Mental Health Rehabilitative and Mental Health Targeted Case Management Services

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Agenda

- Overview
- Provider Qualifications and Training
- Prior Authorizations
- Mental Health Rehabilitative (MHR)/Mental Health Targeted Case Management (MHTCM) Services and Billing Guidelines
- Superior HealthPlan Departments
- Questions and Answers

Overview

Mental Health Rehabilitative and Mental Health Targeted Case Management

To provide MHR/TCM services for Superior HealthPlan members, Organizations must:

- The organization must meet all applicable state and regulatory requirements prior to rendering MHR/TCM services.
- Be appropriately enrolled with Texas Medicaid.
- Have a behavioral health contract with Superior.
- Be attested by Superior.

MHR/TCM services are included in the Texas Medicaid benefit package for STAR, STAR Health, STAR Kids and STAR+PLUS. Please note that MHR/TCM is a Medicaid (ONLY) benefit.

How do I become Contracted with Superior?

- Prospective Provider Organizations can submit a network participation request on Superior's Request Network Participation, Non-Contracted Providers Only online form.
- Network participation decisions will be based on current need for additional providers in the area of the organization.
- Once a determination regarding network adequacy is made, you may submit attestation documents.
  - Be clear with Contract Management on the services you plan to provide (only MHR TCM Services or other services such a Counseling & Therapy).
  - Ensure all licensed and non-licensed practitioners who will provide MHR/MHTCM services are included in your attestation documents.

Where are the Attestation Forms Located?

- This attestation from can be found under the Credentialling section of Superior's Forms webpage:
  - Mental Health Rehabilitation and Targeted Case Management Annual Attestation Packet (MHR/TCM) (PDF)
    - Newly contracted providers may submit the Mental Health Rehabilitation and Targeted Case Management Annual Attestation Packet during the contracting process.
    - Existing providers who would like to begin offering MHR/TCM services will need to submit a request during the annual Attestation period starting which begins May 1st through July1st of each year for the following SFY.

How do I Enroll with Texas Medicaid?

- Texas Medicaid & Healthcare Partnership (TMHP) enrollment process found on the TMHP Provider Enrollment webpage.
- For Medicaid enrollment, providers will need to work directly with TMHP Provider Enrollment:
  - For more information, please call the TMHP Contact Center at: 1-800-925-9126 (Option 3)

Adequacy Specialty	PEMS ENROLLMENT CODES					
	ProvType_Code	Type_Description	ProvSpecialty_Code	Specialty_Description	Taxonomy	Taxonony Description
MENTAL HEALTH TARGETED CASE MANAGEMENT (MHTCM) AND MENTAL HEALTH REHABILITATIVE (MHR) SERVICES	12	LOCAL MENTAL HEALTH/BEHAVIORAL HEALTH AUTHORITIES (LMHAS/LBHAS)	47	(FFS AND MCO)	251B0000X	Agencies Case Management
MENTAL HEALTH TARGETED CASE MANAGEMENT (MHTCM) AND MENTAL HEALTH REHABILITATIVE (MHR) SERVICES	12	NON-LMHAS/LBHAS (PRIVATE PROVIDERS)	PR	MCOS ONLY	251B0000X	Agencies Case Management

Please Note: Non-Local Mental Health Authority (non-LMHA) providers of Mental Health Targeted Case Management and Mental Health Rehabilitative (MHTCM/MH Rehab) services must enroll under the correct provider type.

What do Mental Health Rehabilitative (MHR) Services include?

- Services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.
- MHR services include:
  - Crisis Intervention Services (H2011)
  - Medication Training and Support Services (H0034)
  - Psychosocial Rehabilitative Services (H2017)
  - Skills Training and Development Services (H2014)
  - Day Program for Acute Needs (H2012)

Please Note: The information above and on the following slides comes from the Texas Medicaid Provider Procedures Manual (TMPPM), which is updated monthly. For the latest information, please review the Texas Medicaid Provider Procedure Manual.

What is Mental Health Targeted Case Management (TCM)?

- TCM acts as a navigator, linking people to support, while MHR provides direct, skills-based training to build independence.
- Mental Targeted Case Management (T1017):
  - Assist persons in gaining access to needed medical, social/behavioral, educational and other services and supports.
  - Include monitoring of service effectiveness as frequently as necessary (at least annually).

Please note: The information above and on the following slides comes from the Texas Medicaid Provider Procedures Manual (TMPPM), which is updated monthly. For the latest information, please review the Texas Medicaid Provider Procedure Manual.

How are Members Assessed for MHR/TCM Services?

- Individuals with a Severe and Persistent Mental Illness (SPMI) or a Severe and Emotional Disturbance (SED) are assessed to determine the need for MHR/MHTCM services using:
  - Adults Needs and Strengths Assessment (ANSA 2.1)
  - Child and Adolescent Needs and Strengths Assessment (CANS 1.0)
    - Please Note: The CANS referenced throughout this training refers to the CANS 1.0, which is a separate assessment from the CANS 3.0 (formally CANS 2.0).
- Superior providers are required to utilize the Department of State Health Services (DSHS) Texas Resilience and Recovery (TRR) Utilization Management (UM) Guidelines.
  - To review these guidelines, please review HHSC's Texas Resilience and Recovery Utilization Management Guidelines and Manual.

