Clinical Policy: Mental Health Rehabilitation and Targeted Case Management (MHR/TCM) Services

Reference Number: TX.CP.MP.544
Last Review Date: 1/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

To provide guidelines for the authorization of Mental Health Rehabilitation and Targeted Case Management (MHR/TCM) services for Medicaid and Skills Training Services for CHIP members. This policy is applicable to Multi-Specialty Groups (non- LMHA) providers of MHR/TCM services.
This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

For a listing of procedure codes, please see the Coding Implications section below.

Policy/Criteria

I. It is the policy of Superior HealthPlan that Medicaid Mental Health Rehabilitation and Targeted Case Management (MHR/TCM) and CHIP Skills Training services are **medically necessary** when the following are met:

A. **Required Documentation**: MHR/TCM provider must submit the following information prior to providing services to a member.

1. Prior Authorization Request Form
2. Documentation of Licensed Practitioner of the Healing Arts (LPHA) clinical diagnosis that must fulfill all of the following:
   a. Rendered by an LPHA, acting within the scope of their license, who has interviewed the member; *and*
   b. Based on diagnostic criteria from the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; *and*
   c. Documented in writing, including the date, signature, and credentials of the person making the diagnosis; and *must* be updated at least annually; *and*
   d. Supported by and included in the uniform assessment.
3. Clinical Management for Behavioral Health Services (CMBHS) Report, including the complete Uniform Assessment (Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)).
   NOTE: CANS 3.0 will not meet this requirement
4. The assessment must be completed by a Qualified Mental Health Professional-Community Services (QMHP-CS) with appropriate supervision and training and have all the following documented:
   a. the members' identifying information;
   b. completion of the uniform assessment(s) and assessment guideline calculations;
   c. The member's present status and relevant history, including education,
   d. employment, housing, legal, military, developmental, and current available social and support systems;

e. The member's co-occurring substance use, intellectual or developmental
f. disability, or physical health condition, if any;
g. The members' relevant past and current medical and psychiatric information, which may include trauma history;
h. Information from the member and LAR, if applicable, regarding the member's strengths, needs, natural supports, community participation, responsiveness to previous treatment, as well as preferences for and objections to specific treatments;
i. The need or desire of the member for family member involvement or other identified natural supports in treatment and mental health community services, if the member is an adult without a LAR;
j. The identification of the LAR's or family members' need for education and support services related to the member's mental illness or emotional disturbance and the plan to facilitate the LAR's or family members' receipt of the needed education and support services;
k. Recommendations and conclusions regarding treatment needs,
l. The mode of delivery; and
m. Date, signature, and credentials of the staff member completing the assessment.

5. Recovery Plan with all the required elements indicated in the following section.

B. **Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary**

1. An MHR/TCM provider must develop a written recovery/treatment plan:
   a. Before the provision of mental health targeted case management or mental health rehabilitative services; *and*
   b. Within 10 business days after the date the member is eligible and has been authorized for routine care services.
      NOTE: The recovery plan must be completed prior to the start of services. The dates on the recovery plan should align with the prior authorization request.
2. Credentials for completing recovery/treatment plan. A staff member credentialed as a QMHP-CS, at a minimum, is responsible for completing and signing the plan.
3. **Content of recovery plan**
   a. The plan must reflect input from the member and each of the disciplines of treatment to be provided to the member based on the assessment. The plan must include *all* the following:
      i. a description of the members' presenting problem(s);
      ii. a description of the members' strengths;
      iii. a description of the members' needs arising from the mental illness or serious emotional disturbance;
      iv. a description of the members' co-occurring substance use disorder, intellectual or developmental disability, or physical health condition(s), if any;

v. a description of the recovery goals and objectives based on the assessment, and expected outcomes of the treatment in accordance with paragraph (2) of this subsection;
vi. the expected date by which the recovery/treatment goals will be achieved; and
vii. a list of the type(s) of intervention(s) within each form of treatment that will be provided to the member (e.g., psychosocial rehabilitation, medication services, supported employment), and for each type of service listed:
a) a description of the strategies to be implemented by staff members in providing the service and achieving goals;
b) the frequency, number of units (e.g.), and duration of each service to be provided (e.g., .5 hours of counseling per month, 1.5 hours of skills training per month for 3 months); *and*
c) the credentials of the staff member responsible for providing the service.

