SPECIAL MEDICAID BULLETIN
Inpatient and Outpatient Behavioral Health Services
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Inpatient and Outpatient Behavioral Health Overview

Effective for dates of service on or after January 1, 2009, Texas Medicaid will implement prior authorization changes for inpatient and outpatient behavioral health services.

Behavioral health services, including diagnostic interviews, psychotherapy/counseling (individual, group, or family counseling), psychological and neuropsychological testing, pharmacological regimen oversight, pharmacological management, and chemical dependency treatment in chemical dependency treatment facilities (CDTFs), are benefits of Texas Medicaid when these services are provided to clients who are experiencing a significant behavioral health issue that is causing distress, dysfunction, and/or maladaptive functioning as a result of a confirmed or suspected psychiatric condition, as defined in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

The 12-Hour System Limitation

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:

- Clinical Nurse Specialist (CNS)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Psychologist

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Because doctors of medicine (MDs) and doctors of osteopathy (DOs) can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

All providers, including MDs, DOs, and each provider to whom they delegate are subject to retrospective review as outlined below.

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

The Health and Human Services Commission (HHSC) and TMHP routinely perform retrospective review of all providers. In addition, all provider types including MDs, DOs, and each provider to whom they delegate are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day.

Retrospective review may include:

- All behavioral health procedure codes included in the 12-hour system limitation.
- All evaluation and management (E/M) procedure codes, including those listed in the E/M section of the *Current Procedural Terminology* (CPT), billed with a psychiatric diagnosis code.
- All remaining behavioral health procedure codes not included in the 12-hour system limitation such as group therapy and pharmacological management.

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.

Behavioral health services that are 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

The table to the right lists the inpatient and outpatient 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.

Procedure Code	Time Indicated in Procedure Code Description	Time Applied
1-90801	NA	60 minutes
1-90802	NA	60 minutes
1-90804	20-30 minutes	30 minutes
1-90805	20-30 minutes	30 minutes
1-90806	45-50 minutes	50 minutes
1-90807	45-50 minutes	50 minutes
1-90808	70-80 minutes	80 minutes
1-90809	70-80 minutes	80 minutes
1-90810	20-30 minutes	30 minutes
1-90811	20-30 minutes	30 minutes
1-90812	45-50 minutes	50 minutes
1-90813	45-50 minutes	50 minutes
1-90814	70-80 minutes	80 minutes
1-90815	70-80 minutes	80 minutes
1-90816	20-30 minutes	30 minutes
1-90817	20-30 minutes	30 minutes
1-90818	45-50 minutes	50 minutes
1-90819	45-50 minutes	50 minutes
1-90821	70-80 minutes	80 minutes
1-90822	70-80 minutes	80 minutes
1-90823	20-30 minutes	30 minutes
1-90824	20-30 minutes	30 minutes
1-90826	45-50 minutes	50 minutes
1-90827	45-50 minutes	50 minutes
1-90828	70-80 minutes	80 minutes
1-90829	70-80 minutes	80 minutes
1-90847	NA	50 minutes
5-96101	60 minutes	60 minutes
1-96118	60 minutes	60 minutes

NA = Not Applicable

For questions, call the TMHP Contact Center at 1-800-925-9126. ■

Inpatient Behavioral Health Services

Reimbursement limitations for inpatient behavioral health services include the National Correct Coding Initiative (CCI) guidelines.

Inpatient behavioral health services, provided in the inpatient hospital setting and performed by the following providers are benefits to clients of any age with the diagnoses outlined in this article:

- County Indigent Health Care Program (CIHCP)
- Physician/Psychiatrist
- Physician/Psychiatrist groups
- NP
- CNS
- PA
- Licensed Psychologist
- Licensed Psychologist groups
- Hospitals

Physicians, psychologists, PAs, NPs, and CNSs are not required to obtain prior authorization for inpatient behavioral health services.

Acute Care Hospital, Freestanding/State Psychiatric Facilities

Inpatient admissions to acute care hospitals, freestanding psychiatric facilities, and state psychiatric facilities for psychiatric conditions are benefits of Texas Medicaid as outlined below:

Facility	THSteps-CCIP* Program (Clients 20 years of age or younger)	Medicaid (Clients any age)
Acute Care Hospital	No	Yes
Freestanding Psychiatric Facility	Yes	No
State Psychiatric Facility	Yes	No

* Texas Health Steps-Comprehensive Care Inpatient Psychiatric Program

Admissions to acute care hospitals must be medically necessary.

Inpatient psychiatric treatment in a nationally-accredited freestanding psychiatric facility or a nationally-accredited state psychiatric hospital is a benefit of Texas Medicaid for clients 20 years of age or younger who are eligible for THSteps benefits at the time of the service request and service delivery. Admissions to freestanding and state psychiatric facilities must be medically necessary unless the admission is court ordered for a mental health commitment or a condition of probation.

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

Inpatient psychiatric treatment is a benefit of Texas Medicaid if:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally-accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, or amphetamines) without an accompanying medical complication are not a benefit of Texas Medicaid. Additionally, admissions for chronic diagnoses (such as mental retardation, organic brain syndrome, or chemical dependency or abuse) are not a benefit for acute care hospitals without an accompanying medical complication or medical condition. The UB-04 CMS-1450 claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Supporting documentation (certification of need) must be documented in the individual client's record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by HHSC or its designee.

Documentation Requirements

When a client requires admission, or once the client becomes Medicaid eligible while in the facility, a certi-

fication of need must be completed and placed in the client's record within 14 days of the admission.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period

Authorization Requirements for Acute Care Hospitals

Prior authorization is not required for Texas Medicaid fee-for-service clients admitted to psychiatric units in acute care hospitals.

Prior authorization is required for Primary Care Case Management (PCCM) clients admitted to psychiatric units in acute care hospitals.

Scheduled admissions for inpatient PCCM psychiatric services require prior authorization.

Urgent or emergent admissions for inpatient PCCM psychiatric services require retrospective prior authorization. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility. Fax the completed PCCM Inpatient/Outpatient Authorization Form (available on page 36) to the PCCM Inpatient Prior Authorization Department at 1-512-302-5039 or call 1-888-302-6167. The PCCM Inpatient/Outpatient Authorization Form may also be submitted online on the TMHP website at www.tmhp.com.

Authorization Requirements for Freestanding and State Psychiatric Facilities

Prior authorization is required under THSteps-CCIP for admission to freestanding psychiatric facilities or state psychiatric hospitals for clients birth through 20 years of age.

A completed Psychiatric Inpatient Initial Admission Request Form (available on page 35) or Psychiatric Inpatient Extended Stay Request Form (available on page 34) prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Psychiatric Inpatient Initial Admission Request Form or 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 client.

For initial inpatient admissions to freestanding and state psychiatric facilities, the completed Psychiatric Inpatient Initial Admission Request Form must be faxed to the CCIP unit at 1-512-514-4211 or submitted online on the TMHP website at www.tmhp.com no later than the date of the client's admission unless the admission is after 5 p.m., on a holiday, or a weekend. When the admission occurs after 5 p.m., on a holiday, or on a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider should contact the CCIP unit by telephone at 1-800-213-8877 and fax the Psychiatric Inpatient Initial Admission Request Form to the CCIP unit on the following business day.

- To complete the prior authorization process the provider must fax the completed Psychiatric Inpatient Admission Form to the CCIP prior authorization unit or submit the form online on the TMHP website at www.tmhp.com.
- To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity.

- All psychiatric admission requests for clients 11 years of age or younger will be reviewed by a psychiatrist.
- Psychiatric admission requests for clients 12 years of age through 20 years of age will be reviewed by a mental health professional. Any requests for psychiatric admissions which do not meet the criteria for admission will be referred to a psychiatrist for final determination.

Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the CCIP unit by telephone at 1-800-213-8877 or by fax at 1-512-514-4211 requesting prior authorization for a continuation of stay. The Psychiatric Inpatient Extended Stay Request Form may also be submitted online on the TMHP website at www.tmhp.com. Requests for a continuation of stay

must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5 p.m. of the next business day.

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

Medicaid Clinical Criteria–Initial Inpatient Psychiatric Stay

The client must have a valid AXIS I, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) diagnosis as the principle admitting diagnosis. Also, outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required. The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - — Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.
  - — 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).
  - — Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
  - — Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client (the medical [AXIS III] diagnosis must be treatable in a psychiatric setting).
- The client is a danger to others. This behavior must be attributable to the client's specific AXIS I or DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  - — 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.
  - — 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.
  - — Active hallucinations or delusions directing or likely to lead to serious harm of others.
- The client 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 client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.
- The client has a severe eating or substance abuse disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
- The client exhibits severe disorientation to person, place, or time.
- The client'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.
- The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.
- The client is involved in the legal system, manifests psychiatric symptoms and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

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

- 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.

- Implementation of an individualized treatment plan.
- Provision of services which can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented.

Proper treatment of the client'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 client's needs.

Continued Stays

Continued stays are considered for THSteps clients in freestanding and state psychiatric hospitals when the client meets at least one of the criteria from above and has a treatment/therapy regimen which must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the TMB and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans should be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Treatment/therapy requires an inpatient level of care.
- Initial discharge plans have been formulated and actions have been taken toward implementation including documented contact with a local mental health provider.

Continued 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 which 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.

Reimbursement for Freestanding and State Psychiatric Hospitals

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 denied dates of service.

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.

- Appeals of a denial for an initial admission and/or a continued stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.
- Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.
- Appeals are reviewed first by an experienced psychiatric 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 via fax by the TMHP THSteps-CCIP unit.

Revenue code A-124 must be billed for inpatient psychiatric services for children and adolescents in freestanding and state psychiatric facilities.

Physician, Psychiatrist, Psychologist, NP, CNS, and PA Services

NPs, CNSs, PAs, and psychologists are limited in the Medicaid claims processing system to a maximum combined total of 12 hours per day for inpatient and/or outpatient behavioral health services.