Organizational Qualifications & Practitioner Training

Attestation Submission

Annual Attestation Process

- Organizations who wish to provide MHR/TCM to Superior members for the following SFY must submit an attestation packet with required documentation during Superior's open attestation period.
- Attestation packets must be submitted annually for review between **May 1 and July 1** of the calendar year and Superior will complete their review by August 15 of each year.
- This packet must be completed fully and emailed to MHRTCMAttestations@superiorhealthplan.com by July 1st annually.
- Providers who do not submit timely or submit an incomplete form will no longer be able to deliver MHR/TCM services after August 31st to Superior members.

Organization Requirements

- Ability to assess for individual member need and level of care utilizing the ANSA 2.1 and CANS 1.0 tools and provide MHR/TCM services per the DSHS Texas Resiliency and Recovery (TRR) Utilization Management Guidelines.
- Ability to provide Covered Persons with the full array of TRR services either directly or by sub-contract.
- Additionally, the organization must have:
  - More than one provider in order to support adequate delivery of services.
  - Employ a credentialed and contracted Licensed Practitioner of the Healing Arts (LPHA) who is fully trained per HHSC UMCM 15.3 and agrees to provide appropriate supervision to un-licensed MHR/TCM providers.
- An LPHA must be one of the following professionals:
  - Physician
  - Licensed Professional Counselor (LPC)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Psychologist
  - Advanced Practice Nurse (APN)
  - Licensed marriage and family therapist (LMFT)
- Have and utilize a Clinical Management for Behavioral Health Services (CMBHS) account.
  - More information may be found on HHSC's Clinical Management for Behavioral Health Services.

Organizational vs. Practitioner Requirements

To be successfully attested as an MHR/TCM provider with Superior, the following requirements must be met:

At the organization level:

- Have more than one provider.
- Have a credentialed and contracted LPHA on staff.
- Provide a screenshot of the CMBHS landing page of the organization.
- Offer the full array of services per population served.
- For organizations that serve children, have at least one staff member that has completed, or is in process of completing the full Wraparound Planning training series.

The Organization is the attesting entity

At the Practitioner level

- Provide a fully completed Training Worksheet for each staff member attesting to training dates of all required training outlined in the UMCM 15.3.
- If treating children, provide:
  - Current CANS 1.0 3-6 and CANS 6-17 certifications
  - Nurturing Parent Facilitator Training certification
  - Wraparound Planning certifications as applicable
- If treating adults provide:
  - Current ANSA 2.1 certification

Supporting documentation is sent on the practitioner's qualifications (licensed and unlicensed staff)

Accessing CANS and ANSA

- Child and Adolescent Needs & Strength (CANS) and Adult Needs & Strengths Assessment (ANSA) training may be found at Transformational Collaborative Outcomes Management (TCOM) Training webpage.
  - Once you have registered or reactivated your account in TCOM Training, you will need to select the course that is appropriate for you. There is an option to purchase courses in **bundles**, which will appear based on the **agency type** you selected during registration.
  - **Important:** When purchasing course bundles, you have the option to select a bundle that includes **CANS 3–6 1.0, CANS 6–17 1.0, ANSA 2.1 assessments. Please note:** Version **3.0** (formerly **CANS 2.0**) is **not accepted** for this purpose.

Wraparound

Providers will need to complete the prerequisites before being able to access the training.

The prerequisites include:

1. NWIC: Wraparound Overview
2. NWIC: Team Roles in Wraparound
3. System of Care Module

The wraparound series consists of:

1. Introduction to Wraparound*
2. Engagement in the Wraparound Process*
3. Intermediate Wraparound*
4. Advanced Wraparound*

*The up-to-date information on the titles of all trainings in the Wraparound Series and instructions for accessing the training are located in **Chapter 15.3** of the Texas Medicaid and CHIP - Uniform Managed Care Manual.*

*Superior will collect copies of these as part of the attestation process.

Wraparound

- **Only providers who have completed Wraparound training** are permitted to deliver **Intensive Case Management** services
- Attested organizations may begin providing services **before completing Wrap training** only if they can show proof that they are registered for the next available training session and have completed all required prerequisites.
- **At least one staff member** within the organization must be fully Wrap trained or actively in the process of completing the Wrap training series.

