nationally accredited facility or hospital~~

~~**11.4.** The provider is enrolled in Texas Medicaid~~

12. ~~Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally-accredited state psychiatric hospital is a benefit of Texas Medicaid for persons who are 20 years of age or younger, and who are eligible for THSteps benefits at the time of the service request and service delivery.~~ All Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, known as Texas Health Steps in Texas, are available to persons 20 years of age and younger in a Medicaid covered inpatient psychiatric facility, as required by Section 12005 of the 21st Century Cures Act.

~~**13.** Services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the person receiving care.~~

~~**14.** Use the following revenue code for inpatient psychiatric services for children and adolescents in freestanding and state psychiatric facilities:~~

~~**Table B: Revenue Codes**~~

~~**Revenue Code**~~	~~**Description**~~
~~A 124~~	~~Room and board semi-private (2) psychiatric~~

~~**15.** Inpatient admissions without an accompanying medical complication or condition are not a benefit of Texas Medicaid including, but not limited to:~~

~~**15.1.** Single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines)~~

~~**15.2.** Chronic diagnoses (such as intellectual disability, organic brain syndrome, or chemical dependency or abuse)~~

Initial Inpatient Psychiatric ~~Stay~~ Services

16. The person must have as the principal reason for admission a psychiatric diagnosis, ~~a valid diagnosis~~ as listed in the current version of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) ~~as the principal admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required~~. and documented reasons by a psychiatrist for why an inpatient level of care is required or that outpatient treatment has been attempted and failed. The person must meet ~~at least~~ one of the following criteria:

16.1. ~~The person is presently a danger to self, demonstrated by at least one of the following:~~ A present danger to self, e.g., recent suicide attempt, active suicidal ideations with intent to act, ~~a deadly plan,~~ recent self-mutilative behaviors or threats of same with a likelihood of acting, command audio or visual hallucinations or delusions that are likely to lead to serious self-harm, and other indirect or direct acts that are hazardous to the life of the person;

~~**16.1.1.** Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.~~

~~**16.1.2.** Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).~~

~~**16.1.3.** Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or impairment resulting in a significant inability to care for self.~~

~~**16.1.4.** Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the life of the person receiving services. The medical diagnosis must be treatable in a psychiatric setting.~~

16.2. ~~The person is a danger to others. This behavior must be attributable to the person's specific diagnosis as listed in the current version of the DSM, and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:~~ A present danger to others (behavior must be attributed to the DSM diagnosis and can be adequately treated in an inpatient setting), e.g., recent life threating actions, homicidal threats with a deadly plan and available means to accomplish the plan, recent serious assaultive or sadistic behaviors or active threats of same with a likelihood of acting, or command auditory or visual hallucinations or delusions that are likely to lead to harm to others;

~~**16.2.1.** Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat.~~

~~**16.2.2.** Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior.~~

~~**16.2.3.** Active hallucinations or delusions directing or likely to lead to serious harm of others.~~

16.3. ~~The person exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the person unmanageable and unable to cooperate in treatment, and the person is in need of assessment and treatment in a safe and therapeutic setting.~~ The person is at risk of substantial physical or mental deterioration because of the mental illness, e.g., acute or chronic psychosis or thought disorganization or severe disorientation to person, place or time;

16.4. The person exhibits behaviors because of the mental illness that prevent, or interfere with, safe or effective treatment in a less restrictive setting; and/or

~~**16.5.** The person has a severe eating or substance use disorder that requires 24-hour-a-day medical observation, supervision, and intervention.~~

~~**16.6.** The person exhibits severe disorientation to person, place, or time.~~

~~**16.7.** The person's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.~~

~~**16.8.** The person requires medication therapy or complex diagnostic evaluation where the person's level of functioning precludes cooperation with the treatment regimen.~~

16.9. The person exhibits psychiatric symptoms, is involved in the legal system, ~~manifests psychiatric symptoms,~~ and is ordered by a court to undergo a comprehensive assessment in ~~a hospital~~ an inpatient psychiatric setting to clarify the diagnosis and treatment needs.

17. The proposed treatment~~/therapy~~ requires 24-hour-a-day medical observation, supervision, and intervention and includes ~~must include all of the following~~:

17.1. Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board (TMB);

17.1.1. For children and adolescents, a psychiatrist must also have ~~and with~~ documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents~~.~~ (treatment~~/therapy~~ plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry~~.~~);

17.2. Implementation of an individualized ~~treatment~~ recovery plan; and

17.3. Provision of services ~~that can~~ are reasonably ~~be~~ expected to improve the person's condition or prevent further regression, so that a lesser level of care ~~can~~ may be implemented.

18. Proper treatment of the person's psychiatric condition ~~requires services on an inpatient basis under the direction of a psychiatrist and~~ is ~~being~~ provided in the least restrictive environment available~~,~~ and ambulatory care resources available in the community do not meet the needs of the person~~'s needs~~.

Extended ~~Stays~~ Inpatient Psychiatric Services

19. Extended inpatient psychiatric services, i.e. extended stays, are considered for ~~children and youth~~ persons who require an inpatient level of care beyond the initial five-day admission period, as evidenced by continuing to meet at least one of the medical criteria listed in the initial inpatient psychiatric services section above. ~~enrolled in THSteps in freestanding and state psychiatric hospitals when the child or youth meets at least one of the criteria from above and have a treatment/therapy regimen, which must include all of the following~~ Treatment must include:

19.1. Active supervision, in accordance with facility guidelines, state and federal requirements and accreditation standards, by a psychiatrist with the appropriate credentials, as determined by the ~~Texas Medical Board (~~TMB~~)~~

19.1.1. For children and adolescents, a psychiatrist must also have ~~and with~~ documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents (treatment~~/therapy~~ plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry); and

~~**19.2.** Treatment/therapy requires an inpatient level of care.~~

19.3. Formulation and implementation of an initial discharge plan~~s have been formulated and actions have been taken toward implementation, including~~ to include documented contact with a ~~local~~ community-based mental health provider.