All providers, including MDs, DOs, and each provider to whom they delegate are subject to retrospective review as outlined in the 12-hour system limitation discussed on page 1.

Court-Ordered Services

Authorization

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.

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

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

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.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from the court order, the additional services will be reviewed for medical necessity. Requested services beyond those court-ordered are subject to medical necessity review.

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

Electroconvulsive Therapy (ECT)

A hospital visit subsequent care (procedure codes 1-99231, 1-99232, 1-99233, 1-99238, and 1-99239) may be allowed on the same day as electroshock therapy (procedure code 1-90870).

Anesthesia for ECT will be denied as part of pharmacological management (procedure code 1-90862) when billed on the same date of service by the same provider.

Family Counseling

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

According to the definition of "family" provided by 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:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister
- Foster parent
- Legal guardian

Hospital Discharge

Procedure code 1-99238 or 1-99239 must be submitted when billing for a hospital discharge.

Reimbursement
Procedure code 1-99238 will be denied as part of another service when billed for the same date of service by the same provider as procedure code 1-99239.

Court-ordered services are not subject to the 12-hour system limitation, the 5-day admission limitation, or the 7-day continued stay limitation.

Inpatient Consultations

Procedure codes 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255 will be denied as part of another service when billed for the same date of service by the same provider as pharmacological management (procedure code 1-90862).

Narcosynthesis

Narcosynthesis is a benefit of Texas Medicaid when billed using procedure code 1-90865. Narcosynthesis is not a benefit when provided by an NP, CNS, PA, or psychologist.

Pharmacological Management Services

Pharmacological management services are a benefit of Texas Medicaid when billed using procedure code 1-90862. Pharmacological management services are limited to the DSM diagnoses listed in Table B on page 28. Pharmacological management services do not count towards the 12-hour per day per provider limitation.

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

Pharmacological management must be provided during a face-to-face visit with the client and any inpatient psychotherapy/counseling must be less than 20 minutes.

The focus of a pharmacological management visit is the use of medication to treat a client's signs and symptoms of mental illness, not to provide in depth inpatient psychotherapy/counseling. When the client 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.

Pharmacological management describes a physician service and cannot be provided by a nonphysician or 'incident to' a physician service, with the exception of NPs, CNSs, and PAs whose scope of license in this state permits them to prescribe.

Documentation Requirements

Documentation of medical necessity for pharmacological management must be dated (month/day/year), signed by the performing provider, and address all of the following information in the client's medical record legibly:

- A complete diagnosis as listed in the latest edition of the DSM
- Medication history
- Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment
- Problems, reactions and side effects, if any, to medications and/or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)

Reimbursement

Texas Medicaid does not reimburse pharmacological management for the actual administration of medication or for observation of the client taking an oral medication. The administration and supply of oral medication are noncovered services.

Pharmacological management, neurobehavioral status exam (procedure code 1-96116), and any E/M service as listed in Table D on page 30 will be denied as part of a diagnostic interview (procedure codes 1-90801 and 1-90802) when billed for the same date of service by the same provider.

E/M services include pharmacological management. Pharmacological management will be denied as part of any E/M service as listed in Table D on page 30 when billed for the same date of service by the same provider.

If the primary reason for the inpatient visit is for inpatient psychotherapy/counseling, then the specific inpatient psychotherapy/counseling procedure code must be billed. Pharmacological management will be denied as part of another service when billed for the same date of service, by the same provider, as any of the following inpatient psychotherapy/counseling services:

Procedure Codes				
1-90816	1-90817	1-90818	1-90819	1-90821
1-90822	1-90823	1-90824	1-90826	1-90827
1-90828	1-90829	1-90847		

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

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

Psychiatric Diagnostic Interviews

A psychiatric diagnostic interview examination and an interactive psychiatric diagnostic interview examination are benefits of Texas Medicaid for psychiatrists, psychologists, NPs, CNSs, and PAs when performed in the inpatient setting and based on medical necessity. A psychiatric diagnostic interview examination may be billed using procedure code 1-90801, and an interactive psychiatric diagnostic interview examination may be billed using procedure code 1-90802.

A psychiatric diagnostic interview examination includes a history, mental status, a disposition, and includes communication with family members. Medical interpretation of laboratory and other medical diagnostic studies are considered part of the service. Documentation time and time spent on medical records is not reimbursed separately, but is part of the diagnostic interview service.

An interactive psychiatric diagnostic interview may be a benefit when medically necessary and is limited to the

DSM diagnoses listed in Table A on page 27. Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A psychiatric diagnostic interview may be incorporated into an E/M service listed in Table D on page 30 provided the required elements of the E/M service are fulfilled. An E/M procedure code may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a diagnostic interview.

Due to the nature of these visits, the general time frame for such a diagnostic interview visit is one hour. A psychiatric diagnostic interview or an interactive psychiatric diagnostic interview examination counts towards the 12-hour per day per provider system limitation.

In addition to the inpatient psychotherapy/counseling documentation requirements outlined in this article on page 11, supporting documentation for psychiatric diagnostic interview examinations must include all of the following:

- The reason for referral/presenting problem.
- Prior history, including prior treatment.
- Other pertinent medical, social, and family history.
- Clinical observations and mental status examinations.
- A complete diagnosis as listed in the latest edition of the DSM.
- Recommendations, including expected long-term and short-term benefits.
- For the interactive diagnostic interview, the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.

Domains of a Clinical Evaluation

The following domains must be included in the evaluation documentation:

- Reason for the evaluation
- History of the present illness
- Past psychiatric history
- History of alcohol and other substance use
- General medical history
- Developmental, psychosocial, and sociocultural history
- Occupational and military history
- Legal history
- Family history of psychiatric disorder
- Mental status examination

Reimbursement

A psychiatric diagnostic interview (procedure codes 1-90801 and 1-90802) is limited to once per day per client any provider, regardless of the number of professionals involved in the interview.

A psychiatric diagnostic interview (procedure code 1-90801) will be denied as part of an interactive psychiatric diagnostic interview (procedure code 1-90802) when billed for the same date of service by the same provider.

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802) will be denied as part of another service when billed within 30 days of any consultation (procedure codes 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255) by the same provider.

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802) and pharmacological management (procedure code 1-90862) will be denied as part of another service when billed for the same date of service by the same provider as inpatient psychotherapy (procedure codes 1-90816, 1-90817, 1-90818, 1-90819, 1-90821, 1-90822, 1-90823, 1-90824, 1-90826, 1-90827, 1-90828, and 1-90829), narcosynthesis for psychiatric diagnostic and therapeutic purposes (procedure code 1-90865), and ECT (procedure code 1-90870).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), insight oriented behavior modifying, and/or supportive psychotherapy (procedure code 1-90816), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as individual psychotherapy 20 to 30 minutes with medical E/M services (procedure code 1-90817).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), insight oriented behavior modifying, and/or supportive psychotherapy (procedure codes 1-90816 and 1-90817), and pharmacological management (procedure code 1-90862) will be denied as part of another service when billed for the same date of

service by the same provider as individual psychotherapy 45 to 50 minutes (procedure code 1-90818).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), insight oriented behavior modifying, and/or supportive psychotherapy (procedure codes 1-90816, 1-90817, and 1-90818), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as individual psychotherapy 45 to 50 minutes with medical E/M services (procedure code 1-90819).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), insight oriented behavior modifying, and/or supportive psychotherapy (procedure codes 1-90816, 1-90817, and 1-90818), and pharmacological management (procedure code 1-90862), will be denied as part of another service when billed for the same date of service by the same provider as individual psychotherapy 75 to 80 minutes (procedure code 1-90821).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), insight oriented behavior modifying, and/or supportive psychotherapy (procedure codes 1-90816, 1-90817, 1-90818, and 1-90819), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as individual psychotherapy 75 to 80 minutes with medical E/M services (procedure code 1-90822).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), interactive psychotherapy (procedure code 1-90823), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 20 to 30 minutes with medical E/M (procedure code 1-90824).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), interactive psychotherapy (procedure codes 1-90823 and 1-90824), and pharmacological management (procedure code 1-90862) will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 45 to 50 minutes (procedure code 1-90826).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), interactive psychotherapy (procedure codes 1-90824 and 1-90826), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 45 to 50 minutes with medical E/M (procedure code 1-90827).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), interactive psychotherapy (procedure code 1-90826), and pharmacological management (procedure code 1-90862) will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 75 to 80 minutes (procedure code 1-90828).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), interactive psychotherapy (procedure code 1-90828), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as interactive psychotherapy 75-80 minutes with medical E/M (procedure code 1-90829).

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), pharmacological management (procedure code 1-90862), and any E/M service as listed in Table D on page 30 will be denied as part of another service when billed for the same date of service by the same provider as narcosynthesis (procedure code 1-90865).

Psychological and Neuropsychological Testing

Psychological testing (procedure code 5-96101) and neuropsychological testing battery (procedure code 1-96118) are benefits of Texas Medicaid when submitted with the diagnoses listed in Table E on page 30 when performed by a psychologist or psychiatrist.

Psychologists licensed by the Texas State Board of Examiners of Psychologists and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness/debility.

Behavioral health testing may be performed during an assessment by an NP, CNS, or PA.

Refer to the "Outpatient Behavioral Health Services" article on page 12 of this bulletin, for limitations that apply to psychological and neuropsychological testing in the outpatient setting.

Documentation Requirements

Documentation is required to support medical necessity and must be maintained by the provider in the client's medical record.

The following lists the documentation that must be maintained by the provider in the client's medical record:

- The name of the test(s) (e.g., WAIS-R, Rorschach, MMPI)
- The original testing materials
- Narrative descriptions of the test findings
- An explanation to substantiate the necessity of retesting, if testing is repeated

Authorization Requirements

Psychological or neuropsychological 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 during the client's inpatient stay.