b. The goals and objectives with expected outcomes must:
i. specifically address the member's unique needs, preferences, experiences, and cultural background;
ii. specifically address the member's co-occurring substance use or physical health disorder, if any;
iii. be expressed in terms of overt, observable actions of the member;
iv. be objective and measurable using quantifiable criteria; *and*
v. reflect the member's self-direction, autonomy, and desired outcomes.

4. **Review of recovery/treatment plan** (applicable only to requests for continuation of services)
An MHR/TCM provider *must* complete the assessment within the timeframe below:
a. Review a member's continued eligibility for services as specified in §354.2703;
i. A QMHP-CS conducts an assessment to determine the individual's continued eligibility for services.
a) An adult is automatically eligible for continued services, regardless of whether his or her level of functioning has improved and regardless of requirements described in this section, if the individual has a diagnosis of:
- schizophrenia (including schizoaffective disorder);
- bipolar disorder; *or*
- major depressive disorder with a level of functioning that qualified the individual initially, *or*
- an adult is reassessed for continued eligibility for mental health rehabilitation at least every 180 days or more frequently if clinically indicated.

- A child or youth is reassessed for continued eligibility for mental health rehabilitation:

b) at least every 90 days; or more frequently if clinically indicated.

- If more than 180 days have passed for adults or 90 days for children between assessments, there may be a gap in authorization.

b. Review a member's plan prior to requesting authorization for the continuation of services, including all the following:
   i. determining if the plan adequately addresses the needs of the member;
   ii. documenting progress on all goals and objectives; and
   iii. documenting any recommendation for continuing services, any change from current services, and any discontinuation of services.

C. **Deviations**

1. Deviations will be reviewed utilizing the Texas Resilience and Recovery Utilization Management Guidelines.
   a. Child and Adolescent Services: Appendix G: Reasons for Deviation
   b. Adult Mental Health Services: XI: Deviations

II. Exclusions

The covered Medicaid services listed below must not be provided concurrently and will not be reimbursed separately:

A. Routine (T1017-TF) and Intensive Case Management Services (T1017-TG) are not to be authorized or provided concurrently.
B. If psychosocial rehabilitative services (H2017) are in the treatment plan, the treatment plan cannot simultaneously include skills training and development (H2014) or targeted case management (T1017) services.
C. Psychosocial rehabilitative services (H2017) may not be provided to a person who is currently admitted to a crisis stabilization unit.
D. Services are not reimbursable in the inpatient setting.

Definitions:

Community Services Specialist (CSSP): CSSP providers are eligible to deliver Mental Health Targeted Case Management (MHTCM) and Mental Health (MH) Rehabilitative services and must meet the following minimum credentialing requirements:

- High school diploma or high school equivalency;
- If practicing prior to August 30, 2004, at least three consecutive years of documented, full-time experience providing MH rehabilitative services qualifies the individual to continue delivering services under legacy standards established before newer credentialing requirements were implemented; *and*
- Demonstrated competency in the provision and documentation of MHTCM and MH rehabilitative services;

A CSSP performing MHTCM and MH rehabilitative services must:

- Be an employee of the provider where MHTCM services are delivered.
- Be clinically supervised by at least a QMHP-CS.

Crisis Intervention Service:

- The services in this level of care are brief interventions provided in the community that ameliorate a crisis and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.

Deviation:

- A request from the provider for prior authorization to a LOC, other than the CMBHS's recommended LOC. The request includes the reason for why the member requires interventions higher or lower than the recommended LOC (refusal of recommended LOC by the person receiving services may be noted as part of the justification).