20. Extended stays are considered for children and adolescents in STAR Health whose discharge plan does not include returning to their natural home. If the Department of Family and Protective Services ~~party responsible for placement~~ has provided the ~~provider~~ psychiatric facility with three documented placement options for which the child or adolescent meets admission criteria, but cannot accept the child or adolescent, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.

~~Behavioral Health Service Providers~~

~~**21.** Behavioral health service providers include:~~

~~**21.1.** Advanced Practice Registered Nurse (APRN)~~

~~**21.2.** Physician Assistant (PA)~~

~~**21.3.** Physician (M.D. or D.O.)~~

~~**21.4.** Licensed Psychologist~~

~~**21.5.** Licensed Psychological Associate (LPA) in accordance with the Texas State Board of Examiners of Psychologists (TSBEP)~~

~~**21.6.** Provisionally Licensed Psychologist (PLP) under the direct supervision of a psychologist in accordance with the TSBEP~~

~~**22.** APRNs, PAs, and psychologists are limited in the Medicaid claims processing system to a maximum combined total of 12 hours per day for inpatient and outpatient behavioral health services. All providers listed above are subject to retrospective review as outlined in the Reimbursement section of this policy.~~

~~**23.** Because doctors of medicine (M.D.'s) and doctors of osteopathy (D.O.'s) can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation. M.D.'s and D.O.'s, and each provider to whom they delegate are subject to retrospective review as outlined in the Reimbursement section of this policy.~~

~~**24.** Because a psychologist can delegate to multiple LPAs, PLPs, psychology interns and post-doctoral fellows and may submit claims for LPA, PLP, psychology interns and post-doctoral fellow services in excess of 12 hours per day, LPAs, PLPs, psychology interns and post-doctoral fellows are not subject to the 12-hour system limitation. LPAs, PLPs, psychology interns and post-doctoral fellows who perform delegated psychology services under the delegating psychologist's Medicaid provider~~

identifier are subject to retrospective review as outlined in the Reimbursement section of this policy.

Psychotherapy for Alzheimer's Disease and Dementia

25. Treatment for Alzheimer's disease or dementia may be a benefit of Texas Medicaid for persons in the following stages:

25.1. Stage 1- No impairment (normal function)

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

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

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

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

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

25.3.1.1. Noticeable problems coming up with the right word or name

25.3.1.2. Trouble remembering names when introduced to new people

25.3.1.3. Having noticeably greater difficulty performing tasks in social or work settings.

25.3.1.4. Forgetting material that one has just read

25.3.1.5. Losing or misplacing a valuable object

25.3.1.6. Increasing trouble with planning or organizing

25.4. Alzheimer's disease and dementia benefits are not covered when the person is in a skilled nursing facility or a nursing home.

26. Psychotherapy (procedure codes 1-90832, 1-90833, 1-90834, 1-90836, 1-90837, 1-90838, 1-90847, 1-90853, 1-90899) for persons with Alzheimer's disease or dementia is limited to the stages above and only to the diagnoses listed below:

Table C: Diagnosis Codes—Psychotherapy

Diagnosis Code	Description
F0390	Unspecified dementia without behavioral disturbance

Diagnosis Code	Description
F0391	Unspecified dementia with behavioral disturbance
G3184	Mild cognitive impairment, so stated
R41841	Cognitive communication deficit

Licensed Psychological Associate (LPA), Provisionally Licensed Psychologist (PLP), Psychological Interns and Post-Doctoral Fellows

27. LPAs, PLPs, psychology interns and post-doctoral fellows are expected to abide by their scopes and standards of practice.

28. Services performed by an LPA, PLP, psychology intern or post-doctoral fellow are a benefit of Texas Medicaid when the following conditions are met:

28.1. The services are performed under the required supervision of a licensed psychologist per TSBEP requirements

28.2. The supervising psychologist must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction

28.3. The LPA, PLP, psychology intern or post-doctoral fellow performing the psychological service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist

28.4. The TSBEP requires a PLP to work under the 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 provider identifier

Psychiatric Diagnostic Evaluations

29. Psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) is a benefit of Texas Medicaid when provided by physicians, psychologists, APRNs, PAs, LPAs, PLPs, psychology interns and post-doctoral fellows.

30. Psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792) is a benefit of Texas Medicaid when provided by physicians, APRNs, and PAs.

31. A psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) includes a history, mental status, and a disposition. It includes communication with family members. Documentation time and time spent on medical records is not reimbursed separately but is part of the diagnostic interview service.

32. A psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792) may be covered to the extent it is medically necessary, and includes a history, mental status, and a disposition. It includes communication with family members. Medical interpretation of laboratory and other medical diagnostic studies are considered part of the service. Examples of medical necessity include, but are not limited to, persons whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia. Documentation time and time spent on medical records is not reimbursed separately but is part of the diagnostic interview service.

33. A psychiatric diagnostic interview may be incorporated into an evaluation and management (E/M) service (see Appendix) provided the required elements of the E/M service are fulfilled. An E/M procedure code (see Appendix) may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a diagnostic interview (procedure code 1-90792).

34. Due to the nature of these visits, the general time frame for such a diagnostic evaluation visit is one hour. A psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) or a psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792) counts towards the 12-hours per day, per provider system limitation.

Pharmacological Management Services

35. Pharmacological management services are a benefit for Texas Medicaid when the appropriate E/M code is utilized, and are considered as part of the E/M services.