Reimbursement

Interpretation and reporting are included in the reimbursement for the psychological (procedure code 5-96101) and neuropsychological (procedure code 1-96118) testing.

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

Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial diagnostic interview or interactive psychiatric diagnostic interview examination. Psychological testing performed on the same date of service as neuropsychological testing (procedure code 1-96118) will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

Providers must bill the preponderance of each half hour of testing and indicate that number of units on the claim form:

- 0.5 units = 30 minutes
- 1.0 units = 60 minutes
- 1.5 units = 90 minutes

Inpatient Psychotherapy/Counseling

Inpatient psychotherapy/counseling (procedure codes 1-90816, 1-90817, 1-90818, 1-90819, 1-90821, 1-90822, 1-90823, 1-90824, 1-90826, 1-90827, 1-90828, 1-90829, and 1-90847) is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client 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.

Inpatient psychotherapy/counseling is limited to the DSM diagnosis codes listed in Table A on page 27.

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

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 client that necessitated the need for the psychotherapy/counseling in the client's medical record. The medical record (inpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the psychotherapy/counseling and the outcome.

Inpatient psychotherapy/counseling counts towards the 12-hour per day per provider system limitation.

Documentation Requirements

Each client 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/day/year) and signed by the performing provider. Those services not supported by the documentation in the client's medical record are subject to recoupment. Documentation must include the following:

- Notations of the session beginning and ending times
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to, the following:
  - A complete diagnosis as listed in the current edition of the DSM
  - Background, symptoms, impression
  - Narrative description of the assessment

— Behavioral observations during the session
— Narrative description of the counseling session
— Treatment plan, and recommendations

Reimbursement
Procedure codes 1-90816, 1-90817, 1-90818, 1-90819, 1-90821, 1-90822, 1-90823, 1-90824, 1-90827, 1-90828, 1-90829, and 1-90847 must be submitted when billing for inpatient psychotherapy/counseling.

Psychotherapy (procedure code 1-90847) will be denied as part of narcosynthesis (procedure code 1-90865) when billed for the same date of service by the same provider.

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 client per session.

Noncovered Services
The following services are not benefits of Texas Medicaid:

- Psychoanalysis (procedure code 1-90845)
- Family psychotherapy without the client present (procedure code 1-90846)
- Multiple family group psychotherapy (procedure code 1-90849)
- Adult and individual activities
- Biofeedback
- Day-care
- Hypnosis
- Intensive outpatient program services
- Marriage counseling
- Music/dance therapy
- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
- Recreational therapy
- Services provided by a psychiatric nurse, mental health worker, psychiatric assistant, psychologist assistant, or licensed chemical dependency counselor
- Thermogenic therapy

For questions, call the TMHP Contact Center at 1-800-925-9126. ■

Outpatient Behavioral Health Services

Reimbursement limitations for outpatient behavioral health services include the National Correct Coding Initiative (CCI) guidelines.

Behavioral health services performed by the following providers are benefits to clients of any age with a diagnosis as outlined in this article when provided in the office, home, skilled nursing or intermediate care facility, outpatient hospital, extended care facility, or in other locations:

- Physicians/Psychiatrist
- NP
- CNS
- LCSW
- PA
- LPC
- LMFT
- Licensed Psychologist

Annual Encounters/Visits Limitations

Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client, for each calendar year. An encounter/visit is defined as any/all outpatient behavioral health services (i.e., examination, therapy, psychological and/or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes outpatient encounters/visits by all practitioners.

Each individual encounter/visit and each hour of psychological/neuropsychological testing will count toward the 30-encounter/visit limitation even when services are performed by different providers on the same date of service.

Services exceeding 30 encounters/visits per calendar year per client *must* be prior authorized. Prior authorization must be obtained *before* providing the 25th service in a calendar year.

Authorization Requirements After the Annual Encounter/Visit Limitation Has Been Met

All outpatient behavioral health services for all provider types approved to deliver outpatient services will require

prior authorization once the annual encounter/visit limitation has been met with the exception of the following:

- Chemical dependency treatment facility (CDTF) services.
- CIHCP services.
- Federally Qualified Health Center (FQHC) and rural health clinic (RHC) services.
- Laboratory and radiology services.
- Mental health and mental retardation (MHMR) services.
- Pharmacological regimen oversight (procedure code 1-M0064) and pharmacological management (procedure code 1-90862).
- School health and related services (SHARS) behavioral health rehabilitation services.
- One psychiatric interview (procedure codes 1-90801 or 1-90802) per client, per year, per provider (same provider).

Prior authorization will be considered in increments of up to ten services per request once the annual encounter/visit limitation has been met. If the client changes providers during the year and the new provider is unable to obtain complete information on the client, prior authorization may be made when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the 25th encounter/visit and before rendering services. This information must be submitted in addition to the usual medical necessity information.

Prior authorization will not be granted to providers who have been seeing a client and have a well established relationship or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. All requests for prior authorization, with the exception of psychological and neuropsychological testing, must include a completed Extended Outpatient Psychotherapy/Counseling Request Form (available on page 33) dated and signed by the performing provider with the following information:

- Client name, Medicaid number, date of birth, age, and sex.
- Provider name and identifier.
- A complete diagnosis as listed in the current edition of the DSM.
- History of substance abuse.
- Current medications.
- Current living condition.
- Clinical update, including specific symptoms and responses to past treatment, treatment plan (measurable short-term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and the planned frequency of encounters/visits).
- Number of services requested for each type of therapy and the dates based on the frequency of encounters/visits that the services will be provided.
- The date on which current treatment is to begin.
- An indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services.

The Extended Outpatient Psychotherapy/Counseling Request Form may be mailed to the Special Medical Prior Authorization Department at 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727, or faxed to 1-512-514-4213. The Extended Outpatient Psychotherapy/Counseling Request Form may also be submitted online on the TMHP website at www.tmhp.com.

All of the required areas on the Extended Outpatient Psychotherapy/Counseling Request Form must be completed. If additional room is needed for a particular section of the form, providers may state "see attached" in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.

The request must be signed and received no later than the start date listed on the request form and no earlier than 30 days prior to the start date listed on the form.

To avoid unnecessary denials, the provider must provide correct and complete information, including accurate documentation of medical necessity for the services requested. The provider must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for outpatient behavioral health services.

The diagnosis code that supports medical necessity for the billed outpatient behavioral health service must be referenced on the claim.

Psychiatrist, NP, CNS, and PA Services

The following procedure codes may be reimbursed for outpatient behavioral health services when provided by a psychiatrist, NP, CNS, or PA:

Procedure Codes				
1-90801	1-90802	1-90804	1-90805	1-90806
1-90807	1-90808	1-90809	1-90810	1-90811
1-90812	1-90813	1-90814	1-90815	1-90847
1-90853	1-90857	1-90862	1-90865	5-96101
1-96118	1-M0064			

Exception: *Procedure codes 5-96101, 1-96118, and 1-90865 are not a benefit when provided by an NP, CNS, or PA.*

CDTF Services

CDTF services must be determined by a qualified credentialed counselor (QCC) (as defined by Department of State Health Services [DSHS] licensure standards) to be reasonable and necessary for a person who is chemically dependent. Chemical dependency is defined as "meeting at least three of the diagnostic criteria for psychoactive substance dependence in the latest edition of the DSM." Sufficient documentation must be maintained in the client record to support the diagnosis and justify the placement decision into the program.

CDTF services are limited to diagnosis codes 30390, 30400, 30410, 30420, 30430, 30440, 30450, 30460, and 30480.

CDTF services are limited to clients 20 years of age or younger.

DSHS limits CDTF programs as follows:

- Adolescent programs may serve children 13 years of age through 17 years of age. However, young adults 18 years of age through 20 years of age may be admitted to an adolescent program when the screening process indicates the individual's needs, experiences, and behavior are similar to those of adolescent clients.
- Adult programs serve individuals 18 years of age or older. (Texas Medicaid coverage for adult CDTF programs is limited to clients 18 years of age through 20 years of age.) However, adolescents 17 years of age may be admitted to an adult program when they are referred by the adult criminal justice system or when the screening process indicates the individual's needs, experiences, and behavior are similar to those of adult clients.
- Every exception to the general age requirements shall be clinically justified and documented in writing by a QCC. Supporting documentation, including the QCC admission approval, must be maintained by the facility in the client's medical record.

Outpatient group counseling for chemical dependency is limited to 135 hours, per client per calendar year (January 1 through December 31). Outpatient individual counseling for chemical dependency is limited to 26 hours per client per calendar year. Outpatient group and individual counseling is only payable in the outpatient setting. Clients in an inpatient status are not eligible for these outpatient services.

CDTF outpatient counseling services do not include chemical dependency education, life skills training, assessments, or prevention services. Clients in a residential CDTF are not eligible for CDTF outpatient services.

The following procedure code and modifier combinations must be used to identify outpatient counseling services provided by a QCC (as defined by the DSHS licensure standards):

- Procedure code 9-H0004 with modifier HF
- Procedure code 9-H0005 with modifier HF

Procedure code 9-H0004 with modifier HF identifies individual counseling services provided in 15-minute increments.

Procedure code 9-H0005 with modifier HF identifies group counseling services provided in one hour increments.

While CDTF services must be provided or supervised by a QCC, such as a licensed chemical dependency counselor (LCDC), LCDCs are not reimbursed separately through Texas Medicaid.

Authorization Requirements

Prior authorization is not required for CDTF services up to the limits listed in the 'Reimbursement' section below. Prior authorization will not be issued for additional hours.

Reimbursement

CDTF services are limited to a maximum of 135 hours of outpatient group counseling for chemical dependency per client per calendar year, or up to 26 hours of outpatient individual counseling for chemical dependency per client per calendar year.

Exceptions to the general age requirements for CDTF services may be considered on appeal when submitted with a covered CDTF diagnosis and a copy of the admission approval signed and dated by the QCC.

