

Clinical Policy: Child and Adolescent Strengths and Needs (CANS)

3.0 Medical Necessity Criteria

Reference Number: TX.CP.MP.543

Last Review Date: 01/25

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The purpose of this policy is to provide guidelines for the request of a Child and Adolescent Strength and Needs (CANS) 3.0 Assessment for STAR Health members.

The Texas CANS assessment is a comprehensive trauma-informed behavioral health evaluation and communication tool. It is intended to prevent duplicate assessments by multiple parties, decrease unnecessary psychological testing, aid in identifying placement and treatment needs, and inform case planning decisions (*Texas Health and Human Services*).

The Texas CANS 3.0 assessment is administered to members age 3-17 and is completed within 30 days of coming into care and re-administered annually thereafter. Providers bill for this service using code 90791, modifier TJ.

Policy/Criteria

- I. It is the policy of Superior HealthPlan that a CANS 3.0 assessment is **medically necessary** when the severity of need and intensity of service criteria are met:
 - A. Severity of Need: (either 1 or 2)
 1. CANS 3.0 assessment within the initial 30 days of a member becoming STAR Health eligible or within the 30 days before or after their annual anniversary of eligibility (60 day span) for members 3-17 years old.
 2. CANS 3.0 assessment would require pre-authorization and be clinically appropriate in the following circumstances:
 - a. CANS 3.0 assessment requested by non-participating provider
 - b. CANS 3.0 assessment being requested in addition to the initial or annual anniversary of eligibility:
 - i. Court ordered completion of a CANS 3.0 assessment
 - ii. CANS 3.0 assessment being completed in lieu of psychological testing, in order to determine a member's DFPS level of care required for placement
 - iii. CANS 3.0 assessment being completed in lieu of psychological testing for the completion of an adoption
 - B. Intensity of Services:
 1. A licensed mid-level provider or psychologist, or other qualified provider as permitted by applicable state and/or federal law, who has completed CANS 3.0 certification and who is credentialed by and contracted with the Plan, administers the assessment; AND

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2. Completion of the CANS 3.0 will be done face to face or via Telehealth clinical setting in the span of one unit of service.

II. It is the policy of Superior HealthPlan that the **exclusion criteria** for a CANS 3.0 assessment is as follows:

- A. CANS 3.0 completion for a routine update
- B. More than one unit of service per CANS 3.0 assessment administered
- C. CANS 3.0 and psychological evaluation or neuropsychological testing (CPT 96130-96133) and/or test administration and scoring (CPT 96136-96139) completion on the same day without clinical justification

Note: In the event of an adverse determination, the pre-appeals process should be followed.

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 2020, 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® Codes	Description
90791 Modifier TJ	PSYCHIATRIC DIAGNOSTIC EVALUATION .
96130	PSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL - FIRST HOUR
96131	PSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL – ADDITIONAL HOUR
96132	NEUROPSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL – FIRST HOUR
96133	PSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL – ADDITIONAL HOUR
96136	PSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL – FIRST 30 MINUTES
96137	PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TEST EVALUATION SERVICES BY PHYSICIAN OR QUALIFIED PROFESSIONAL EACH ADDITIONAL 30 MINUTES
96138	PSYCHOLOGICAL/NEUROLOGICAL TEST EVALUATION SERVICES BY TECHNICIAN FIRST 30 MINUTES

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CPT® Codes	Description
96139	PSYCHOLOGICAL/NEUROLOGICAL TEST EVALUATION SERVICES BY TECHNICIAN EACH ADDITIONAL 30 MINUTES

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date. New policy.	11/18	11/18
Updated to new template from TX.UM.43 (TX.CP.MP.543 nomenclature implementation)	11/19	11/19
Annual review, no revisions	09/20	09/20
Renamed Child and Adolescent Strength and Needs (CANS) 3.0 Medical Necessity Criteria	01/21	01/21
Annual review, no revision	09/21	09/21
Annual review, no revision	09/22	09/22
Annual review, no revision	09/23	09/23
Annual review, no revision	09/24	09/24
Ad hoc review. Changed CANS 2.0 to CANS 3.0 assessment throughout policy (effective 1/1/25 per DFPS).	01/25	01/25

References

1. Senate Bill 125, Family and Protective Services, Health and Human Services Commission
2. Texas Health and Human Services Commission
3. Texas Department of Family and Protective Services (DFPS)

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

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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.

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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.

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