Indications

36. Pharmacological management is not intended to refer to a brief evaluation of the person's state, simple dosage adjustment, or long term medication. It is intended for use for persons who are being managed primarily by psychotropics, antidepressants, electroconvulsive therapy (ECT), and/or other types of psychopharmacologic medications. Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects and represents a very skilled aspect of a person's care.

37. The focus of a pharmacological management visit is the use of medication to treat a person's signs and symptoms of mental illness, not in-depth inpatient psychotherapy/counseling. When the person continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal inpatient psychotherapy/counseling in a given day, the focus of the service is broader and is considered inpatient psychotherapy/counseling rather than pharmacological management.

38. Psychiatric E/M codes describe a physician service and cannot be provided by a nonphysician or "incident to" a physician service, with the exception of APRNs and PAs whose scope of license in this state permits them to prescribe.

39. Texas Medicaid does not reimburse for actual administration of medication or for observation of the person taking an oral medication. Administration and supply of oral medication are not a benefit.

Inpatient Psychological and Neuropsychological Testing

NOTE: Refer to the Outpatient Mental Health Services policy for limitations that apply to psychological and neuropsychological testing in the outpatient setting.

40. Psychological testing (procedure codes 1-96130, 1-96131*, 1-96136, and 1-96137*) and neuropsychological testing (procedure codes 1-96132, 1-96133*, 1-96136, and 1-96137*) are benefits of Texas Medicaid for the diagnoses listed in the Appendix, when performed by a psychiatrist, psychologist, LPA, PLP, psychology intern or post-doctoral fellow. Each hour of testing counts towards the 12-hour per day, per provider system limitation.

41. Psychologists licensed by the TSBEP and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness/debility. LPAs, PLPs, psychology interns and post-doctoral

~~fellows licensed by the TSBEP are authorized to perform counseling and testing for mental illness and/ or debility when delegated and supervised by a licensed psychologist.~~

~~42.~~ ~~Behavioral health testing may be performed during an assessment by an APRN or PA.~~

~~Inpatient Psychotherapy/Counseling~~

~~43.~~ ~~Psychotherapy/counseling is the treatment for mental illness and behavioral disturbances, in which the clinician establishes a professional contract with the person and, through definitive therapeutic communication or therapeutic interactions, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.~~

~~Family Counseling~~

~~44.~~ ~~When providing family counseling services (procedure code 1-90847), the person receiving Texas Medicaid services and a family member must be present during the face-to-face visit.~~

~~45.~~ ~~According to the definition of family provided by the HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. The following specific relatives are included in family counseling services:~~

~~45.1.~~ ~~Father or mother~~

~~45.2.~~ ~~Grandfather or grandmother~~

~~45.3.~~ ~~Brother or sister~~

~~45.4.~~ ~~Uncle, aunt, nephew, or niece~~

~~45.5.~~ ~~First cousin or first cousin once removed~~

~~45.6.~~ ~~Stepfather, stepmother, stepbrother, or stepsister~~

~~45.7.~~ ~~Foster parent~~

~~45.8.~~ ~~Legal guardian~~

Prior Authorization/Authorization Requirements

Electronic Signature Language

46. Prior authorization~~/authorization~~ requests may 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~~ person'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~~/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. Prescribing or ordering providers, dispensing providers, ~~clients' responsible adults, and clients~~ persons receiving services and responsible adults of persons receiving services may sign prior authorization~~/authorization~~ forms and supporting documentation using electronic or wet signatures.

47. To complete the prior authorization~~/authorization~~ process by paper, the provider must fax or mail the completed prior authorization~~/authorization~~ request form to the ~~[~~TMHP Prior Authorization Department ~~prior authorization/authorization unit]~~ and retain a copy of the signed and dated prior authorization~~/authorization~~ form in the ~~client's~~ person's medical record.

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

49. 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 ~~equipment or supplies~~ services requested. The physician must maintain documentation of medical necessity in the ~~client's~~ person's medical record.

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

51. Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services ~~equipment or supplies~~.

Prior Authorization~~/Authorization Not required~~

~~**52.** Psychological (procedure codes 1-96130, 1-96131*, 1-96136, 1-96137*) or neuropsychological (procedure codes 1-96132, 1-96133*, 1-96136, 1-96137*) testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility does not require prior authorization.~~

~~**53.** Behavioral health services provided in the inpatient setting does not require prior authorization with the exception of procedure code 1-90899.~~

Acute Care Hospitals

54. Prior authorization is not required for persons ~~with fee-for-service benefits~~ in FFS Medicaid ~~when~~ admitted to a psychiatric unit~~s~~ in an acute care hospital~~s~~.

~~Freestanding and State~~ Psychiatric Facilities ~~for Children and Adolescents~~

55. Prior authorization is not required for initial admissions to ~~freestanding~~ psychiatric facilities ~~or state psychiatric hospitals~~ for persons who are birth through 20 years of age or 65 years of age and older in FFS Medicaid for a maximum of five days, based on medical necessity.