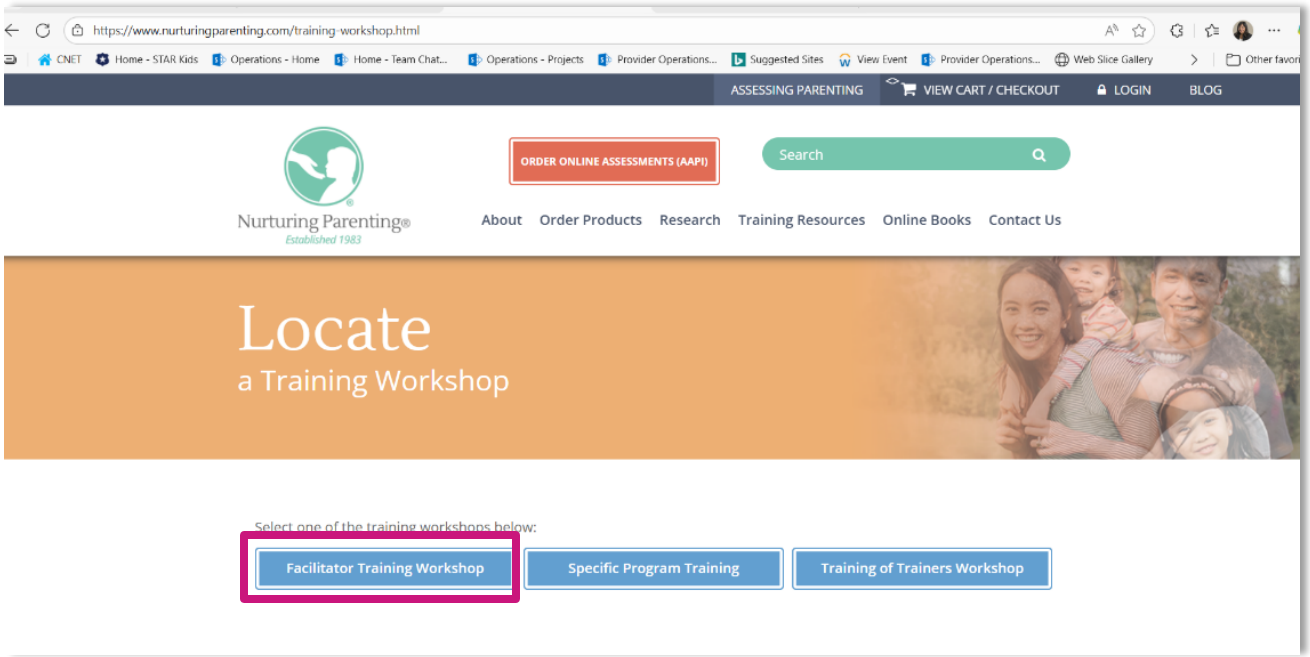
Nurturing Parenting Program – Tertiary Treatment Protocols Training

- All staff delivering services to children must have attended an in-person training (Virtual training is acceptable).
- These trainings do not require renewals
- The UMCM Chapter 15.3 offers two (2) training resources:
  - Centralized Training In-person & Virtual Workshops
  - Nurturing Parenting National Website
- Superior will collect copies of your official Nurturing Program Training certificates as part of the attestation process

Please Note: Attending a Facilitator Training workshop does not qualify you to be an organizational trainer, it qualifies you to Facilitate the Nurturing Programs.

Nurturing Parenting Facilitator Workshop

- Nurturing Parenting offers a 3-day workshop on Nurturing Parenting® Program Facilitator Trainings.
  - To access this training go to *Training Resources* then to *Locate a Training Workshop* then select **Facilitator Training Workshop.**



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Nurturing Parenting - Organizational Trainer

To become an Organizational Trainer, you can complete the Training of Trainers Workshop offered on the Nurturing Parenting national website

Training Resources- > Locate a training workshop -> Training of Trainers Workshop

Prerequisites to attending the Training of Trainers includes:

1. Successful completion of a 3-day Nurturing Parenting® Program Facilitator Training conducted by a Recognized Trainer/Consultant followed by: A **minimum** of 2 years' experience facilitating at least one Nurturing Parenting® Program being implemented within the agency of employment as written for the complete number of sessions (Full fidelity) ;
2. Expertise in the philosophy and goals of Nurturing Parenting® as demonstrated by successful group or home-based implementation of the programs;
3. Expertise in the Adult-Adolescent Parenting Inventory (AAPI-2.5), the Nurturing Skills Competency Scale (NSCS) and other assessments and inventories of the Nurturing Parenting Programs;
4. A letter of recommendation from your direct supervisor attesting to your success as a Nurturing Parenting® Program facilitator within your designated agency.
5. Phone Interview.

***Criteria for Attendance at this Workshop is managed by Nurturing Parenting. The most up to date information is found on their website.**

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Prior Authorizations Requirements

Prior Authorizations

- Prior Authorization is required for select TCM and MHR Services.
  - Please note: Local Mental Health Authorities (LMHA) and approved Centers for Excellence are not required to submit PA requests for MHR TCM services.
- Services are subject to retrospective review and recoupment if documentation does not support the service billed.
- The participating provider must obtain prior authorization prior to the services being rendered, failure to do so may result in a contractual denial.
- Retrospective authorizations are not approved without documentation explaining why the request was not submitted prior to rendering the service.