Court-Ordered and DFPS-Directed Services

Authorization Requirements

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

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

Court-ordered services are not subject to the 12-hour system limitation when billed with modifier H9.

Specific DFPS-directed services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from or go beyond the DFPS direction, the additional services will be reviewed for medical necessity.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional psychological or neuropsychological testing hours may be considered when supported by court-order or DFPS-direction, or as an exception on a case-by-case basis. All documentation must be maintained by the provider in the client's record.

Court-ordered and DFPS-directed services are not subject to the 12-hour per day per provider system limitation and will be prior authorized with modifier H9.

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

LCSW, LMFT, and LPC Services

LCSWs, LMFTs, and LPCs are expected to abide by their scopes and standards of practice. The following procedure codes may be reimbursed for outpatient behavioral health services provided by LCSWs, LMFTs, and LPCs:

Procedure Codes				
1-90804	1-90806	1-90808	1-90847	1-90853

LCSW

A specialty within the practice of social work that requires the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, and/or persons who are adversely affected by social or psychosocial stress or health impairment.

The practice of clinical social work requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions, and addictions, including severe mental illness in adults and serious emotional disturbances in children.

The practice of clinical social work acknowledges the practitioners ability to engage in Baccalaureate social work practice and Master's social work practice. Treatment methods include the provision of individual, marital, couple, family, and group therapy mediation, counseling, supportive counseling, direct practice, and psychotherapy.

Clinical social workers are qualified to use the DSM, the *International Classification of Diseases* (ICD), and other diagnostic classification systems in assessment, diagnosis, and other activities.

The practice of clinical social work may include independent clinical practice and the provision of clinical supervision.

LMFT

A licensed marriage and family therapist utilizes:

- The knowledge organized in the DSM as well as the ICD.
- Systems, methods, and processes which include all of

the following:

- — Interpersonal
- — Cognitive
- — Cognitive-behavioral
- — Developmental
- — Psychodynamic affective methods and strategies
- — Formal and informal instruments and procedures, for which the therapist has received appropriate training and supervision in individual and group settings
- — Play and play media as the child's natural medium of self-expression, and verbal tracking of the child's play behaviors on an individual basis when appropriate

LPC

The practice of professional counseling is limited to professional counselors appropriately trained and competent in the use of specific methods, techniques, or modalities. A licensed professional counselor utilizes all of the following:

- Interpersonal
- Cognitive
- Cognitive-behavioral
- Behavioral
- Psychodynamic affective methods and strategies
- Family systems methods and strategies
- Play and play media as the child's natural medium of self-expression, and verbal tracking of the child's play behaviors on an individual basis when appropriate

Pharmacological Regimen Oversight and Management Services

Pharmacological regimen oversight (procedure code 1-M0064) and pharmacological management (procedure code 1-90862) services are a benefit of Texas Medicaid when provided by a physician, NP, CNS, or PA and are limited to the DSM diagnoses listed in Table B on page 28.

Pharmacological regimen oversight (procedure code 1-M0064) and pharmacological management (procedure code 1-90862) services do not count towards the 12-hour per day per provider system limitation.

Indications

Pharmacological regimen oversight refers to a brief, face-to-face office encounter/visit for the sole purpose of evaluating, monitoring, or changing drug prescriptions or simple drug dosage adjustments and is a lesser level of drug monitoring than pharmacological management.

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 client care. It is intended for use for clients who are being managed primarily by psychotropics, antidepressants, ECT, and other types of psychopharmacologic medications. Procedure code 1-90862 cannot be billed when only a brief office encounter/visit to evaluate the client's state is provided.

The focus of a pharmacological management encounter/visit is the use of medication to treat a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal outpatient psychotherapy/counseling in a given day, the focus of the service is broader and would be considered outpatient psychotherapy/counseling rather than pharmacological management.

Pharmacological management must be provided during a face-to-face encounter/visit with the client, and any outpatient psychotherapy/counseling provided during the pharmacological management encounter/visit must be less than 20 minutes.

Procedure codes 1-M0064 and 1-90862 describe a physician service and cannot be provided by a nonphysician or "incident to" a physician service, with the exception of NPs, CNSs, and PAs whose scope of license in this state permits them to prescribe.

Procedure codes 1-M0064 or 1-90862 do not refer to the actual administration of medication or observation of the client taking an oral medication. Administration and supply of oral medication are noncovered services.

Documentation Requirements

Documentation of medical necessity for pharmacological management must be dated (month/day/year) and signed by the performing provider and address all of the following information in the client's medical record legibly:

- A complete diagnosis as listed in the latest edition of the DSM
- Medication history

- Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment
- Problems, reactions and side effects, if any, to medications and/or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)

Documentation of medical necessity for pharmacological regimen oversight must address all of the following in the client's medical record:

- The client is evaluated and determined to be stable, but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels; or
- The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment; and
- The provider has documented the medication history in the client's records with current signs and symptoms, and new medication modifications with anticipated outcome.

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 client that necessitated the need for the pharmacological regimen oversight or pharmacological management in the client's medical record. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the pharmacological regimen oversight or pharmacological management treatment and the outcome.

Authorization Requirements

Pharmacological regimen oversight and pharmacological management do not require prior authorization.

Reimbursement

Only one pharmacological regimen oversight or pharmacological management will be reimbursed for the same date of service. If the two procedure codes are billed for the same date of service by any provider, procedure code 1-M0064 will deny as part of procedure code 1-90862.

E/M services include pharmacological regimen oversight and pharmacological management. Pharmacological regimen oversight or pharmacological management will be denied as part of any E/M service listed in Table D on page 30 billed for the same date of service by the same provider.

If the primary reason for the office encounter/visit is for outpatient psychotherapy/counseling, then the specific outpatient psychotherapy/counseling procedure code should be billed. Pharmacological regimen oversight or pharmacological management will be denied as part of any outpatient psychotherapy/counseling service billed for the same date of service, by the same provider.

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

Pharmacological regimen oversight or pharmacological management is limited to one service per day per client, by any provider in any setting. Reimbursement for procedure code 1-M0064 is limited to the office setting.

Anesthesia for ECT will be denied as part of pharmacological management (procedure code 1-90862) when billed on the same date of service by the same provider.

Psychiatric Diagnostic Interviews

Psychiatric diagnostic interviews are benefits of Texas Medicaid when provided by psychiatrists, psychologists, NPs, CNSs, or PAs.

An interactive interview may be a benefit when it is medically necessary, and is limited to the DSM diagnoses listed in Table A listed on page 27.

Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by expressive or receptive language impairment from various causes such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A psychiatric diagnostic interview may be incorporated into an E/M service provided the required elements of the E/M service are fulfilled. An E/M procedure code may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a psychiatric diagnostic interview.

One psychiatric diagnostic interview examination or interactive psychiatric diagnostic interview examination per client per year per provider (same provider) does not require prior authorization when performed in the office, home, nursing facility, outpatient, or other setting and is limited to once per day per client by any provider, regardless of the number of professionals involved in the interview. Additional psychiatric diagnostic interviews may be considered for prior authorization on a case-by-case basis when submitted with supporting documentation.

Note: *Psychiatric diagnostic interviews performed in the inpatient setting are not limited to once per year, but are based on medical necessity.*

Due to the nature of these encounters/visits, the general timeframe for such a psychiatric diagnostic interview encounter/visit is one hour. A psychiatric diagnostic interview or an interactive psychiatric diagnostic interview examination counts towards the 12-hour per day per provider system limitation.

Documentation Requirements

In addition to the outpatient psychotherapy/counseling documentation requirements outlined in this article, supporting documentation for psychiatric diagnostic interview examinations must include all of the following:

- The reason for referral/presenting problem
- Prior history, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- A complete diagnosis as listed in the current edition of the DSM
- Recommendations, including expected long-term and short-term benefits
- For the interactive psychiatric diagnostic interview, the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques

Domains of a Clinical Evaluation

The following domains must be included in the evaluation documentation:

- The reason for the evaluation
- History of the present illness
- Past psychiatric history
- History of alcohol and other substance use
- General medical history
- Developmental, psychosocial, and sociocultural history
- Occupational and military history
- Legal history
- Family history of psychiatric disorder
- Mental status examination

The treating provider must document the medical necessity for the chosen treatment and list the diagnosis code that most accurately describes the condition of the client that necessitated the need for the psychiatric diagnostic interview in the client's medical record. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the psychiatric diagnostic interview and the outcome.

Authorization Requirements

Psychiatric diagnostic interviews are limited to once per client by the same provider per year and do not require prior authorization when performed in the office, home, nursing facility, outpatient, or other setting. Psychiatric diagnostic interviews are limited to once per day per client by any provider, regardless of the number of professionals involved in the interview.

Additional psychiatric diagnostic interviews may be considered for prior authorization on a case-by-case basis when submitted with supporting documentation, including but not limited to the following:

- A court order or a DFPS directive
- If a new episode of illness occurs after a hiatus

Reimbursement

A psychiatric diagnostic interview examination and interactive psychiatric diagnostic interview examination may be reimbursed to psychiatrists, psychologists, NPs, CNSs, and PAs. A psychiatric diagnostic interview is limited to:

- Once per client per day any provider, regardless of the number of professionals involved in the interview.
- Once per client per year per provider (same provider) in the office, home, nursing facility, outpatient, or other setting (this limitation does not apply to the inpatient setting).

A psychiatric diagnostic interview (procedure code 1-90801) will be denied as part of an interactive psychiatric diagnostic interview (procedure code 1-90802) when billed for the same date of service by the same provider.

Procedure codes 1-90801 and 1-90802 will be denied as part of another service when billed within 30 days of any consultation (procedure codes 3-99241, 3-99242, 3-99243, 3-99244, 3-99245, 3-99251, 3-99252, 3-99253, 3-99254, and 3-99255) by the same provider.

Pharmacological regimen oversight management (procedure code 1-90862), a neurobehavioral status exam and any E/M service listed in Table D on page 30 will be denied as part of a psychiatric diagnostic interview when billed for the same date of service by the same provider.