~~**55.1.** Initial admissions are for a maximum of five days based on Medicaid eligibility and documentation of medical necessity which must be maintained in the person's medical record.~~

~~Prior Authorization/Authorization Is Required~~

~~**56.** Requests for prior authorization for procedure code 1-90899 (Unlisted psychiatric service or procedure) must be submitted by the provider to the Special Medical Prior Authorization (SMPA) department by mail or approved electronic method using the SMPA request form with documentation supporting medical necessity including:~~

~~**56.1.** Diagnosis~~

~~**56.2.** Prior treatment for this diagnosis and the medical necessity of the requested procedure~~

~~**56.3.** A clear, concise description of the procedure to be performed~~

~~**56.4.** Reason for recommending this particular procedure~~

~~**56.5.** A procedure code that is comparable to the procedure being requested~~

~~**56.6.** Documentation that this procedure is not investigational or experimental~~

56.7. ~~The physician's intended fee for this procedure~~

~~Freestanding and State Psychiatric Facilities for Children and Adolescents~~

57. Prior authorization is required ~~under THSteps-CCIP~~ for extended stays in ~~freestanding~~ psychiatric facilities ~~or state psychiatric hospitals~~ for persons who are birth through 20 years of age and 65 years of age and older in FFS Medicaid for up to seven days per extension request.

~~**58.**~~ Providers must submit a completed Psychiatric Inpatient Extended Stay Request Form that describes the necessary inpatient psychiatric services and reflects the need for an extended stay in relation to the original need for admission to include any change in the diagnosis of the person. Additional documentation or information supporting the need for an extended stay may be attached to the form. ~~A completed Psychiatric Inpatient Extended Stay Request Form prescribing the inpatient psychiatric services must be signed and dated by the supervising psychiatrist familiar with the person receiving the services prior to requesting authorization. The completed Psychiatric Inpatient Extended Stay Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital's medical record for the person receiving care.~~

~~**NOTE:** To complete the prior authorization process by paper, the provider must fax or mail the completed documentation to the CCIP prior authorization unit and retain a copy of the signed and dated documentation in the person's medical record at the provider's place of business.~~

~~**NOTE:** To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic method and retain a copy of the signed and dated documentation in the person's medical record at the provider's place of business.~~

59. ~~Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the CCIP unit when requesting prior authorization for an extended stay.~~ Requests for an extension of stay must be received on or before the fifth day of an initial admission and/or on or before the last day authorized or denied for subsequent stay requests. If an extended stay is requested and the fifth day of the initial admission or the last date authorized or denied of the previous stay falls on a holiday or a weekend, the request for an extended stay is due by 5:00 p.m. of the next business day. The provider is notified of the decision in writing by the TMHP Prior Authorization Department ~~CCIP unit~~.

59.1. ~~All psychiatric admission~~ Extended stay requests for persons who are 11 years or age or younger require review ~~will be reviewed~~ by a psychiatrist.

59.2. ~~Psychiatric admission~~ Extended stay requests for persons who are 12 through 20 years of age require review ~~will be reviewed~~ by a mental health professional. Any requests for ~~psychiatric~~ extended stays that do not meet the medical necessity criteria for extended stays ~~will~~ shall be referred to a psychiatrist for final determination.

~~**60.** The Psychiatric Inpatient Extended Stay Request Form must reflect the need for extended stay in relation to the original need for admission. Any change in the person's diagnosis must be noted on the request. Additional documentation or information supporting the need for extended stay may be attached to the form. Up to seven days may be authorized for an extension request.~~

Prior Authorization Appeals

61. All prior authorization requests not submitted or received by the TMHP Prior Authorization Department ~~THSteps-CCIP unit~~ in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

62. All denials may be appealed. The TMHP Prior Authorization Department ~~THSteps-CCIP unit~~ must receive ~~these~~ appeals within 15 days of receipt of the TMHP Prior Authorization Department ~~THSteps-CCIP unit~~ denial notice.

62.1. Appeals of a denial for an extended stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

62.2. Appeals of a denial for late submission of information, must be accompanied by documentation that the provider believes supports the compliance with HHSC claims submission guidelines.

63. Appeals are reviewed first by an experienced psychiatric licensed clinical social worker (LCSW) or a registered nurse (RN) to determine if the required criteria ~~is~~ are documented and then forwarded to a psychiatrist for final determination. The provider ~~will~~ shall be notified of all denial determinations in writing by the TMHP Prior Authorization Department ~~THSteps-CCIP unit~~.

~~Prior authorization requests must include the following documentation.~~

~~Initial Inpatient Psychiatric Stay~~

~~**64.** The person must have a valid diagnosis as listed in the current version of the DSM as the principal admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required.~~

~~**65.** The person must meet at least one of the following criteria:~~

~~**65.1.** The person is presently a danger to self, demonstrated by at least one of the following:~~

~~**65.1.1.** Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.~~

65.1.2. Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).

65.1.3. Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or impairment resulting in a significant inability to care for self.

65.1.4. Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the life of the person receiving services. The medical diagnosis must be treatable in a psychiatric setting.

65.2. The person is a danger to others. This behavior must be attributable to the person's specific diagnosis as listed in the current version of the DSM, and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:

65.2.1. Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat.

65.2.2. Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior.

65.2.3. Active hallucinations or delusions directing or likely to lead to serious harm of others.

65.3. The person exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the person unmanageable and unable to cooperate in treatment, and the person is in need of assessment and treatment in a safe and therapeutic setting.

65.4. The person has a severe eating or substance use disorder that requires 24-hour-a-day medical observation, supervision, and intervention.

65.5. The person exhibits severe disorientation to person, place, or time.

65.6. The person's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.

65.7. The person requires medication therapy or complex diagnostic evaluation where the person's level of functioning precludes cooperation with the treatment regimen.

