Licensed Clinical Social Worker (LCSW)

28.1 Enrollment ................................................................. 28-2
28.2 Reimbursement ............................................................... 28-2
28.3 Benefits and Limitations .................................................. 28-2
28.4 Documentation Requirements ......................................... 28-4
28.5 Claims Information ....................................................... 28-4
   28.5.1 Claim Filing Resources .............................................. 28-4
28.1 Enrollment

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid.

LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted. Important: All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Medicaid, providers can also be subject to Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: “Provider Enrollment” on page 1-3 for more information about enrollment procedures. “Managed Care” on page 7-1.

28.2 Reimbursement

According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the applicable fee schedule on the TMHP website at www.tmhp.com.

Under 1 TAC §355.8261, a Federally Qualified Health Center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Refer to: “Reimbursement Methodology” on page 2-2 for more information about reimbursement.

28.3 Benefits and Limitations

LCSW counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder, when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (SNF) (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9). When billing for contracted LCSW counseling services provided to Medicaid clients who are 20 years of age or younger and reside in a residential treatment facility, providers should use POS 9 (other location).

LCSWs must not bill for services provided by people under their supervision, including services provided by students, interns, or licensed professionals under their supervision. Only the licensed LCSW and Medicaid-enrolled practitioner providing the service may bill Medicaid. LCSWs who are employed by or remunerated by another provider may not bill Medicaid directly for counseling services if that billing would result in duplicate payment for the same services.

Procedure codes 90806, 90847, and 90853 are allowable for services provided by an LCSW on an hourly basis. When billing or providing family counseling services (procedure code 90847), note the following requirements for Medicaid reimbursement:

• The client must be present when family counseling services are provided.
• Family counseling is only reimbursable for one family member per session.

According to the definition of “family” provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families (TANF). 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

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

• 30 minutes are billed as 0.5 hour.
• 60 minutes are billed as 1 hour.
• 90 minutes are billed as 1.5 hours.
• 120 minutes are billed as 2 hours.

The time indicated on the claim form must be the time actually spent with the client. Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

Refer to: “Benefits and Limitations” on page 38-2 for details about the 12-hours-per-day behavioral health services limitation.

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior
authorized. This limitation includes encounters/visits by
all practitioners. School Health and Related Services
(SHARS) behavioral rehabilitation services, mental
health/mental retardation (MMMR) services, laboratory,
radiology, and medication monitoring services are not
counted toward the 30-encounter/visit limitation. An
encounter/visit is defined as each hour of therapy,
psychological, and/or neuropsychological testing
rendered per hour, per provider. Clients should receive no
more than four hours of therapy per day. Each Medicaid
client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for 6
months of weekly therapy or 12 months of biweekly
therapy, is adequate for 75 to 80 percent of clients. Clinici-
ans should plan therapy with this limit in mind. However,
may be medically necessary for some clients to receive
extended encounters/visits. In these situations, prior
authorization is required. A provider who sees a client
regularly and anticipates that the client will require
encounters/visits beyond the 30-encounter/visit limit must
submit the request for prior authorization before the
client’s 25th encounter/visit.

It is recognized that a client may change providers in the
middle of the year, and the new provider may not be able
to obtain complete information on the client. In these
instances, prior authorization may be made before
rendering services when the request is accompanied by
an explanation as to why the provider was not able to
submit the prior authorization request by the client’s 25th
encounter/visit.

All authorization requests for an extension of outpatient
psychotherapy sessions beyond the annual
30-encounter/visit limitation are limited to ten
encounters/visits per request and must be submitted on
the Extended Outpatient/Counseling Request Form.
Requests must include the following:
• Client name and Medicaid number
• Provider name and provider identifier
• Clinical update, including specific symptoms, response
to past treatment, and 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 and type of services requested, and the dates
based on the frequency of encounters/visits that the
services will be provided

All areas of request must be completed with the infor-
mation required by the form. If additional room is needed,
providers may state “see attached,” but the attachment
must contain the specific information required in that
section of the form.

Refer to: “Request for Extended Outpatient Psycho-
therapy/Counseling Form” on page B-89.

Prior authorization is not granted to providers who have
been seeing a client for an extended period of time or from
the start of the calendar year and who have not requested
prior authorization before the 25th encounter/visit. It is
recommended that a request for extension of outpatient
behavioral health services 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 is dependent
on 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 request for additional
encounters/visits must include new documentation that
addresses the client’s current condition, treatment plan,
and the therapist’s rationale supporting the medical
necessity for these additional encounters/visits. Prior
authorization for an extension of outpatient behavioral
health services is granted when the treatment is
mandated by the courts as a court-ordered service. A copy
of the court order for outpatient treatment signed by the
judge must accompany prior authorization requests.

Mail or fax the request to:
Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 512-514-4213

Providers can submit requests for extended outpatient
psychotherapy/counseling through the TMHP website.

Refer to: “Prior Authorization Requests Through the TMHP
Website” on page 5-5 for additional information,
including mandatory documentation and
retention requirements.

The following services are not covered by Medicaid
(except where specifically indicated in other sections):
• Music or dance therapy
• Services provided by a licensed chemical dependency
counselor (LCDC), psychiatric nurse, mental health
worker, or a psychologist assistant
• Thermogenic therapy, recreational therapy, psychiatric
daycare, and biofeedback
• Hypnosis
• Adult activity and individual activity (these types of
services would be payable only if guidelines of group
therapy are met and are termed group therapy)

Refer to: “Managed Care” on page 7-1 for more infor-
mation, or contact the client’s behavioral health
organization (BHO). Do not bill TMHP for services
rendered to NorthSTAR clients.
28.4 Documentation Requirements

Services that are not supported by required documentation in the client's record are subject to recoupment. Clients for whom services are billed must have the following documentation included in their records and the documentation must comply with these standards:

- All entries must be clearly documented and legible to individuals other than the author.
- All entries must be dated (month/day/year) and signed by the performing provider.

Documentation:
- Notations of the beginning and ending session times
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Diagnosis
  - Behavioral observations during the session
  - Narrative description of the counseling session
  - Narrative description of the assessment, treatment plan, and recommendations

28.5 Claims Information

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid's responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. Medicaid is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: “Part B” on page 2-6.

“Medicare Part B Crossovers” on page 4-14.

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

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

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.

“Claims Filing” on page 5-1 for general information about claims filing.

“CMS-1500 Claim Filing Instructions” on page 5-26. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>xiii</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>3-1</td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions</td>
<td>5-26</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>5-15</td>
</tr>
<tr>
<td>Communication Guide</td>
<td>A-1</td>
</tr>
<tr>
<td>Request for Extended Outpatient Psychotherapy/ Counseling Form</td>
<td>B-89</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker (LCSW) Claim Example</td>
<td>D-20</td>
</tr>
<tr>
<td>Acronym Dictionary</td>
<td>F-1</td>
</tr>
</tbody>
</table>