Psychiatric diagnostic interviews, pharmacological management and any E/M service in Table D on page 30 will be denied as part of group outpatient psychotherapy/counseling.

All providers are subject to retrospective review of claims and services performed or billed in excess of 12 hours per day.

Psychological and Neuropsychological Testing

Psychological testing and neuropsychological testing are a benefit of Texas Medicaid when provided by a psychiatrist or psychologist for the diagnoses listed in Table E on page 30. Each hour of testing counts towards the 12-hour per day, per provider system limitation.

Documentation Requirements

The following documentation must be maintained by the provider in the client's medical record:

- The Extended Outpatient Psychotherapy/Counseling Request Form
- The name of the test(s) (e.g., WAIS-R, Rorschach, MMPI)
- The original testing materials
- Narrative descriptions of the test findings
- An explanation to substantiate the necessity of retesting, if testing is repeated

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 client that necessitated the need for the psychological/neuropsychological testing in the client's medical record. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the psychological/neuropsychological testing and the outcome.

Psychologists licensed by the Texas State Board of Examiners of Psychologists and enrolled as Texas Medicaid providers are authorized to perform counseling and testing for mental illness/debility.

Psychological and neuropsychological testing are not benefits when provided by an NP, CNS, or PA. Behavioral health testing may be performed during an assessment by an NP, CNS, or PA. Psychological or neuropsychological testing is limited to a total of four hours per day, and eight hours per calendar year, per client, for any provider. Hours billed beyond four hours per day or eight hours per calendar year will be denied without prior authorization.

All supporting documentation must be maintained by the provider in the client's medical record.

Authorization Requirements

If the client requires more than four hours of testing per day, or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity and must be submitted on the Extended Outpatient Psychotherapy/Counseling Request Form for the additional hours. The number of hours prior authorized are based on the client's medical necessity as supported by the submitted documentation. Additional testing hours may be considered as an exception on a case-by-case basis when supported by medical necessity. All documentation must be maintained by the provider in the client's medical record.

Reimbursement

Psychological or neuropsychological testing is limited to a total of four hours per day, and eight hours per client per calendar year for any provider.

Interpretation and reporting are included in the reimbursement for the psychological and neuropsychological testing.

Psychological and neuropsychological testing will not be reimbursed to an NP, CNS, or PA. Behavioral health

testing may be performed during an assessment by an NP, CNS, or PA, and should be billed as part of the appropriate office encounter/visit code.

Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial psychiatric diagnostic interview or interactive psychiatric diagnostic interview examination. Psychological testing performed on the same date of service as neuropsychological testing will be denied as part of another service. All documentation must be maintained by the provider in the client's medical record.

Providers must bill the preponderance of each half hour of testing and indicate that number of units on the claim form:

- 0.5 units = 30 minutes
- 1.0 units = 60 minutes
- 1.5 units = 90 minutes

Behavioral health testing performed by an NP, CNS, or PA during an assessment will be denied as part of another service.

Outpatient Psychotherapy/Counseling

Outpatient psychotherapy/counseling is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client 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.

Psychotherapy/counseling is covered for the following procedure codes when performed by the identified provider:

Procedure Code	NP or CNS	LCSW	LMFT	LPC	PA	Psychiatrist	Psychologist
1-90804	•	•	•	•	•	•	•
1-90805	•				•	•	
1-90806	•	•	•	•	•	•	•
1-90807	•				•	•	
1-90808	•	•	•	•	•	•	•
1-90809	•				•	•	
1-90810	•				•	•	•
1-90811	•				•	•	
1-90812	•				•	•	•
1-90813	•				•	•	
1-90814	•				•	•	•
1-90815	•				•	•	
1-90847	•	•	•	•	•	•	•
1-90853	•	•	•	•	•	•	•
1-90857	•				•	•	•
1-90862	•				•	•	
1-90865	•				•	•	

Initial Outpatient Psychotherapy/Counseling – Individual, Group, or Family

Outpatient psychotherapy/counseling is a benefit of Texas Medicaid and is limited to the DSM diagnosis codes listed in Table A on page 27.

The appropriate service is chosen on the basis of the type of outpatient psychotherapy/counseling, the place of service, the face-to-face time spent with the client during outpatient psychotherapy/counseling, and whether evaluation and management services are furnished on the same date of service as outpatient psychotherapy/counseling.

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 client that necessitated the need for the psychotherapy/counseling in the client's medical record. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the psychotherapy/counseling and the outcome.

Outpatient psychotherapy/counseling counts towards the 12-hour per day per provider system limitation.

Documentation Requirements

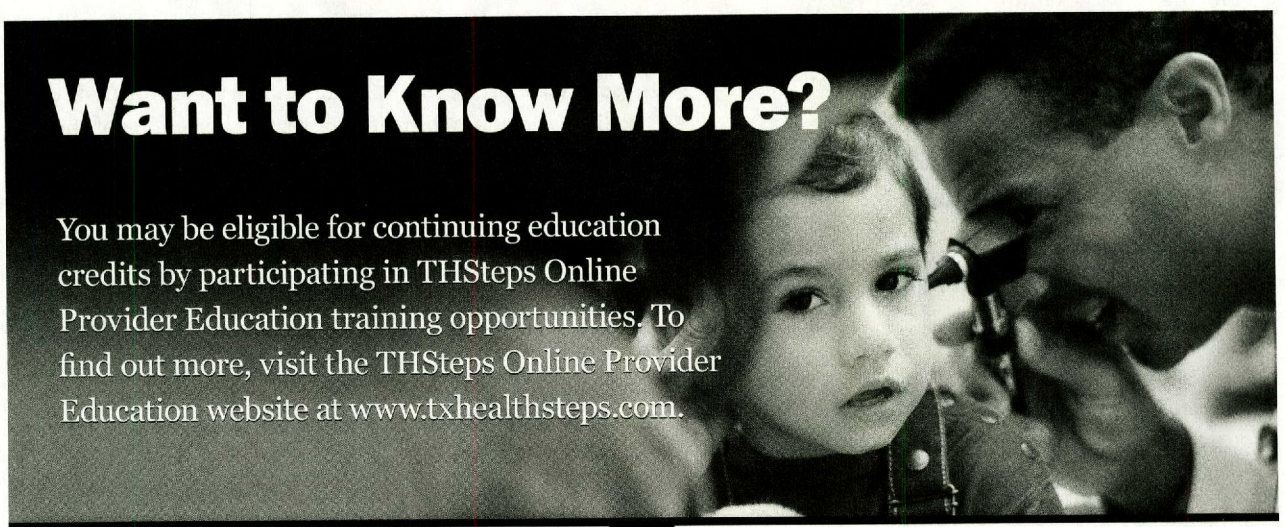
Each client for whom services are provided must have supporting documentation included in their medical records. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/day/year) and signed by the performing provider. Those services not supported by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

- Notations of the session beginning and ending times.
- All pertinent information regarding the client's condition to substantiate the need for services, including, but not limited to, the following:
  - A complete diagnosis as listed in the current edition of the DSM.
  - Background, symptoms, impression.
  - Narrative description of the assessment.
  - Behavioral observations during the session.
  - Narrative description of the counseling session.
  - Treatment plan and recommendations.

Authorization Requirements

After the annual 30-encounter/visit limitation is met, prior authorization will be considered in increments of up to ten services per request. All requests for prior authorization must include a completed Extended Outpatient Psychotherapy/Counseling Request Form, including:

- Client name and Medicaid number, date of birth, age, and sex.
- Provider name and identifier.
- A complete diagnosis as listed in the current edition of the DSM.
- History of substance abuse.
- Current medications.
- Current living condition.
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length



of treatment anticipated, and planned frequency of encounters/visits).

- Number, type of services requested, and the dates based on the frequency of encounters and/or visits that the services will be provided.
- Date on which the current treatment is to begin.
- Indication of court-ordered or DFPS-directed services.

Note: *All areas of the Extended Outpatient Psychotherapy/ Counseling Request Form must be completed with the information required by the form. If additional room is needed for a particular section of the form, providers may state, "see attached," in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.*

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized will be dependent upon the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional request(s) must include new documentation concerning the client's current condition.

Client Condition Requirements

The following documentation requirements must be submitted when requesting prior authorization for outpatient services beyond the 30 encounter/visit annual limitation:

- A description of why treatment is being sought at the present time.
- A mental status examination which validates a diagnosis as listed in the current edition of the DSM.
- A description of any existing psychosocial and/or environmental problems.
- A description of the current level of social and occupational/educational functioning.

Initial Assessment Requirements

There must be a pertinent history that contains all of the following:

- A chronological, psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment.
- A social and family history.
- An educational and occupational history.

Active Treatment Plan Requirements

The treatment plan must contain:

- A description of the primary focus of the treatment.
- Clearly defined discharge goals that will indicate that treatment can successfully be concluded.
- The expected number of sessions it will take to reach the discharge goals, and standards of practice for the client's diagnosis.
- Family therapy services are appropriately planned unless there are valid clinical contraindications.

When a medication regimen is planned by a psychiatrist, PA, NP, or CNS it must meet the following:

- Guidelines specific to the medication or medications prescribed.
- Accepted standard of practice for the diagnosis for which it is prescribed.
- Accepted standard of practice for the age group for which it is prescribed.

Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals.
- An identification of the client's aftercare needs that includes a plan of transition.

Subsequent Outpatient Psychotherapy/ Counseling – Individual, Group, or Family

Client Condition Requirements

All of the requirements for the first authorized treatment sessions must be met in addition to an assessment of the client's response to treatment that indicates one of the following:

- The client has not achieved the discharge goal necessary to conclude treatment, but the description of the client's progress indicated that treatment can be concluded within a short period of time.
- The client's psychiatric condition has not responded to a trial of short-term outpatient therapy and there is potential for serious regression or admission to a

more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).