65.8. The person is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.

66. The proposed treatment/therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

66.1. Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised

~~experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.~~

~~**66.2.** Implementation of an individualized treatment plan.~~

~~**66.3.** Provision of services that can reasonably be expected to improve the person's condition or prevent further regression so that a lesser level of care can be implemented.~~

~~**67.** Proper treatment of the person's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the person's needs.~~

~~Extended Stays~~

~~**68.** Extended stays are considered for children and youth enrolled in THSteps in freestanding and state psychiatric hospitals when the child or youth meets at least one of the criteria from above and have a treatment/therapy regimen, which must include all of the following:~~

~~**68.1.** Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.~~

~~**68.2.** Treatment/therapy requires an inpatient level of care.~~

~~**68.3.** Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.~~

~~**69.** Extended stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.~~

Authorization Requirements

~~Court-Ordered Services~~

~~**70.** A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.~~

71. Court-ordered <u>inpatient psychiatric</u> services are not subject to the five-day <u>initial</u> admission limitation or the seven-day stay limitation. ~~Court-ordered services include:~~

~~**71.1.** Mental health commitments~~

71.2. ~~Condition of probation (COP~~)

72. ~~For court-ordered admissions, a copy of the doctor's certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.~~ <u>Providers must submit the following documentation for authorization of court-ordered inpatient psychiatric services no later than seven calendar days after the date on which services began:</u>

72.1. A copy of the court order signed by the presiding judge or magistrate that includes the statute under which the court is ordering services to determine incarceration status of the person.

~~**73.** Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. A copy of the court document signed by the judge must accompany prior authorization requests. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.~~

Documentation Requirements

~~Psychiatric Diagnostic Evaluation~~

~~**74.** In addition to the inpatient psychotherapy/counseling documentation requirements outlined in this policy, supporting documentation for psychiatric diagnostic interview examinations must include:~~

~~**74.1.** Reason for referral/presenting problem~~

~~**74.2.** Prior history, including prior treatment~~

~~**74.3.** Other pertinent medical, social, and family history~~

~~**74.4.** Clinical observations and mental status examinations~~

~~**74.5.** A complete diagnosis as listed in the current edition of the DSM~~

~~**74.6.** Recommendations, including expected long-term and short-term benefits~~

~~**74.7.** For the psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792), the medical record must indicate the medical services addressed in the session.~~

~~Domains of a Clinical Evaluation~~

~~**75.** The following domains must be included in the evaluation documentation:~~

~~**75.1.** Reason for the evaluation~~

~~**75.2.** History of the present illness~~

~~**75.3.** Past psychiatric history~~

~~**75.4.** History of alcohol and other substance use~~

~~**75.5.** General medical history~~

~~**75.6.** Developmental, psychosocial, and sociocultural history~~

~~**75.7.** Occupational and military history~~

~~**75.8.** Legal history~~

~~**75.9.** Family history of psychiatric disorder~~

75.10. Mental status examination

Pharmacological Management

76. Documentation of pharmacological management must be dated (month/date/year) and signed by the performing provider and address all of the following information in the person's medical record in legible format:

76.1. A complete diagnosis as listed in the current edition of the DSM

76.2. Medication history

76.3. Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the person requires a medication adjustment

76.4. Problems, reactions, and side effects, if any, to medications and/or ECT

76.5. Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any

76.6. Any medication modifications

76.7. The reasons for medication adjustments/changes or continuation

76.8. Desired therapeutic drug levels, if applicable

76.9. Current laboratory values, if applicable

76.10. Anticipated physical and behavioral outcome(s)

Inpatient Psychological and Neuropsychological Testing

77. The treating provider must document the medical necessity for the chosen treatment in the person's medical record and also include the diagnosis code that most accurately describes the person's condition that necessitated the psychological/neuropsychological testing. The medical record (outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, be clear and concise, and document the reason(s) for the psychological/neuropsychological testing and the outcome.

78. In addition, the following documentation must be maintained by the provider in the person's medical record.

78.1. The Psychological/Neuropsychological Testing Request Form

78.2. The name of the tests(s) (e.g.,WAIS-R, Rorschach, MMPI)

78.3. The scoring of the test

78.4. Location the testing is performed

78.5. The name and credentials of each provider involved in administering the test, interpretation and preparing the report

78.6. Interpretation of the test to include narrative descriptions of the test findings

~~**78.7.** Length of time spent by each provider, as applicable, in face-to-face administration, interpretation, reporting the test, integrating the test interpretation, and writing the comprehensive report based on the integrated data~~

~~**78.8.** Treatment including how test results affect the prescribed treatment~~

~~**78.9.** Recommendations for further testing to include an explanation to substantiate the necessity of retesting, if testing is repeated~~

~~**78.10.** Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the person's condition requires testing over two days and the person does not return, or the person's condition precludes completion of the testing~~

~~**79.** The original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC.~~

~~Inpatient Psychotherapy/Counseling~~

~~**80.** Each person for whom services are provided must have supporting documentation included in their medical record. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider. Those services not supported by the documentation in the person's medical record are subject to recoupment. Documentation must include the following:~~

~~**80.1.** Notations of the session beginning and ending times~~

~~**80.2.** All pertinent information regarding the person's condition to substantiate the need for services, including, but not limited to, the following:~~

~~**80.2.1.** A complete diagnosis as listed in the current edition of the DSM~~

~~**80.2.2.** Background, symptoms, impression~~

~~**80.2.3.** Narrative description of the assessment~~

~~**80.2.4.** Behavioral observations during the session~~

~~**80.2.5.** Narrative description of the counseling session~~

~~**80.2.6.** Treatment plan and recommendations~~

~~Acute Care Hospitals, Freestanding and State Psychiatric Facilities~~

81. The certification of need for services (42 CFR §441.152) for persons 20 years of age and younger must specifically address: ~~Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:~~

81.1. Why ~~the ambulatory care resources in the community~~ community-based services cannot meet the treatment needs of the person; ~~receiving the services~~

81.2. Why inpatient psychiatric services ~~treatment~~ under the care of a psychiatrist are required to treat the acute episode of the person ~~receiving the services~~; and

81.3. How inpatient psychiatric ~~the~~ services can reasonably be expected to improve the condition or prevent further regression of the person's condition in a proximate ~~time~~ period.