Family Partners:

- A certified family partner (CFP) must have a high school diploma or high school equivalency and one cumulative year of participating in mental health services as the parent or legally authorized representative (LAR) of a child receiving mental health services.
- A CFP must be supervised by at least a QMHP-CS and must satisfy all staff credentialing, competency, training, and clinical supervision requirements.
- Services provided by a CFP must be included in the treatment plan.
- Family partners must be credentialed as a CFP within one year of their hire date.
- The family partner service is provided to parents or LARs for the benefit of the Medicaid eligible child.

Licensed Practitioner of the Healing Arts (LPHA):

- An individual who possesses any of the following licenses is considered a Licensed Practitioner of the Healing Arts (LPHA) and is automatically certified as a QMHP-CS:
    - Physician
    - Physician Assistant
    - Advanced Practice Registered Nurse
    - Psychologist
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Professional Counselor (LPC)

Medication Training and Support:

- Education and guidance about medications and their possible side effects are provided to individuals and family members.

Peer Provider:

- Peer providers must have a high school diploma or high school equivalency, one cumulative year of receiving mental health services, and be clinically supervised by an LPHA. The supervising LPHA must conduct at least monthly documented meetings with the peer provider and conduct an additional monthly documented observation of the peer providing services.

- A peer provider must satisfy all staff credentialing, competency, training, and clinical supervision requirements.
- Services provided by a peer provider must be included in the treatment plan.

Psychosocial Rehabilitation:

- Social, educational, vocational, behavioral, and cognitive interventions designed to improve deficits related to an individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, resulting from a diagnosis of a severe and persistent mental illness.

Qualified Mental Health Professional-Community Services (QMHP-CS): A staff member must meet at least one of three minimum requirements to be credentialed as a QMHP-CS:

- The staff member has at least a bachelor's degree from an accredited college or university and a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention.
- The staff member is a registered nurse.
- The staff member is a Licensed Practitioner of the Healing Arts (LPHA).

Skills Training and Development:

- Training provided to an individual that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual's functioning, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual's community integration and increases his or her ability to stay in the community.

Targeted Case Management: Primarily site-based services that assist an adult, child or adolescent, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs.

- Routine:
  - Primarily office-based case management activities that assist a person, caregiver, or LAR in obtaining and coordinating access to necessary care and services appropriate to the child's or youth's needs. Available for all ages.
- Intensive:
  - A level of mental health targeted case management that includes a focused effort to coordinate community resources, uses evidence-based wraparound process planning to address a child's or youth's unmet needs across life domains, and assists a child or youth in gaining access to necessary care and services appropriate to the child's or youth's needs. Available for ages 20 and below.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are

from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®	Description
N/A	N/A

HCPCS Codes	Description
H0034	Medication Training and Support
H0034 – HA Modifier	Individual Services for a Child/Youth
H0034 – HQ Modifier	Group
H2011	Crisis Intervention Service
H2011 – ET Modifier	Individual Crisis Services
H2011 – HA Modifier	Individual Services for a Child/Youth
H2014	Skills Training and Development
H2014 – HA	Individual Services for a Child/Youth
H2014 – HQ	Group
H2017	Psychosocial Rehabilitation
H2017 – HQ	Group
T1017 – HA	Individual Services for a Child/Youth
T1017 – TF Modifier	Routine Case Management
T1017 – TG	Intensive Case Management

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created.	11/25	11/25
Clarification to products and services provided for CHIP and Medicaid with no clinical criteria changes.	1/26	1/26

References

1. TMPPM – Intellectual Disability Service Coordination, Mental Health Targeted Case Management, and Mental Health Rehabilitative Services
2. Texas Resilience and Recovery Utilization Management (UM) Guidelines – Child and Adolescent Services
3. Texas Resilience and Recovery Utilization Management (UM) Guidelines – Adult Services
4. Texas Administrative Code – Chapter 354, Subchapter M. Mental Health Targeted Case Management and Mental Health Rehabilitation

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.