- The client's condition is one which includes long-standing, pervasive symptoms and/or patterns of maladaptive behavior.

Active Treatment Plan Requirements
There must be an assessment, which explains the client's inability to achieve the treatment objectives as expected. This assessment must address the following:

- Factors that interfered or are interfering with the client's ability to make progress as expected.
- The continued appropriateness of the treatment goals.
- The continued appropriateness of the type of therapy being utilized.
- The need for obtaining consultation.
- The current diagnosis and the need for revisions and/or additional assessments.

The ongoing treatment plan must reflect the initial treatment plan requirements and the additional information must include:

- Changes in primary treatment focus or discharge goals have been identified and are consistent with the client's current condition.
- The expected progress toward the discharge goals is described within the extended time frame.
- Appropriate adjustments have been made in the medication regimen based on the client's therapeutic response.
- No contraindications to the use of the prescribed medications are present.

Discharge Plan Requirements
Discharge planning must reflect the following:

- A plan for concluding the client's treatment based on an assessment of the client's progress in meeting the discharge goals.
- An identification of the client's aftercare needs that includes a plan of transition.

For questions about inpatient and outpatient behavioral health services, please contact the TMHP Contact Center at 1-800-925-9126.

Reimbursement
Outpatient psychotherapy/counseling is limited to no more than four hours per client, per day. The diagnosis code that supports medical necessity for the billed outpatient health service must be referenced on the claim.

An NP, CNS, PA, or psychiatrist may bill an E/M encounter/visit if less than 20 minutes of outpatient psychotherapy/counseling are provided.

When more than one type of session is provided on the same date of service (e.g., outpatient, individual, group, or family psychotherapy/counseling) each session type will be reimbursed individually. Services are reimbursed only for the Medicaid eligible client per session.

Only the LCSW, LMFT, LPC, NP, CNS, PA, or psychologist actually performing the mental health service may bill Texas Medicaid. The LCSW, LMFT, LPC, NP, CNS, PA, or psychologist must not bill for services performed by people under their supervision. A psychiatrist may bill for services performed by people under their supervision.

LCSW, LMFT, LPC, NP, CNS, PA, or psychologist who are employed by or remunerated by another provider may not bill Texas Medicaid directly for counseling services if that billing would result in duplicate payment for the same services.

When multiples of each type of session are billed, the most inclusive code from each type of session is paid and the others are denied.

LMFTs must bill with modifier U8.

The services of a psychological associate (Masters level psychologist), psychiatric nurse, or behavioral health worker are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Interpretation and documentation time, including time to document test results in the client's medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes. Providers must bill the preponderance of each half hour of psychological or neuropsychological testing or therapy and indicate that number of units on the claim form.

A psychiatric diagnostic interview (procedure codes 1-90801 and 1-90802), pharmacological regimen oversight (procedure code 1-M0064), pharmacological management (procedure code 1-90862), or any E/M service listed in Table D on page 30 will be denied as part of narcosynthesis (procedure code 1-90865).

Procedure codes 1-90804, 1-90847, 1-90853, and 1-90857 will be denied as part of narcosynthesis when billed on the same date of service by the same provider.

Providers must bill the preponderance of each half hour of group counseling sessions and indicate the number of units on the claim form:

- 0.5 units = 30 minutes
- 1.0 units = 60 minutes
- 1.5 units = 90 minutes

Insight Oriented Behavior Modifying and/or Supportive Outpatient Psychotherapy/Counseling

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), pharmacological regimen oversight (procedure code 1-M0064) and pharmacological management (procedure code 1-90862) will be denied as part of the following outpatient psychotherapy/counseling services when billed on the same date of service by the same provider in addition to the limitations detailed below by procedure code:

- Insight oriented outpatient psychotherapy/counseling without medical E/M services (procedure codes 1-90804, 1-90806, and 1-90808):
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90804 (20 to 30 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90805, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90806 (45 to 50 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90805, 1-90806, 1-90807, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90808 (75 to 80 minutes).
- Insight oriented outpatient psychotherapy/counseling with medical E/M services (procedure codes 1-90805, 1-90807, and 1-90809):
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90862, 1-M0064, and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90805 (20 to 30 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90805, 1-90806, 1-90862, 1-M0064, and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90807 (45 to 50 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90805, 1-90806, 1-90807, 1-90808, 1-90862, and 1-M0064 and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90809 (75 to 80 minutes).
- Interactive outpatient psychotherapy/counseling without medical E/M services (procedure codes 1-90810, 1-90812, and 1-90814):
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90810 (20 to 30 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90804, 1-90805, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90812 (45 to 50 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90812, 1-90862, and 1-M0064 will be denied as part of procedure code 1-90814 (75 to 80 minutes).
- Interactive outpatient psychotherapy/counseling with medical E/M services (procedure codes 1-90811, 1-90813, and 1-90815):
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90810, 1-90862, 1-M0064, and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90811 (20 to 30 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90811, 1-90812, 1-90862, 1-M0064, and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90813 (45 to 50 minutes).
  - Procedure codes 2-36640, 1-90801, 1-90802, 1-90812, 1-90813, 1-90814, 1-90862, 1-M0064, and any E/M service listed in Table D on page 30 will be denied as part of procedure code 1-90815 (75 to 80 minutes).

Family Therapy

When providing family counseling services (procedure code 1-90847), the Texas Medicaid client and a family member must be present during the face-to-face encounter/visit.

According to the definition of family provided by 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:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister
- Foster parent
- Legal guardian

Reimbursement

Regardless of the number of family members present per session, family psychotherapy/counseling is reimbursed for only one Medicaid eligible client per session.

Procedure code 1-90847 is limited to one service per family per day.

Psychiatric diagnostic interviews (procedure codes 1-90801 and 1-90802), pharmacological regimen oversight (procedure code 1-M0064), pharmacological management (procedure code 1-90862), and any E/M service listed in Table D on page 30 will be denied as part of family outpatient psychotherapy/counseling.

Noncovered Services

The following services are not benefits of Texas Medicaid:

- Adult and individual activities
- Biofeedback
- Day-care
- Family psychotherapy without the client present
- Hypnosis
- Intensive outpatient program services
- Marriage counseling
- Multiple family group psychotherapy
- Music/dance therapy
- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
- Psychoanalysis
- Recreational therapy
- Services provided by a psychiatric nurse, mental health worker, psychiatric assistant, psychologist assistant, or licensed chemical dependency counselor
- Thermogenic therapy

Additional Benefit Changes

The following benefit changes are effective for dates of service January 1, 2009.

The following diagnosis codes are no longer payable when billed with procedure code 5-96101 or 1-96118:

Diagnosis Codes			
0360	0361	03681	04503
04510	04523	04593	0462
0463	0468	0469	0470
0471	0478	0479	048
0490	0491	0498	0499

The following procedure codes are no longer payable to a registered nurse or nurse midwife in any place of service:

Procedure Codes			
1-90801	1-90802	1-90804	1-90805
1-90806	1-90807	1-90808	1-90809
1-90810	1-90811	1-90812	1-90813
1-90814	1-90815	1-90846	1-90847
1-90853	1-90857	1-90862	1-M0064

The following procedure codes are no longer payable to all provider types in an independent laboratory or birthing center setting:

Procedure Codes				
1-90802	1-90847	1-90853	1-90857	1-90862

The following procedure codes are no longer payable when billed with any of the diagnosis codes on the following page:

Procedure Codes			
1-90801	1-90802	1-90804	1-90805
1-90806	1-90807	1-90808	1-90809

Procedure Codes			
1-90810	1-90811	1-90812	1-90813
1-90814	1-90815	1-90847	1-90853
1-90857			

Diagnosis Codes				
2900	29010	29011	29012	29013
29020	29021	2903	2908	2909
2914	29182	2922	29285	2931
29500	29501	29502	29503	29504
29505	29511	29512	29513	29514
29515	29521	29522	29523	29524
29525	29531	29532	29533	29534
29535	29541	29542	29543	29544
29545	29550	29551	29552	29553
29554	29555	29561	29562	29563
29564	29565	29571	29572	29573
29574	29575	29580	29581	29582
29583	29584	29585	29591	29592
29593	29594	29595	29610	29611
29612	29613	29614	29615	29616
29681	29682	29699	2970	2972
2978	2979	2980	2981	2982
2983	2984	29901	29911	29981
29990	30009	30010	30020	3005
30089	30110	30111	30112	30121
3013	30151	30159	30184	30189
3020	3021	30250	30251	30252
30253	30391	30392	30393	30401

Diagnosis Codes				
30402	30403	30411	30412	30413
30421	30422	30423	30431	30432
30433	30441	30442	30443	30451
30452	30453	30461	30462	30463
30470	30471	30472	30473	30481
30482	30483	30491	30492	30493
30501	30502	30503	30521	30522
30523	30531	30532	30533	30541
30542	30543	30551	30552	30553
30561	30562	30563	30571	30572
30573	30580	30581	30582	30583
30591	30592	30593	30740	30741
30743	30748	30749	30754	30781
3080	3081	3082	3084	3089
3091	30922	30923	30929	30982
30983	30989	3100	31200	31201
31202	31203	31210	31211	31212
31213	31220	31221	31222	31223
31235	3124	3130	3131	31321
31322	3133	31383	3141	3142
3148	99550	99551	99555	99559
99580	99582	99584	99585	V110
V111	V112	V113	V118	V119
V170	V400	V401	V402	V403
V409	V6284	V790	V791	V792
V793	V798	V799		