82. ~~Supporting~~ Documentation of medical necessity ~~(certification of need)~~ for inpatient psychiatric services in an acute care hospital or psychiatric facility, to include the certification of need for services (42 CFR §441.152) for persons 20 years of age and younger, must be:

82.1. Documented in the person's medical record;

82.2. ~~This documentation must be~~ Maintained by each facility as applicable to state and federal guidelines; and

82.3. ~~Be~~ Readily available for review whenever requested by ~~the Health and Human Services Commission (~~HHSC~~)~~ or its designee.

~~Psychological and Neuropsychological Testing Services~~

~~**83.** Psychological (procedure codes 1-96130, 1-96131*, 1-96136, 1-96137*) or neuropsychological (procedure codes 1-96132, 1-96133*, 1-96136, 1-96137*) testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing services performed while the person is an inpatient.~~

~~**84.** In addition to documentation requirements outlined in the "Prior Authorization/Authorization Requirements" section of this policy, if any, the following requirements apply:~~

~~**84.1.** All services outlined in this policy are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.~~

Reimbursement/Billing Guidelines

~~**85.** Procedure codes 1-90833, 1-90836, and 1-90838 are add-on codes that require the appropriate E/M primary code for reimbursement.~~

~~**86.** Providers must submit the documentation required for prior authorization as outlined in the Authorization section of this policy supporting medical necessity with the claims for procedure code 1-90899.~~

~~Alzheimer's Disease and Dementia~~

~~**87.** Treatment for Alzheimer's disease or dementia may be reimbursed by Texas Medicaid for persons in the following stages:~~

~~**87.1.** Stage 1- No impairment (normal function)~~

~~**87.1.1.** The person does not experience any memory problems. An interview with a medical professional does not show any evidence of symptoms of dementia~~

~~**87.2.** Stage 2- Very mild cognitive decline (may be normal age-related changes or earliest signs of Alzheimer's disease)~~

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

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

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

87.3.1.1. Noticeable problems coming up with the right word or name

87.3.1.2. Trouble remembering names when introduced to new people

87.3.1.3. Having noticeably greater difficulty performing tasks in social or work settings.

87.3.1.4. Forgetting material that one has just read

87.3.1.5. Losing or misplacing a valuable object

87.3.1.6. Increasing trouble with planning or organizing

88. Psychotherapy (procedure codes 1-90832, 1-90833, 1-90834, 1-90836, 1-90837, 1-90838, 1-90847, 1-90853, 1-90899) for persons with Alzheimer's disease or dementia is limited to the stages above and only to the diagnoses listed below:

Table [X]: Diagnosis Codes—Psychotherapy

Diagnosis Code	Description
F0390	Unspecified dementia without behavioral disturbance
F0391	Unspecified dementia with behavioral disturbance
G3184	Mild cognitive impairment, so stated
R41841	Cognitive communication deficit

Psychiatric Diagnostic Evaluation

89. The following procedure codes must be used for inpatient psychotherapy/counseling:

Table [X]: Procedure Codes

Procedure Code	Description
1-90791	Psychiatric diagnostic evaluation (without medical services)
1-90792	Psychiatric diagnostic evaluation (with medical services)

Inpatient Psychotherapy/Counseling

90. The following procedure codes must be used for inpatient psychotherapy/counseling:

Table [X]: Procedure Codes

Procedure Code	Description
1 90832	Psychotherapy, 30 minutes with patient
1-90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service. (List separately in addition to the code for primary
1-90834	Psychotherapy, 45 minutes with patient
1 90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service. (List separately in addition to the code for primary
1-90837	Psychotherapy, 60 minutes with patient
1 90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service. (List separately in addition to the code for primary
1 90847	Family psychotherapy (conjoint psychotherapy) (with patient present)

91. Inpatient psychotherapy/counseling is limited to the diagnosis codes listed in the appropriate table in the Appendix.

92. Psychotherapy/counseling intervention that includes a medical E/M component is limited to psychiatrists, APRNs, and PAs.

93. Behavioral health providers must use one of the modifiers in the table below to indicate who rendered the service. Psychologist services are identified with modifier AH, LPA services are identified with a state defined modifier UC, and PLP services are identified with a state defined modifier U9, psychology intern and post-doctoral fellow services must be billed with modifier UB.

Table [X]: Modifiers—Licensed Psychologist Services and Delegated Services

Modifier	Description
AH	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

94. The appropriate service is chosen on the basis of the type of inpatient psychotherapy/counseling, the place of service, the face-to-face time spent with the person during inpatient psychotherapy/counseling, and whether E/M services are furnished on the same date of service as inpatient psychotherapy/ counseling.

95. The treating provider must document the medical necessity of the chosen treatment and list the diagnosis code that most accurately describes the condition of the person that necessitated the need for the psychotherapy/counseling in the person's medical record. The medical record (inpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, clear and concise, documenting the reason(s) for the psychotherapy/counseling and the outcome.