Prior Authorizations

- **Applicable Plans**: Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS)

- PA is not needed for:
  - Crisis Intervention (H2011)
  - Day Program (H2012)
  - Outpatient Therapy including individual, family and group therapy
  - Medication Management Appointments

- Be sure to include the applicable modifier on the auth request

Procedure Code	Modifier	Description
H0034	HA- Individual services for a child/Youth HQ- Group	Medication Training and Support
H2014	HA- Individual services for a child/Youth HQ- Group	Skills Training and Development
H2017	Use HQ for Group	Psychosocial Rehabilitation
T1017	TF- Routine TG- Intensive	Routine Case Management

Prior Authorizations

- **Applicable Plans**: CHIP
- PA is not needed for:
  - Outpatient Therapy including individual, family and group therapy
  - Medication Management Appointments
- Be sure to include the applicable modifier on the auth request

Procedure Code	Modifier	Description
H2014	HA- Individual services for a child/Youth HQ- Group	Skills Training and Development

Clinical Documentation Requirements

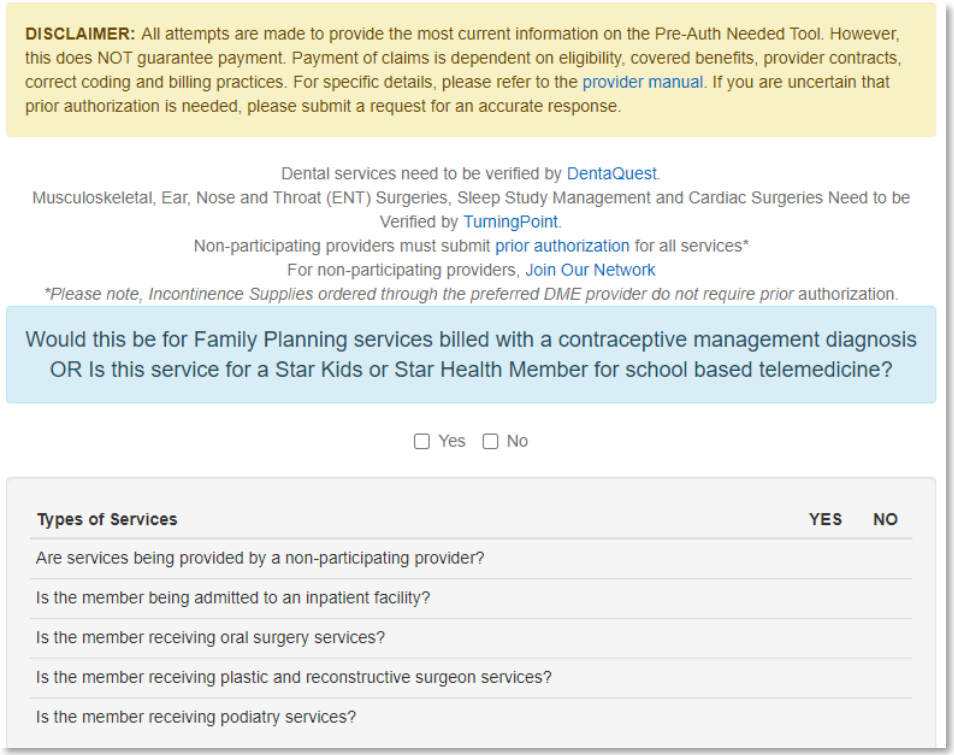
- All MHR/TCM services require authorization.

- All requests require clinical documentation, including:
  - Prior Authorization Request Form
  - Clinical Diagnosis given within the past 12 months
  - Clinical Management for Behavioral Health Services (CMBHS) Report
  - A Recovery Plan

- Continuation of Services Requests are required based on the member's age and Level of Care (LOC):
  - Every 90 days for ages 4-17
  - Every 180 days for ages 18 and up
  - At any point a change in LOC is needed or clinically indicated

Medicaid/CHIP Pre-Authorization Tool

- Providers can determine if a prior authorization is required by using the Pre-Auth Needed Tool, answering a series of questions and searching by procedure codes.
- These tools can be found by product on Superior's Authorization Requirements webpage.



DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Dental services need to be verified by DentaQuest.
Musculoskeletal, Ear, Nose and Throat (ENT) Surgeries, Sleep Study Management and Cardiac Surgeries Need to be Verified by TurningPoint.
Non-participating providers must submit prior authorization for all services*
For non-participating providers, Join Our Network
*Please note, Incontinence Supplies ordered through the preferred DME provider do not require prior authorization.

Would this be for Family Planning services billed with a contraceptive management diagnosis OR Is this service for a Star Kids or Star Health Member for school based telemedicine?

