Behavioral Health Evaluations and Therapies

Outpatient Codes and Considerations

Outpatient behavioral health services can help when our UnitedHealthcare Community Plan members in Texas experience distress, dysfunction and/or maladaptive functioning as a result of a psychiatric condition as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Behavioral health therapy is a benefit for members in the Children's Health Insurance Program (CHIP), STAR, STAR Kids and STAR+PLUS.

The following procedure codes may be reimbursed for these outpatient services. For corresponding diagnosis codes for psychotherapy interventions, visit tmhp.com > Providers > Medicaid Provider Manual > Outpatient Mental Health Services.

<table>
<tr><th colspan="2" rowspan="2">Therapy or Service Type</th><th rowspan="2">Time (minutes)</th><th colspan="2">Codes</th></tr>
<tr><th>Physician[1]</th><th>Non-physician</th></tr>
<tr><td rowspan="2">Psychiatric Diagnostic Evaluation</td><td>Without medical services</td><td rowspan="2">60</td><td colspan="2">90791[2]</td></tr>
<tr><td>With medical services</td><td>90792[2]</td><td>NA</td></tr>
<tr><td colspan="2" rowspan="6">Individual Therapy</td><td>30</td><td colspan="2">90832[3]</td></tr>
<tr><td>30</td><td colspan="2">90833[3,4]</td></tr>
<tr><td>45</td><td colspan="2">90834[3]</td></tr>
<tr><td>45</td><td>90836[3,4]</td><td>NA</td></tr>
<tr><td>60</td><td colspan="2">90837[3]</td></tr>
<tr><td>60</td><td>90838[3,4]</td><td>90838[3]</td></tr>
<tr><td rowspan="2">Family (Conjoint) Therapy</td><td>Without patient present</td><td rowspan="2">50</td><td colspan="2">90846[3] (ages 0 -20)</td></tr>
<tr><td>With patient present</td><td colspan="2">90847[3] (any age)</td></tr>
<tr><td colspan="2">Group (other than multi-family group)</td><td>60</td><td colspan="2">90853[3]</td></tr>
<tr><td colspan="2">Electroconvulsive Therapy</td><td></td><td colspan="2">90870</td></tr>
<tr><td colspan="2">Other Psychiatric Services</td><td></td><td colspan="2">90899</td></tr>
</table>

[1] Includes psychiatrists and physician-supervised providers including advanced practice registered nurse and physician assistants.
[2] Psychiatric diagnostic evaluations (procedure codes 90791 or 90792) are limited to once per member, per rolling year, same provider in the office, home, outpatient hospital or other settings, regardless of the number of professionals involved in the interview. Additional psychiatric diagnostic evaluations may be considered on a case-by-case basis through appeal.
[3] Services limited to four psychotherapy individual, family or group sessions per day and 30 per individual, group or family therapy per calendar year (CY) per member. Units over the 30 per CY will be reviewed through the alert process. Claims not supporting medical necessity for units over the limit will be denied.
[4] These add-on procedures for physician and physician-supervised providers need to be billed with the appropriate evaluation and management (E/M) codes.

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Diagnostic Evaluation
A psychiatric diagnostic evaluation without medical services may be reimbursed to a:

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

A psychiatric diagnostic evaluation with medical services may be reimbursed to a physician, APRN and PA.

Psychologists cannot bill for 90833, 90836 or 90838.

Electroconvulsive Therapy
Individual psychotherapy, psychological testing, neurobehavioral testing or neuropsychological testing billed in addition to electroconvulsive therapy (ECT) on the same day, by any provider will be denied as part of another procedure on the same day. ECTbilled in addition to group psychotherapy or family psychotherapy on the same day, by the same provider, will be denied as part of another procedure.

Modifier Requirements
Use a modifier to identify a separate and distinct service when performing individual psychotherapy (90832, 90834, 90837) and family psychotherapy (90846, 90847) on the same day for the same client. When billing for these services, submit the family psychotherapy procedure code with the modifier on the claim to indicate that the procedure or service was distinct or independent from other services performed on the same day for the same member.

Federally Qualified Health Centers (FQHC) must submit claims using one of the following appropriate modifiers. LMFTs must include a U8 modifier on the claim to differentiate them from a licensed professional counselor.

Modifier	Description
AH	Clinical Psychologist
AJ	Social worker
AM	Physicians and physician-supervised prescribers. Includes advanced practice registered nurse and physician assistants.
U1	LPC
U2	LMFT

Daily Limits

Psychologists, APRNs, PAs, LCSWs, LMFTs and LPCs must be currently enrolled in Texas Medicaid and are limited to a maximum combined total of 12 hours per provider, per day for inpatient or outpatient behavioral health services.

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Psychological (96130, 96131, 96136, 96137) and neuropsychological testing (96132, 96133, 96136, 96137), neurobehavioral status exams（96116, 96121) and development testing (96110, 96113, 96113) are included in the total allowed 12 hours per provider, per day.

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

Doctors of medicine (MDs) and doctors of osteopathic medicine (DOs) aren't subject to the 12-hour limitation because they can delegate services, and may submit claims in excess of 12 hours per day.

Psychologists can delegate to multiple Licensed Psychological Associates (LPAs), Provisionally Licensed Psychologists (PLPs), interns or post-doctoral fellows. This means delegated services aren't subject to the 12-hour limitation because they may submit claims for delegated services in excess of 12 hours per day.

Court-ordered and Department of Family and Protective Services (DFPS) directed services aren't subject to the 12-hour per provider, per day system limitation when billed with modifier H9.

Delegated Services

Any outpatient mental health services provided by a psychologist, LPA, PLP, psychological intern or post-doctoral fellow need to be billed with a modifier under the supervising psychologist's Medicaid provider identifier or the Medicaid identifier of the legal entity employing the supervising psychologist. Claims submitted by a psychologist without a modifier or with two of these modifiers on the same detail will be denied.

Services performed by the LPA or PLP will be reduced by 70 percent of the psychologist reimbursement fee schedule rate. Services performed by the psychology intern or the post-doctoral fellow will be reduced to 50 percent of the psychologist reimbursement fee schedule rate.

To help prevent denials, please use the most appropriate single modifier along with procedure codes for licenses psychologists and their delegated services.

Modifier	Description
AH	Clinical Psychologist
UB	Intern or post-doctoral psychology Fellow
UC	Licenses Psychological Associates (LPAs)
U9	Provisionally Licensed Psychologists (PLPs)

Only LCSW, LMFT, LPC, APRN or PA actually performing the service may bill Texas Medicaid and must not bill for services performed by people under their supervision. These provider types can't delegate to another provider under their licensee like physicians and psychologists.

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Diagnosis Requirements

Procedure codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847 and 90853 can only be billed with one of the state required diagnoses. Claims billed without one of the required diagnosis codes will be denied. For required diagnosis codes, go to tmhp.com > Providers > Medicaid Provider Manual > Outpatient Mental Health Services > 4.2 Services, Benefits, Limitations.

Retrospective Review

We're reviewing our claims payments for these services for the past year. Errors may have occurred related to missing or inappropriate corresponding codes or therapy duration in excess of allowable time without a prior authorization for continued treatment. We'll reach out directly if it's determined we've made payments in error.

We're Here to Help

If you have questions, please contact your Provider or Physician Advocate or call Customer Service at **888-887-9003**, 8 a.m. – 6 p.m., Central Time, Monday – Friday. Thank you.

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