~~**96.** Inpatient psychotherapy/counseling counts towards the 12 hours per day, per provider system limitation.~~

~~Narcosynthesis~~

~~**97.** The following procedure code must be used for narcosynthesis.~~

~~**Table H: Procedure Codes – Narcosynthesis**~~

~~Procedure Code~~	~~Description~~
~~1-90865~~	~~Narcosynthesis for psychiatric diagnostic and therapeutic purposes~~

~~**NOTE:** Procedure code 1-90865 is not a benefit when provided by an APRN, PA, psychologist, PLP, LPA, psychology intern or post-doctoral fellow.~~

98. ~~Use~~ The following revenue code must be used for inpatient psychiatric services for persons birth through 20 years of age and 65 years of age and older in psychiatric facilities for FFS Medicaid ~~children and adolescents in freestanding and state psychiatric facilities:~~

Table A ~~B:~~ Revenue Codes

Revenue Code	Description
A-124	Room and board-semi-private (2) psychiatric

~~Hospital Discharge~~

99. The following procedure codes must be used for a hospital discharge:

Table B: Procedure Codes – Hospital Discharge

Procedure Code	Description
1-99238	Hospital discharge day management, 30 minutes or less
1-99239	Hospital discharge day management, more than 30 minutes

~~**100.**~~ Except for court-ordered services, ~~Inpatient~~ admissions to acute care hospitals and psychiatric facilities~~, freestanding, and state psychiatric facilities~~ are subject to the Texas Medicaid retrospective utilization review ~~(UR)~~ requirements. ~~The UR requirements are applicable, regardless of the hospital's designation as a psychiatric unit versus medical/surgical unit.~~

~~Unlisted psychiatric service or procedure~~

~~**101.** The following procedure code must be used for any services not listed in another table:~~

~~**Table [X]: Procedure Codes – Unlisted Psychiatric Service or Procedure**~~

~~Procedure Code~~	~~Description~~
~~1-90899~~	~~Unlisted psychiatric service or procedure~~

~~The 12-Hour System Limitation~~

102. The following provider types are limited in the Medicaid claims processing system to reimburse for a maximum combined total of 12 hours per day for inpatient and outpatient behavioral health services:

102.1. APRN

102.2. PA

102.3. Psychologist

103. Because M.D.s and D.O.s can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation. Because a psychologist can delegate to multiple LPAs, PLPs, psychology interns and post-doctoral fellows, may submit claims for LPA, PLP, psychology interns and post-doctoral fellows services in excess of 12 hours per day, LPAs, PLPs, psychology interns and post-doctoral fellows are not subject to the 12-hour system limitation.

Retrospective Review of Behavioral Health Services Billed in Excess of 12-hours per Day

104. No single behavioral health services provider may be reimbursed for more than 12 hours of behavioral health services per day.

105. HHSC and the Texas Medicaid & Healthcare Partnership (TMHP) routinely perform retrospective review of all providers. All provider types are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day, including the following:

105.1. M.D.s and D.O.s and each provider to whom they delegate

105.2. Psychologists, and LPAs, PLPs, psychology interns and post-doctoral fellows performing delegated psychology services under the direct supervision of a psychologist

106. Retrospective review for any provider of behavioral health may include:

106.1. All behavioral health procedure codes included in the 12-hour system limitation.

106.2. All E/M procedure codes, including those listed in the Evaluation and Management Section of the Current Procedural Terminology (CPT) Manual, billed with a psychiatric diagnosis.

106.3. All remaining behavioral health procedure codes not included in the 12-hour system limitation such as group therapy and pharmacological management.

107. Documentation requirements for all services billed are listed for each individual specialty in the Texas Medicaid Provider Procedures Manual. If inappropriate payments are identified on retrospective review for any provider type, the reimbursement will be recouped.

108. Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider's Texas Provider Identifier (TPI) base (the first seven digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

Procedure Codes Included in the 12-hour System Limitation

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

Table [X]: Procedure Codes—Included in the 12-hour System Limitation

Procedure Code	Time Applied
1 90791	60 minutes
1 90792	60 minutes
1 90832	30 minutes
1 90833	30 minutes
1 90834	45 minutes
1 90836	45 minutes
1 90837	60 minutes
1 90838	60 minutes
1 90847	50 minutes
1 96130	60 minutes
1 96131*	60 minutes
1 96132	60 minutes
1 96133*	60 minutes
1 96136	30 minutes
1 96137*	30 minutes

110. Court-ordered services are not subject to the 12-hour system limitation per provider, per day, when the H9 modifier is used:

Table [X]: Modifiers—Court-ordered Services

Modifier	Description
H9	Court-ordered

Psychologist, LPA, PLP, Psychology Interns and Post-Doctoral Fellows Reimbursement

111. Psychological 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 Medicaid identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.

112. Psychologist services must be billed with modifier AH; LPA services must be billed with modifier UC; PLP services must be billed with modifier U9, psychology intern and post doctoral fellow services must be billed with modifier UB. Claims submitted without a modifier or with two of these modifiers on the same detail will be denied.

Table [X]: Modifiers — Licensed Psychologist Services and Delegated Services

Modifier	Description
AH	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

113. Services performed by an LPA must be billed with modifier UC indicating services provided by an LPA and must include the LPA license number. Any claim submitted with modifier UC indicating services provided by an LPA and billed without a license number are subject to retrospective review as outlined in the Reimbursement section of this policy.

114. Services performed by a PLP must be billed with modifier U9 indicating services provided by a PLP must include the PLP license number. Any claim submitted with modifier U9 indicating services provided by a PLP and billed without a license number are subject to retrospective review as outlined in the Reimbursement section of this policy.

115. Retrospective review may be performed to validate that services performed on the same person are not billed for the same time and date of service, and that modifiers billed match the provider performing the services.

Psychiatric Diagnostic Evaluations

116. A psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) may be reimbursed to physicians, psychologists, APRNs, PAs, LPAs, PLPs, psychology interns and post-doctoral fellows.

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

118. A psychiatric diagnostic evaluation (procedure code 1-90791or 1-90792) is limited to once per day, per person, any provider, regardless of the number of professionals involved in the interview.