☐ Yes ☐ No

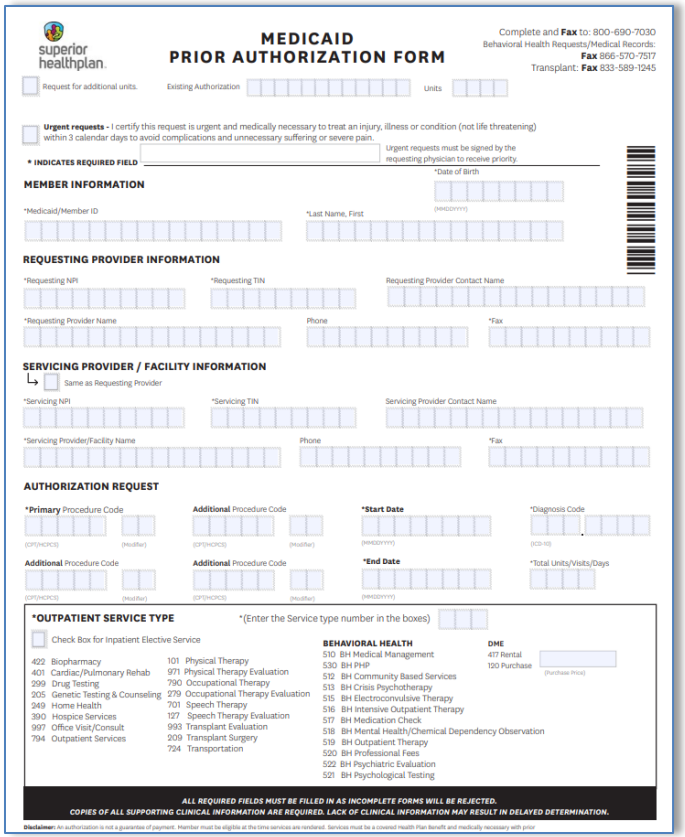
Types of Services	YES	NO
Are services being provided by a non-participating provider?		
Is the member being admitted to an inpatient facility?		
Is the member receiving oral surgery services?		
Is the member receiving plastic and reconstructive surgeon services?		
Is the member receiving podiatry services?		

Prior Authorization Form

- Prior authorizations can be submitted through Superior's Secure Provider Portal.
- Medicaid Authorization Forms and the Texas Standard Prior Authorization Request Form are located on Superior's Forms webpage.

Reminders:

- Modifier is required after the procedure code if it applies to the service
- Number of units per code is required
- Under OP Service Type select 512- BH Community Based Services for MHR TCM auth requests
- Fax number for BH Services is 1-866-570-7517



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MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records: **Fax** 866-570-7517
Transplant: **Fax** 833-589-1245

Request for additional units. Existing Authorization Units

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

Urgent requests must be signed by the requesting physician to receive priority.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Medicaid/Member ID | *Last Name, First | *Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI | *Requesting TIN | Requesting Provider Contact Name
*Requesting Provider Name | Phone | *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI | *Servicing TIN | Servicing Provider Contact Name
*Servicing Provider/Facility Name | Phone | *Fax

AUTHORIZATION REQUEST

*Primary Procedure Code (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | *Start Date (MMDDYYYY) | *Diagnosis Code (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | *End Date (MMDDYYYY) | *Total Units/Visits/Days

***OUTPATIENT SERVICE TYPE** *(Enter the Service type number in the boxes)

Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
299 Drug Testing
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services
101 Physical Therapy
971 Physical Therapy Evaluation
790 Occupational Therapy
279 Occupational Therapy Evaluation
701 Speech Therapy
127 Speech Therapy Evaluation
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
517 BH Medication Check
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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Prior Authorization (PA) Requests

Essential information for PA include:

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)
- Service requested - Healthcare Common Procedure Coding System (HCPCS), with applicable modifiers
- Service requested start and end date
- Quantity of service units for requested HCPC service

Medical Necessity Criteria

Superior's complete criteria can be found in policy **TX.CP.MP.544** Mental Health Rehabilitation and Targeted Case Management. To review this policy please visit Superior's Polices webpage.

Clinical information for Medical Necessity review includes:

- Completed PA request form
- Clinical diagnosis congruent with requested services
- Clinical Management for Behavioral Health Services (CMBHS) Report, including the complete Uniform Assessment (CANS and ANSA).

Medical Necessity Criteria

Clinical information required for Medical Necessity review includes:

- The member's recovery plan, developed prior to provision of services and within 10 Business Days after the member is eligible for services. It should contain input from the member and contain signatures and staff credentials as a QMHP-CS, at a minimum

- Deviations must contain rationale and will be reviewed utilizing the Texas Resilience and Recovery Utilization Management Guidelines.

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

Incomplete Prior Authorization Requests

- *Incomplete Medicaid prior authorization request* is a request in which clinical information/documentation is incomplete or insufficient.
- Medical Management will communicate the request to supply the missing but required clinical information to proceed with the medical necessity review through faxed request to the provider's office.
- The written notice containing the details of the incomplete/insufficient clinical documentation is delivered to the provider via fax, within three (3) Business Days after receipt of a prior authorization request containing all essential information.
- The member/patient receives a written notice of the request for submission of the incomplete clinical information.

