

Clinical Policy: Medical Necessity Criteria: CANS 2.0

Reference Number: TX.CP.MP.543

Last Review Date: 11/19

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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) 2.0 Assessment for STAR Health members.

Senate Bill 125 legislative requires certain assessments for all children and youth coming in the conservatorship of the Department of Family and Protective Services (DFPS). The request of a CANS 2.0 assessment is consistent with Senate Bill 125. The CANS 2.0 assessment is completed within 30 days of coming into care, as well as, an annual update. Providers bill for this service using code 90791 TJ.

Policy/Criteria

- I. It is the policy of Superior HealthPlan that a CANS 2.0 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 2.0 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 2.0 assessment would require pre-authorization and be clinically appropriate in the following circumstances:
 - a. CANS 2.0 assessment requested by non-participating provider
 - b. CANS 2.0 assessment being requested in addition to the initial or annual anniversary of eligibility:
 - i. Court ordered completion of a CANS 2.0 assessment
 - ii. CANS 2.0 assessment being completed in lieu of psychological testing, in order to determine a member's DFPS level of care required for placement
 - iii. CANS 2.0 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 2.0 certification and who is credentialed by and contracted with the Plan, administers the assessment; AND
 2. Completion of the CANS 2.0 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 2.0 assessment is as follows:
 - A. CANS 2.0 completion for a routine update

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- B. More than one unit of service per CANS 2.0 assessment administered
- C. CANS 2.0 and psychological evaluation 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 2019, 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
N/A	

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

References

- Senate Bill 125, Family and Protective Services, Health and Human Services Commission

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

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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.

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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.

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.

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