For more information, call the TMHP Contact Center at 1-800-925-9126. ■

Table A

Psychiatric Diagnostic Interviews, and Psychotherapy/Counseling Services

Procedure codes 1-90801, 1-90802, 1-90804, 1-90805, 1-90806, 1-90807, 1-90808, 1-90809, 1-90810, 1-90811, 1-90812, 1-90813, 1-90814, 1-90815, 1-90816, 1-90817, 1-90818, 1-90819, 1-90821, 1-90822, 1-90823, 1-90824, 1-90826, 1-90827, 1-90828, 1-90829, 1-90847, 1-90853, and 1-90857 may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
29040	29041	29042	29043	2910	2911	2912	2913
2915	29181	29189	2919	2920	29211	29212	29281
29282	29283	29284	29289	2929	2930	29381	29382
29383	29384	29389	2939	2940	29410	29411	2948
2949	29510	29520	29530	29540	29560	29570	29590
29600	29601	29602	29603	29604	29605	29606	29620
29621	29622	29623	29624	29625	29626	29630	29631
29632	29633	29634	29635	29636	29640	29641	29642
29643	29644	29645	29646	29650	29651	29652	29653
29654	29655	29656	29660	29661	29662	29663	29664
29665	29666	2967	29680	29689	29690	2971	2973
2988	2989	29900	29910	29980	30000	30001	30002
30011	30012	30013	30014	30015	30016	30019	30021
30022	30023	30029	3003	3004	3006	3007	30081
30082	30089	3009	3010	30113	30120	30122	3014
30150	3016	3017	30181	30182	30183	3019	3022
3023	3024	3026	30270	30271	30272	30273	30274
30275	30276	30279	30281	30282	30283	30284	30285
30289	3029	30390	30400	30410	30420	30430	30440
30450	30460	30480	30490	30500	30520	30530	30540
30550	30560	30570	30590	3070	3071	30720	30721
30722	30723	3073	30742	30744	30745	30746	30747
30750	30751	30752	30753	30759	3076	3077	30780
30789	3079	3083	3090	30921	30928	3093	3094
30981	3101	311	31230	31231	31232	31234	31239
31281	31282	31289	3129	31323	31381	31382	31389
3139	31400	31401	3149	99552	99553	99554	99581
99583	V6121	V6281	V6282	V6283	V6289	V6101	V6102
V6103	V6104	V6105	V6106	V6109	V6221	V6222	V6229
V7101	V7102	V7109					

Table B

Pharmacological Regimen Oversight and Pharmacological Management Services

Procedure codes 1-M0064 and 1-90862 may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
29040	29041	29042	29043	2910	2911	2912	2913
2915	29181	29189	2919	2920	29211	29212	29281
29282	29283	29284	29289	2929	2930	29381	29382
29383	29384	29389	2939	2940	29410	29411	2948
2949	29510	29520	29530	29540	29560	29570	29590
29600	29601	29602	29603	29604	29605	29606	29620
29621	29622	29623	29624	29625	29626	29630	29631
29632	29633	29634	29635	29636	29640	29641	29642
29643	29644	29645	29646	29650	29651	29652	29653
29654	29655	29656	29660	29661	29662	29663	29664
29665	29666	2967	29680	29689	29690	2971	2973
2988	2989	29900	29901	29910	29911	30000	30001
30002	30011	30012	30013	30014	30015	30016	30019
30021	30022	30023	30029	3003	3004	3006	3007
30081	30082	3009	3010	30113	30120	30122	3013
3014	30150	3016	3017	30181	30182	30183	3019
3022	3023	3024	3026	30270	30271	30272	30273
30274	30275	30276	30279	30281	30282	30283	30284
30285	30289	3029	30300	30390	30400	30410	30420
30430	30440	30450	30460	30470	30480	30490	30500
30520	30530	30540	30550	30560	30570	30590	30650
30651	3070	3071	30720	30721	30722	30723	3073
30742	30744	30745	30746	30747	30750	30751	30752
30753	30759	3076	3077	30780	30789	3079	3083
3090	30921	30928	3093	3094	30981	3099	3101
311	31230	31231	31232	31234	31239	31281	31282
31289	3129	31323	31381	31382	31389	3139	31400
31401	3149	31500	3151	3152	3153	31531	31532
31539	3154	V6101	V6102	V6103	V6104	V6105	V6106
V6109	V6221	V6222	V6229				

Table C

Procedure codes 1-90862 and 1-M0064 are no longer payable when billed with the following diagnosis codes:

Diagnosis Codes							
2900	29010	29011	29012	29013	29020	29021	2903
2908	2909	2914	29182	2922	29285	2931	29500
29501	29502	29503	29504	29505	29511	29512	29513
29514	29515	29521	29522	29523	29524	29525	29531
29532	29533	29534	29535	29541	29542	29543	29544
29545	29550	29551	29552	29553	29554	29555	29561
29562	29563	29564	29565	29571	29572	29573	29574
29575	29580	29581	29582	29583	29584	29585	29591
29592	29593	29594	29595	29610	29611	29612	29613
29614	29615	29616	29681	29682	29699	2970	2972
2978	2979	2980	2981	2982	2983	2984	30009
30010	30020	3005	30089	30110	30111	30112	30121
30151	30159	30184	30189	3020	3021	30250	30251
30252	30253	30301	30302	30303	30391	30392	30393
30401	30402	30403	30411	30412	30413	30421	30422
30423	30431	30432	30433	30441	30442	30443	30451
30452	30453	30461	30462	30463	30470	30471	30472
30473	30481	30482	30483	30491	30492	30493	30501
30502	30503	30521	30522	30523	30531	30532	30533
30541	30542	30543	30551	30552	30553	30561	30562
30563	30571	30572	30573	30580	30581	30582	30583
30591	30592	30593	3060	3061	3062	3063	3064
30650	30652	30653	30659	3066	3067	3068	3069
30740	30741	30743	30748	30749	30754	30781	3080
3081	3082	3084	3089	3091	30922	30923	30929
30982	30983	30989	3100	31200	31201	31202	31203
31210	31211	31212	31213	31220	31221	31222	31223
31235	3124	3130	3131	31321	31322	3133	31383
3141	3142	3148	31501	31502	31509	3155	3158
3159	316						

Table D

The following procedure codes may be billed for physician evaluation and management services:

Procedure Codes							
1-99201	1-99202	1-99203	1-99204	1-99205	1-99211	1-99212	1-99213
1-99214	1-99215	1-99217	1-99218	1-99219	1-99220	1-99221	1-99222
1-99223	1-99231	1-99232	1-99233	1-99234	1-99235	1-99236	1-99238
1-99239	3-99241	3-99242	3-99243	3-99244	3-99245	3-99251	3-99252
3-99253	3-99254	3-99255	1-99281	1-99282	1-99283	1-99284	1-99285
1-99304	1-99305	1-99306	1-99307	1-99308	1-99309	1-99310	1-99315
1-99316	1-99318	1-99324	1-99325	1-99326	1-99327	1-99328	1-99334
1-99335	1-99336	1-99337	1-99341	1-99342	1-99343	1-99344	1-99345
1-99347	1-99348	1-99349	1-99350	1-99354	1-99355	1-99356	1-99357*
1-99360*	1-99455*	1-99456*	1-99460*	1-99461*	1-99462*	1-99463*	1-99464*
1-99465*	1-99468	1-99469	1-99471	1-99472	1-99475*	1-99476*	1-99478
1-99479	1-99480						
*Procedure code will not be denied as part of procedure code 1-90801, 1-90845, 1-90847, or 1-90865.							

Table E

Psychological and Neuropsychological

Procedure codes 5-96101 and 1-96118 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
0460	04611	04619	04672	05821	05829	2900	29010
29011	29012	29013	29020	29021	2903	29040	29041
29042	29043	2908	2909	2911	2912	2915	29189
2919	2920	29211	29212	2922	29281	2929	2930
2931	29381	29382	29383	29384	29389	2939	2940
29410	29411	2948	2949	29500	29501	29502	29503
29504	29505	29510	29511	29512	29513	29514	29515
29520	29521	29522	29523	29524	29525	29530	29531
29532	29533	29534	29535	29540	29541	29542	29543
29544	29545	29550	29551	29552	29553	29554	29555
29560	29561	29562	29563	29564	29565	29570	29571
29572	29573	29574	29575	29580	29581	29582	29583
29584	29585	29590	29591	29592	29593	29594	29595
29600	29601	29602	29603	29604	29605	29606	29610
29611	29612	29613	29614	29615	29616	29620	29621
29622	29623	29624	29625	29626	29630	29631	29632
29633	29634	29635	29636	29640	29641	29642	29643
29644	29645	29646	29650	29651	29652	29653	29654
29655	29656	29660	29661	29662	29663	29664	29665

Diagnosis Codes							
29666	2967	29680	29681	29682	29689	29690	29699
2970	2971	2972	2973	2978	2979	2980	2981
2982	2983	2984	2988	2989	29900	29910	29980
29990	30000	30001	30002	30009	30010	30011	30012
30013	30014	30015	30016	30019	30020	30021	30022
30023	30029	3003	3004	3005	3006	3007	30081
30082	30089	3009	3010	30110	30111	30112	30113
30120	30121	30122	3013	3014	30150	30151	30159
3016	3017	30181	30182	30183	30184	30189	3019
3020	3021	3022	3023	3024	30250	30251	30252
30253	3026	30270	30271	30272	30273	30274	30275
30276	30279	30281	30282	30283	30284	30285	30289
3029	30390	30400	30500	30501	30502	30503	30520
30521	30522	30523	30530	30531	30532	30533	30540
30541	30542	30543	30550	30551	30552	30553	30560
30561	30562	30563	30570	30571	30572	30573	30580
30581	30582	30583	30591	30592	30593	3070	3071
30720	30721	30722	30723	3073	30740	30741	30742
30743	30744	30745	30746	30747	30748	30749	30750
30751	30752	30753	30754	30759	3076	3077	30780
30781	30789	3079	3080	3081	3082	3083	3084
3089	3090	3091	30921	30922	30923	30924	30928
30929	3093	3094	30981	30982	30983	30989	3099
3100	3101	3102	3108	311	31200	31201	31202
31203	31210	31211	31212	31213	31220	31221	31222
31223	31230	31231	31232	31233	31234	31235	31239
3124	31281	31282	31289	3129	3130	3131	31321
31322	31323	3133	31381	31382	31383	31389	3139
31400	31401	3141	3142	3148	3149	31531	31532
31534	3154	3155	3158	3159	317	3180	3181
3182	319	3200	3201	3202	3203	3207	32081
32082	32089	3209	3210	3211	3212	3213	3214
3218	3220	3221	3222	3229	32301	32302	3231
3232	32341	32342	32351	32352	32361	32362	32363
32371	32372	32381	32382	32383	3239	3240	3241
3249	3300	3301	3302	3203	3308	3309	3310
33111	33119	3312	3313	3314	3315	3317	33181
33182	3319	33392	340	34500	34501	34510	34511
3452	3453	34540	34541	34550	34551	34560	34561
34570	34571	34580	34581	34590	34591	3480	3481
34830	34831	34839	38845	430	431	4320	4321
4329	43300	43301	43310	43311	43320	43321	43330