Incomplete Prior Authorization Requests

- Providers must supply the requested clinical information/documentation within three (3) Business Days after the request.
- If the clinical information/documentation is not received within the required timeframe, the case will be reviewed with the incomplete or insufficient information received with the PA request.
- The requested clinical should be faxed to Medical Management, Behavioral Health Services at: 1-866-570-7517

Prior Authorization Denials

Type of Denial

- Adverse Determination (Medical Necessity) Denial - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
  - Medical necessity is defined as health services that are reasonably necessary to:
    - Prevent illness or medical conditions.
    - Provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, or limitations in function.
- Contractual (Administrative) Denials (non-clinical reasons)
  - Failure to obtain prior authorization.
- Non-Covered Benefit Denial
  - Requested service not a Medicaid or CHIP covered benefit.

Opportunity to Discuss Prior to Adverse Determination

- When medical necessity cannot be established, a peer-to-peer discussion is offered.
- A peer-to-peer discussion is available to the ordering physician, nurse practitioner, or physician assistant at any time, including during the prior authorization denial process.
- Pre-Denial Peer-to-Peer:
  - A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination.
- If you miss the Peer-to-Peer window, initiate an appeal by:
  - Phone: 1-877-398-9461
  - Fax: 1-866-918-2266

MHR/TCM Services and Billing Guidelines

Crisis Intervention

- Crisis intervention services are intensive community-based one-to-one services provided to persons who require services to control acute symptoms that place the person at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting.
- According to Texas Resilience and Recovery (TRR) Utilization Management (UM) Guidelines, the utilization of the crisis services array is based on what is medically necessary and available during the psychiatric crisis.
- Procedure code H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination according to medical necessity.

Service	Procedure Code	Modifier 1	Unit
Adult Services	H2011	N/A	15 minutes
Child and Adolescent Services	H2011	HA	15 minutes

Medication Training and Support

- Medication training and support services consist of education and guidance about medications and their possible side effects.
- Procedure code H0034 may be reimbursed for up to 8 units (2 hours) per treatment day in any combination according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Group services for adults	H0034	HQ	N/A	15 minutes
Group services for child/youth	H0034	HA	HQ	15 minutes

Medication Training and Support

- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group for each LOC is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1,2	0.5 hour each (ind and grp)	3.75 hours each (ind and grp)
3	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
4	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
YES Waiver	0.5 hour each (ind and grp)	4.5 hours each (ind and grp)
YC	0.5 hour each (ind and grp)	3 hours each (ind and grp)

TRR UM Adult Guidelines		
LOC	Standard	High Need
1S	1 hour (ind) 0.75 hour (grp)	1.75 hours (ind) 1.25 hours (grp)
2	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 2.15 hours (grp)
3	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 5 hours (grp)
4	1 hour (ind) 0.75 hour (grp)	2.5 hours (ind) 2.75 hours (grp)
TAY	1 hour (ind) 0.75 hour (grp)	1.5 hours (ind) 5 hours (grp)

Psychosocial Rehabilitative Services

- Psychosocial rehabilitative services are social, behavioral and cognitive interventions that build on strengths and focus on restoring the person's ability to develop and maintain social relationships, occupational or educational achievement and other independent living skills.

- Procedure code H2017 may be reimbursed for up to 16 units (4 hours) per treatment day, in any combination, for clients 18 years and older according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Individual services provided by RN	H2017	TD	N/A	15 minutes
Group services	H2017	HQ	N/A	15 minutes
Group services provided by RN	H2017	HQ	TD	15 minutes
Individual crisis services	H2017	ET	N/A	15 minutes

Psychosocial Rehabilitative Services

- This service is available to adults in LOC 3 and 4.
- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Adult Guidelines		
LOC	Standard	High Need
3	3.5 hours (ind) 2.25 hours (grp)	7 hours (ind) 8.6 hours (grp)
4	5.75 hours (ind) 2.5 hours (grp)	14.25 hours (ind) 8.6 hours (grp)

Skills Training and Development

- Skills training focuses on the improvement of communication skills, appropriate interpersonal behaviors and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers.
- Please note that skilled training is the ONLY applicable benefit for CHIP.
- Procedure code H2014 may be reimbursed for up to 16 units (4 hours) per treatment day, in any combination, according to medical necessity.

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Group services for adults	H2014	HQ	N/A	15 minutes
Individual services for child/youth	H2014	HA	N/A	15 minutes
Group services for child/youth	H2014	HA	HQ	15 minutes

Skills Training and Development

- This service is available to children in LOC 2, 3, 4, Youth Empowerment Services (YES) Waiver and Young Child (YC) and adults in LOC 1S, 2, and Transition Age Youth (TAY).
- According to TRR UM Guidelines, the average monthly utilization for this service for individual and group is the following:

TRR UM Child and Adolescent Guidelines

LOC	Standard	High Need
2, 3, 4	3 hours each (ind and grp)	6 hours each (ind and grp)
YES Waiver	3 hours each (ind and grp)	6 hours each (ind and grp)
YC	3 hours each (ind and grp)	6 hours each (ind and grp)

TRR UM Adult Guidelines

LOC	Standard	High Need
1S	2 hours (ind) 0.75 hrs (grp)	3.5 hours (ind) 5 hours (grp)
2	1 hour (ind) 1 hour (grp)	2 hours (ind) 4.25 hours (grp)
TAY	3 hours each (ind and grp)	6 hours each (ind and grp)

Day Program for Acute Needs

- Day programs for acute needs provide short term, intensive treatment to an eligible person who is 18 years of age or older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
- It is available to adults in LOC 3 and 4.
- Procedure code H2012 may be reimbursed for up to 6 units (4.5 to 6 hours) per treatment day, in any combination, for clients 18 and older.