Pharmacological Management

119. Pharmacological management is limited to services provided by physicians, psychiatrists, APRNs, and PAs.

120. The treating provider must document the medical necessity of the chosen treatment and must list on the claim and in the person's medical record the DSM diagnosis code that most accurately describes the condition of the person that necessitated the need for the pharmacological management. The DSM diagnosis code must be referenced on the claim.

Psychological and Neuropsychological Testing Services

121. Psychological testing (procedure codes 1-96130, 1-96131*, 1-96136, 1-96137*) or neuropsychological testing (procedure codes 1-96132, 1-96133*, 1-96136, 1-96137*) is limited to a total of four hours per day, and eight hours per person, per calendar year for any provider. Hours billed beyond four hours per day will be denied without prior authorization. Add-on procedure codes (1-96131*, 1-96133*, and 1-96137*) must be billed with their corresponding primary procedure code (1-96130, 1-96132,

~~or 1- 96136). All supporting documentation must be maintained by the provider in the person's medical record.~~

~~122.~~ ~~The reimbursement for procedure codes 1-96130, 1-96131*, 1-96132, 1-96133*, 1-96136 and 1-96137* includes the face-to-face testing and the scoring and interpretation of the results. The number of units on the claim must reflect the time spent face-to-face testing with the person plus the time spent scoring and interpreting the results in one-hour increments.~~

~~122.1.~~ ~~If the performance, interpretation, and reporting of the testing span more than one day, the date of service on the claim must reflect the date and the time spent for each service performed.~~

~~122.2.~~ ~~Providers must submit only one claim for each psychological or neuropsychological testing performed even if the scoring and interpretation cannot be completed on the same date as the testing.~~

~~122.3.~~ ~~A claim must be not be submitted until testing is complete. Providers can submit one claim with multiple details for each date of service.~~

~~123.~~ ~~The correct modifier AH, UB, UC, or U9 must be appended to the code to identify who rendered the service. If the PLP, LPA, psychology interns, post-doctoral fellows and psychologist all perform services on the same date, one detail must be submitted for each provider with each detail accurately representing the time spent by the psychologist, LPA, PLP, psychology interns and post-doctoral fellows. Time billed for services performed on the same person must not be billed for the same time and date of service.~~

~~124.~~ ~~All services provided by the psychologist, PLP, LPA, psychology intern and post-doctoral fellow count toward the total four hours of testing allowed per person, per day.~~

~~125.~~ ~~Psychological and neuropsychological testing will not be reimbursed to an APRN or a PA. Behavioral health testing may be performed during an assessment by an APRN or a PA, but will not be reimbursed separately. The most appropriate office visit code must be billed.~~

~~126.~~ ~~Psychological (procedure codes 1-96130, 1-96131*, 1-96136, 1-96137*) or neuropsychological testing (procedure codes 1-96132, 1-96133*, 1-96136, 1-96137*) may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation (without medical services) (procedure code 1-90791) or psychiatric diagnostic evaluation (with medical services) (procedure code 1-90792). Psychological testing (procedure codes 1-96130, 1-96131*, 1-96136, 1-96137*) performed on the same date of service as neuropsychological testing (procedure codes 1-96132, 1-96133*, 1-96136, 1-96137*) may be reimbursed on the same date of service.~~

~~127.~~ ~~Psychological testing evaluations (procedure codes 1-96130, 1-96131*) or neuropsychological testing evaluations (procedure codes 1-96132, 1-96133*) may be reimbursed on the same date of service as psychological or neuropsychological testing administration and scoring (procedure codes 1-96136, 1-96137*).~~

~~Court-Ordered Services~~

~~128.~~ ~~Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day.~~

~~Psychotherapy~~

~~**129.** When more than one type of session is provided by any provider on the same date of service (inpatient individual, group, or family psychotherapy/counseling) each session type will be reimbursed individually. Services are reimbursed only for the Medicaid eligible person per session.~~

~~Freestanding and State Psychiatric Facilities~~

~~**130.** All prior authorization requests not submitted or received by the TMHP THSteps-CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.~~

~~**131.** All denials may be appealed. The TMHP THSteps-CCIP unit must receive these appeals within 15 days of the TMHP THSteps-CCIP unit denial notice.~~

~~**131.1.** Appeals of a denial for an extended stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.~~

~~**131.2.** Appeals of a denial for late submission of information, must be accompanied by documentation that the provider believes supports the compliance with HHSC claims submission guidelines.~~

~~Appeals are reviewed first by an experienced psychiatric licensed clinical social worker (LCSW) or a registered nurse (RN) to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing by the TMHP THSteps-CCIP unit.~~

Exclusions

132. ~~The following~~ Inpatient psychiatric services are not a benefit ~~non-covered benefits~~ of Texas Medicaid for the following:

132.1. Persons with a single diagnosis of a substance use disorder, as classified in the current edition of the APA's DSM.

132.2. Persons who are considered incarcerated, which is defined as when a criminal justice facility, such as a city or county jail or state prison, has custody of the person. The definition of 'in custody' includes:

132.2.1. Persons currently residing in a criminal justice facility and receiving treatment through a program at the criminal justice facility.

132.2.2. Persons found incompetent to stand trial and committed pursuant to Texas Code of Criminal Procedure Chapter 46B.

132.2.3. Persons found unfit to proceed and committed pursuant to Texas Family Code Chapter 55

~~**132.3.** Psychoanalysis~~

~~**132.4.** Multiple Family Group Psychotherapy~~

~~**132.5.** Marriage or couples counseling~~

~~**132.6.** Narcosynthesis~~

~~**132.7.** Biofeedback training as part of psychophysiological therapy~~

~~**132.8.** Psychiatric Day Treatment Programs~~

~~**132.9.** Services provided by a psychiatric assistant, psychological assistant (excluding Master's level LPA) or a licensed chemical dependency counselor~~