Diagnosis Codes							
43331	43380	43381	43390	43391	43400	43401	43410
43411	43490	43491	4350	4351	4352	4353	4358
4359	436	4370	4371	4372	4373	4374	4375
4376	4377	4378	4379	4380	43810	43811	43812
43819	43820	43821	43822	43830	43831	43832	43840
43841	43842	43850	43851	43852	43853	4386	4387
43881	43882	43883	43884	43885	43889	4389	7685
7686	77210	77211	77212	77213	77214	7722	7790
78031	78039	79901	79902	8500	85011	85012	8502
8503	8504	8505	8509	85100	85101	85102	85103
85104	85105	85106	85109	85110	85111	85112	85113
85114	85115	85116	85119	85120	85121	85122	85123
85124	85125	85126	85129	85130	85131	85132	85133
85134	85135	85136	85139	85140	85141	85142	85143
85144	85145	85146	85149	85150	85151	85152	85153
85154	85155	85156	85159	85160	85161	85162	85163
85164	85165	85166	85169	85170	85171	85172	85173
85174	85175	85176	85179	85180	85181	85182	85183
85184	85185	85186	85189	85190	85191	85192	85193
85194	85195	85196	85199	85200	85201	85202	85203
85204	85205	85206	85209	85210	85211	85212	85213
85214	85215	85216	85219	85220	85221	85222	85223
85224	85225	85226	85229	85230	85231	85232	85233
85234	85235	85236	85239	85240	85241	85242	85243
85244	85245	85246	85249	85250	85251	85252	85253
85254	85255	85256	85259	85300	85301	85302	85303
85304	85305	85306	85309	85310	85311	85312	85313
85314	85315	85316	85319	85400	85401	85402	85403
85404	85405	85406	85409	986	9941	9947	V110
V111	V112	V113	V170	V401	V402	V6282	V6283
V6284	V695	V7101	V7102	V790	V791	V792	V793
V798							

Extended Outpatient Psychotherapy/Counseling Request Form

1. Identifying Information

Client Information

Medicaid number:			Date: / /	
Client name	Last:		First:	Middle Initial:
Date of birth: / /	Age:	Sex:	Began current treatment: / /	
Current living arrangements:	☐ With parent(s)	☐ Group/foster home	☐ Other (list):	

Provider Information

Performing provider:	Telephone:
Address:	
TPI:	NPI:
Taxonomy:	Benefit Code:

2. Current DSM IV diagnosis (list all appropriate codes):

Axis I diagnosis:				
Axis II diagnosis:		GAF:		
Current substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs

3. Recent primary symptoms that require additional therapy/counseling

Include date of most recent occurrence, frequency, duration, and severity:

4. History

Psychiatric inpatient treatment	☐ Yes	☐ No	Age at first admission:	
Prior substance abuse?	☐ None	☐ Alcohol	☐ Drugs	☐ Alcohol and Drugs

Significant medical disorders:

5. Current psychiatric medications (include dose and frequency):

6. Treatment plan for extension

Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:

7. Number of additional sessions requested (limit 10 per request)

List the specific procedure codes requested:

How many of each type?	IND	Group	Family
Dates	From (start of extension visits): / /	To (end of planned requested visits): / /	

List specific procedure codes requested:

Provider signature: Date: / /

Provider printed name:

Effective Date_07302007/Revised Date_06012007

Psychiatric Inpatient Extended Stay Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information				
Medicaid Number:			Date: / /	
Client Name	Last:		First:	Middle Initial:
Date of birth: / /	Age:		Sex:	Date of admission: / /
Facility Information				
Name:			Contact Person:	
Address:				
TPI:	NPI:		Taxonomy:	Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /		County:	Judge:

IIA. Current status of primary symptoms that require continued acute hospital care
(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

IIB. Other relevant clinical/diagnostic information about the patient from the past 72 hours
(Attach additional pages or documents, as necessary)

IIC. Current psychiatric medication (include total daily doses)	**IID. Discharge criteria**
	1.
	2.
	3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD):	Date: / /
Print name:	Provider license number
Provider TPI:	Provider NPI:

Effective Date_07302007/Revised Date_07102007

Psychiatric Inpatient Initial Admission Request Form

12357-B Riata Trace Parkway, Suite 150
Austin, Texas 78727-6422

TMHP CCIP

Telephone: 1-800-213-8877
Fax: 1-512-514-4211

I. Identifying Information

Medicaid Number:			Date: / /	
Client Name	Last:		First:	Middle Initial:
Date of birth: / /	Age:	Sex:	Date of admission: / /	Time:

Facility Information

Name:		Contact Person:	
Address:			
TPI:	NPI:	Taxonomy:	Benefit Code:
Commitment Type: *(If applicable)*	Effective Date: / /	County:	Judge:

Referral source: ☐ Admitting MD ☐ MH Professional ☐ Other (list):

Current living arrangements: ☐ With parent(s) ☐ Group/foster home ☐ Other (list):

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care

(Include: precipitating events leading to admission)

IIB. Other relevant clinical information, including inability to benefit from less restrictive setting

(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications

(include total daily doses)

IID. Present and past drug/alcohol usage:

Name of chemical	Current use?

IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ] Dates of most recent inpatient stay: / / to / /
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD):	Date: / /
Print name:	Provider license number
Provider TPI:	Provider NPI:

Effective Date_07302007/Revised Date_07102007

Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization, and provide notification of emergency admissions.

Telephone number: 1-888-302-6167 (option 1 inpatient, option 2 outpatient)	Fax number: 1-512-302-5039

Please check the appropriate action you are requesting

Inpatient Services	Outpatient (OP) Services
☐ Notification (complete fields in Section 1 excluding clinical documentation)	☐ Prior authorization for outpatient services (complete Section 1)
☐ DRG or clinical update (complete Section 2)	☐ Update/change codes from original OP PA request (complete Section 2)
☐ Non Routine OB/NB (complete Section 1)	
☐ Prior Authorization of scheduled admission/procedure (complete Section 1)	

Client Information

PCN Number:	Name:	Date of Birth: / /

Facility Information

Name:			
Address:			
Telephone:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Admitting/Performing Physician Information

Name:		Telephone:	
Address:		Fax number:	
TPI:	NPI:	Taxonomy:	Benefit Code:

Form completed by:	Date form completed: / /

Section 1

Service Type	☐ Outpatient Service(s)	☐ Emergent/Urgent Admit	☐ Scheduled Admission/ Procedure	☐ Admit Following Observation

Date of service: / /	Procedure code(s):

Primary diagnosis code:

Secondary diagnosis codes:

*DRG code:	Reference number:	Discharge date: / /

Clinical documentation supporting medical necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:

Section 2 (Update information when necessary)

Primary diagnosis code:

Secondary diagnosis codes:

Date of service: / /	Procedure code(s):	*DRG code:

Clinical documentation to support medical necessity of DRG or procedure code change:

***Only required for DRG admission**

Effective Date_07302007/Revised Date_07302007

Provider Information Change Form

Texas Medicaid fee-for-service, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider ☐	Date : / /
Nine-Digit Texas Provider Identifier (TPI):	Provider Name:
National Provider Identifier (NPI):	Primary Taxonomy Code:
Atypical Provider Identifier (API):	Benefit Code:

List any additional TPIs that use the same provider information:

TPI:	TPI:	TPI:
TPI:	TPI:	TPI:
TPI:	TPI:	TPI:

Physical Address—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Medicaid fee-for-service who change their ZIP Code must submit a copy of the Medicare letter along with this form.

Street address	City	County	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:		

Accounting/Mailing Address—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

Street Address	City	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:	

Secondary Address

Street Address	City	State	Zip Code
Telephone: ( )	Fax Number: ( )	Email:	

Type of Change (check the appropriate box)

☐	Change of physical address, telephone, and/or fax number
☐	Change of billing/mailing address, telephone, and/or fax number
☐	Change/add secondary address, telephone, and/or fax number
☐	Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
☐	Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number:	Effective Date:
Exact name reported to the IRS for this Tax ID:	

Provider Demographic Information—Note: This information can be updated on www.tmhp.com.

Languages spoken other than English:			
Provider office hours by location:			
Accepting new clients by program (check one):	Accepting new clients ☐	Current clients only ☐	No ☐
Patient age range accepted by provider:	Additional services offered (check one):	HIV ☐	High Risk OB ☐
Participation in the Woman's Health Program? Yes ☐ No ☐	Patient gender limitations:	Female ☐	Male ☐ Both ☐

Signature and date are *required* or the form will *not* be processed.

Provider signature:	Date: / /

Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP)
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Fax: 512-514-4214

Effective Date_12042007/Revised Date_11192008

Instructions for Completing the Provider Information Change Form

Signatures

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- For Texas Medicaid fee-for-service and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com. Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General

- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.
- Mail or fax the completed form to:

  Texas Medicaid & Healthcare Partnership (TMHP)
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795
  Fax: 512-514-4214

Effective Date_12042007/Revised Date_11192008