Service	Procedure Code	Unit
Adult day program for acute needs	H2012	45-60 minutes

Mental Health Rehabilitation (MHR) Modifiers

Modifier	Description
95	Delivered by synchronous audiovisual technology
ET	Individual crisis services
FQ	Delivered by synchronous telephone (audio only) technology
HA	Individual services for child/youth
HQ	Group services
HZ	Funded by criminal justice agency
TD	Services rendered by Registered Nurse (RN)

Targeted Case Management (TCM)

- Targeted Case Management (T1017):
  - Assist persons in gaining access to needed medical, social/behavioral, educational and other services and supports.
  - Include monitoring of service effectiveness as frequently as necessary (at least annually).
  - The following activities are included in the Targeted Case Management (TCM) rate and will not be reimbursed separately:
    - Documenting the provision of TCM services.
    - Ongoing administration of the Uniform Assessment to determine amount, duration and type of TCM.
    - Travel time required to provide TCM services at a location not owned, operated or under arrangement with the provider.
  - TCM is not payable when delivered on the same day as psychosocial rehabilitative services.
  - TCM is not payable when the member in admitted to an inpatient hospital.
  - Routine case management and intensive case management cannot be provided concurrently.

Targeted Case Management (TCM)

- Routine case management services are primarily office-based activities that assist a person, caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the person's needs.
  - Routine Case Management is available to adults in LOC 1M, 1S and 2, and also to children.
- Intensive case management incorporates a wraparound approach to care planning and treatment plan implementation. The wraparound process is a strengths-based course of action involving a child or youth (20 years of age and younger) and their family
  - Intensive case management is available to children in Level of Care (LOC) 4, YES Waiver, and YC.
  - It is not available to adults.
- Procedure code T1017 may be reimbursed up to 32 units (8 hours) per day.
  - Intensive case management is available to children in Level of Care (LOC) 4, YES Waiver, and YC.
  - It is not available to adults.

Routine Case Management

- According to TRR UM Guidelines, the average monthly utilization for routine case management is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
1	0.5 hour	1 hour
2, YC	1 hour	2 hours
3	1 hour	6 hours
4	2 hours	6 hours
YES Waiver	4 hours	8 hours

TRR UM Adult Guidelines		
LOC	Standard	High Need
1M	0.5 hour	2.15 hours
1S	0.75 hour	1.25 hours
2	0.25 hour	1 hour

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Routine Mental Health Target Case Management (Adult)	T1017	TF	N/A	15 minutes
Routine Case Management (Child and Adolescent)	T1017	HA	TF	15 minutes

Intensive Case Management

- According to TRR UM Guidelines, the average monthly utilization for intensive case management is the following:

TRR UM Child and Adolescent Guidelines		
LOC	Standard	High Need
4	4 hours	8 hours
YES Waiver	4 hours	8 hours
YC	3.75 hours	6.25 hours

Service	Procedure Code	Modifier 1	Modifier 2	Unit
Intensive Case Management (Child and Adolescent)	T1017	HA	TG	15 minutes

Mental Health Targeted Case Management (MHTCM) Modifiers

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

Mental Health Rehabilitation (MHR)

- Billing for the following services is included in the Medicaid MHR services reimbursement rate(s) and may not be directly billed by the Medicaid provider:
  - Developing and revising the treatment plan.
  - Staffing and team meetings to discuss the provision of MHR services.
  - Monitoring and evaluating outcomes of interventions.
  - Documenting the provision of MHR services.
  - A staff member's travel time to and from a location to provide MHR services.
  - All services provided within a day program for acute needs.
  - Administering the uniform assessment to persons who are receiving MHR services.

Mental Health Rehabilitation (MHR)

- The following MHR services are not reimbursable MHR service:
  - Not included in the person's treatment plan (except for crisis intervention services).
  - Provided to a person receiving TCM services (at the same time).
  - That is not documented.
  - Provided to a person who does not meet the eligibility criteria.
  - Provided to a person who does not have a current uniform assessment (except for crisis intervention services).
  - Provided to a person who is not present, awake and participating during such service.
  - Provided to a person who is admitted to an inpatient hospital.

Mental Health Rehabilitation (MHR)

- A Medicaid provider may only bill for medically necessary MHTCM services that are provided face-to-face to:
  - A Medicaid-eligible person.
  - The Legally Authorized Representative (LAR) of a Medicaid-eligible person who is 21 years of age and older (on behalf of the person).
  - The LAR or primary caregiver of a Medicaid-eligible person who is 20 years of age and younger (on behalf of the person).
- MHR services delivered via group modality are limited to an 8-person maximum for adults and a 6-person maximum for children or adolescents (not including LARs or caregivers).

