Texas Children's	**Outpatient Psychotherapy Visits Greater than 30 per Calendar Year**	
Guideline # 6671	***Categories*** Clinical →Care Coordination, TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Fuller

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs prior authorization of Outpatient Psychotherapy Visits Greater than 30 per calendar year.

DEFINITIONS:

Psychotherapy: The treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the member and, through definitive therapeutic communication or therapeutic interactions, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

GUIDELINE

1. Psychotherapy is limited to 30 individual, group, or family psychotherapy visits per person, per calendar year. Additional psychotherapy services must be prior authorized.

2. All requests for prior authorization for outpatient psychotherapy visits greater than 30 per calendar year are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

   2.1. Providers with established members must request prior authorization when they determine the member is approaching 30 psychotherapy encounters or visits for the calendar year and more visits are needed to accomplish goals of treatment.

   2.2. If the member changes providers during the year and the new provider is unable to obtain complete information on the member's encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

3. Prior authorization is considered in increments of up to 10 additional encounters or visits per request.

4. A request should be submitted no sooner than 30 days before the date of service and no later than the date of service being requested so the most current information is provided. Requests received up to 7 days after the 31st visit may be considered for approval if medical necessity criteria are met.

5. Requests for prior authorization of psychotherapy beyond the 30 visit limit must include:

   5.1. Completed Outpatient Mental Health Services Request Form that includes:

      5.1.1. Member demographics

      5.1.2. Provider name and NPI

      5.1.3. A complete list of diagnosis as listed in the current edition of the DSM

      5.1.4. History of substance abuse, if applicable

      5.1.5. Current medications list

      5.1.6. Psychosocial barriers

      5.1.7. Number, type of services requested, and the dates based on the frequency of encounters or visits for which the services will be provided

      5.1.8. Date on which the current treatment is to begin

      5.1.9. Indication of court-ordered or DFPS-directed services

   5.2. Clinical Documentation of specific symptoms and response to past treatment, treatment plan (measurable short term goals, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters or visits) to include an assessment that explains why the member was unable to achieve the expected treatment objectives within the original treatment timeframe.

6. The number of encounters or visits authorized will be dependent upon the member's symptoms and response to past treatment. Ongoing treatment may be considered medically necessary when:

   6.1. The member has not achieved the discharge goals necessary to conclude treatment, but the member's progress indicates that treatment can be concluded within a short period of time.

   6.2. The member's psychiatric condition has not responded to a trial of short-term outpatient therapy and there is potential for serious regression or admission to a more intensive

setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).

6.3. The member's condition is one that includes long-standing, pervasive symptoms or patterns of maladaptive behavior.

7. All requests that do not meet the guidelines referenced here will be referred to aPhysician Reviewer for review and the Denial Policy will be followed.

8. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

RELATED DOCUMENTS:

Government Agency, Medical Society, and Other Publications:

Outpatient Mental Health Services Request Form, Outpatient Mental Health Services Request Form

REFERENCES:

Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook, Accessed March 3, 2025

https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2025/2025-03-march/2_02_behavioral_health.pdf

Status	Date	Action
Approved	03/13/2025	Clinical & Administrative Advisory Committee