Mental Health Targeted Case Management (MHTCM)

- An MHTCM reimbursable session is the provision of a case management activity by an authorized case manager during a meeting with a person who is authorized to receive that specific type of case management.
- A billable unit of MHTCM is 15 continuous minutes of contact.
- MHTCM is not payable when delivered on the same day as psychosocial rehabilitative services. The following activities are included in the MHTCM rate and will not be reimbursed separately:
  - Documenting the provision of MHTCM services to include developing and revising the plan of care and interventions that are appropriate to a person's needs.
  - On-going administration of the uniform assessment to determine amount, duration, and type of MHTCM.
  - Travel time required to provide MHTCM services at a location not owned, operated, or under arrangement with the provider.
- MHTCM services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR.
- MHTCM services may be provided by synchronous telephone (audio-only) technology to persons with whom the billing provider has an existing clinical relationship and, if clinically appropriate and safe, as determined by the billing provider, and agreed to by the person receiving services or LAR.

Claims Filing

- Claims must be filed within 95 Calendar Days from the Date of Service (DOS).
- A provider may submit a corrected claim or claim appeal within 120 Calendar Days from the date of Explanation of Payment (EOP) or denial is issued.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be:
  - Completed in accordance with Texas Medicaid & Healthcare Partnership (TMHP) billing guidelines.
  - Filed on a red CMS 1500 or UB-04 form. These forms can be located on Superior's Provider Forms webpage.
  - Filed electronically through a clearinghouse.
  - Filed directly through the Superior's Secure Provider Portal.
- 24 (I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims.

Submitting Claims

- Electronic submission: Superior's Secure Provider Portal
- Electronic Claims:
  - To view a list of Superior's Trading Partners, visit Superior's Billing and Coding webpage.
  - Superior Emdeon ID: 68068
- Paper Claims - Initial

  Superior HealthPlan
  Behavioral Health Claims
  P.O. Box 6300
  Farmington, MO 63640-6806
- Paper Claims – Appeals and Corrected Claims

  Superior HealthPlan
  Behavioral Health Appeals
  P.O. Box 6000
  Farmington, MO 63640-3809

Corrected Claims vs. Appeals

- Corrected Claim
  - A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claims' submission required corrections.
- Claim Appeal
  - A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification with supporting documentation to Superior.

Claims Filing Deadlines

- First Time Claim Submission
- 95 days from the Date of Service
- Adjusted or Corrected Claims
  - 120 days from the date of EOP or denial is issued
- Claims Reconsiderations and Appeals
  - 120 days from the date of EOP or denial is issued

Billing Reminder

- Reimbursement of the following services is limited to certain diagnosis codes as outlined in the TMPPM Behavioral Health and Case Management Services Handbook. Those diagnosis should be placed in the **PRIMARY** (first) position. Failure to place the diagnosis code in the correct position may result in a denial of the claim.

Service Category	Procedure Codes
Medication Training and Support	H0034
Day Program for Acute Needs	H2012
Skills Training and Development	H2014
Psychosocial Rehabilitation Services	H2017
Mental Health Targeted Case Management (MHTCM)	T1017

Superior HealthPlan Departments

Behavioral Health Care Management

- Superior has experienced Registered Nurses (RNs), Licensed Professional Counselors (LPCs) and Licensed Clinical Social Workers (LCSWs) who can assist members in coordinating all aspects of their care.
- Care management services are available for any members.
- Levels of care management include:
  - **Care Coordination** – Lowest level; mostly short-term needs, social assistance, stable chronic conditions.
  - **Care Management** – Intermediate needs; may require additional time or resources to ensure member's needs are addressed.
  - **Complex Care Management** – Significant illness burden and complexity; members require longer term, ongoing assistance to address care gaps and service needs.

Service Coordination

- Superior's Service Coordination department can assist with:
  - Case management services and assistance with scheduling outpatient appointments.
  - Face-to-face visits with enrollees in inpatient settings.
  - Assisting inpatient facilities with discharge planning.
  - Assisting with 7-day follow-up.
  - Providing licensed clinicians that are available for enrollees with greater needs.
  - Assisting enrollees with obtaining resources in their area.

Utilization Management

- Superior's Utilization Management department is made up of licensed counselors who can assist with:
  - Monitoring the delivery of services through retrospective review.
  - Giving feedback on quality of care and compliance concerns.
  - Assisting with questions regarding the TRR UM Guidelines and the Texas Administrative Code (TAC) requirements of MHR and TCM.

Provider Services

- Superior's Provider Services department can assist with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims-related questions, please have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Contact Provider Services, Monday – Friday, 8:00 a.m. – 5:00 p.m. (8:00 a.m. – 6 p.m. for STAR Health) CST:
  - 1-877-391-5921

Provider Representative

- Superior's field staff can assist with:
  - Face-to-face orientations
  - Secure Provider Portal Training (PDF)
  - Office visits to review ongoing trends
- Superior Provider Representative offers targeted presentations depending on the type of services you provide.
  - To find their contact information, please visit Find My Provider Representative.

Questions and Answers