BlueCross BlueShield of Texas

Texas Medicaid Behavioral Health Provider Orientation

Blue Cross and Blue Shield of Texas (BCBSTX) Medicaid STAR, CHIP, and STAR Kids

SKSCP-9073-0324
Revised 4/2024

Provider Notification

Effective May 1, 2024, Blue Cross and Blue Shield of Texas Medicaid will be insourcing

- Behavioral Health Services will be managed by BCBSTX and no longer contracted with Magellan.
- Medical and Behavioral Health claim processing

We want to assure you that BCBSTX is committed to ensuring a smooth transition during this period.

Here are some important details:

Behavioral Health:
- Transition Period: BCBSTX will honor all authorizations and referrals on file with Magellan for up to 180 days from the effective date of May 1, 2024.
- This means that any ongoing authorizations and referrals will be honored during this transition period, ensuring that your patients' care remains uninterrupted.

Network:
- Contracting Opportunities: If you are a behavioral health provider who is not currently contracted directly with BCBSTX and would like to be, we encourage you take the next steps. You can begin the contracting and credentialing process by following the Join My Network link provided on our website. BH Providers must be Medicaid attested to join Medicaid.

Medical and BH Claims Processing
- Transition Period: For dates of services prior to 5/1/2024 generating a runout on our legacy system for both medical and behavioral health claims. You may see updated correspondence for DOS after 5/1/2024 generating form our new processing system. We are also accepting 275 EDI transactions with appropriate claims details.

Authorization: To request an authorization, providers should contact the Behavioral Health Utilization Management Department or visit our provider portal (Availity Authorizations).

Behavioral Health Provider Orientation Information

- The BH Provider Orientation and Training webinar is presented four times a year by our Provider Network team.
- Accessible 24/7 on our website.
- We send invitations and reminders via email, in our Monthly Blue Review Newsletter, and post on our website under News and Updates.

BlueCross BlueShield of Texas

Section 1
Provider Compliance

Section 1 – Provider Compliance

BlueCross BlueShield of Texas

Purpose

To do everything in our power to stand with our members in sickness and health. We strive to develop relationships with our members, providers and the communities that we serve in order to better our STAR, CHIP, and STAR Kids member's health.

Texas Health and Human Services

The Texas Health and Human Services Commission delegates the responsibility of educating eligible STAR, CHIP, and STAR Kids members about their health plan options to Maximus.

The State will assign STAR and STAR Kids members to a plan if the member/family does not choose a plan.

CHIP and CHIP Perinate eligible members **must enroll** in a CHIP HMO within 90 days. CHIP eligible members do not default into an HMO. If an HMO is not chosen, the CHIP eligible member will become ineligible.

Note: *CHIP Perinate newborns are eligible for 12 months of continuous coverage beginning with the month of enrollment.*

How to Verify Member Eligibility

Our providers must verify eligibility before each service.

Contact Customer Service for eligibility verification:

STAR/CHIP: 1-877-560-8055

STAR Kids: 1-877-784-6802

Use the State's Automated Inquiry System (AIS) for

STAR and STAR Kids

1-800-925-9126

Utilize online resources:

www.tmhp.com

www.availity.com

CHIP Members receive a card:

- Blue Cross and Blue Shield of Texas member identification card
- They do not receive a State issued Medicaid identification card.

STAR and STAR Kids members will receive two identification cards upon enrollment:

- State issued Medicaid card (Your Texas Medicaid Benefit Card)
- Blue Cross and Blue Shield of Texas Member Identification card

Blue Cross and Blue Shield of Texas identification cards will be re-issued if/when:

- The member changes his/her address
- The member changes his/her PCP
- Upon Request
- At Membership renewal

Cultural Competency

- The Health and Human Services Commission requires all contracting health plans to develop and maintain cultural competency plans and make them available to providers.
- BCBSTX has adopted all 15 **Culturally and Linguistically Appropriate Services (CLAS)** Standards to ensure all members who enter the health care system receive equal, high quality, effective treatment.
- As our contracted health care provider, our expectation is for you to continually improve sensitivities and maintain positive attitudes toward serving diverse cultures. This can help you provide more effective care and services for all people by considering each person's values, life conditions and linguistic needs.

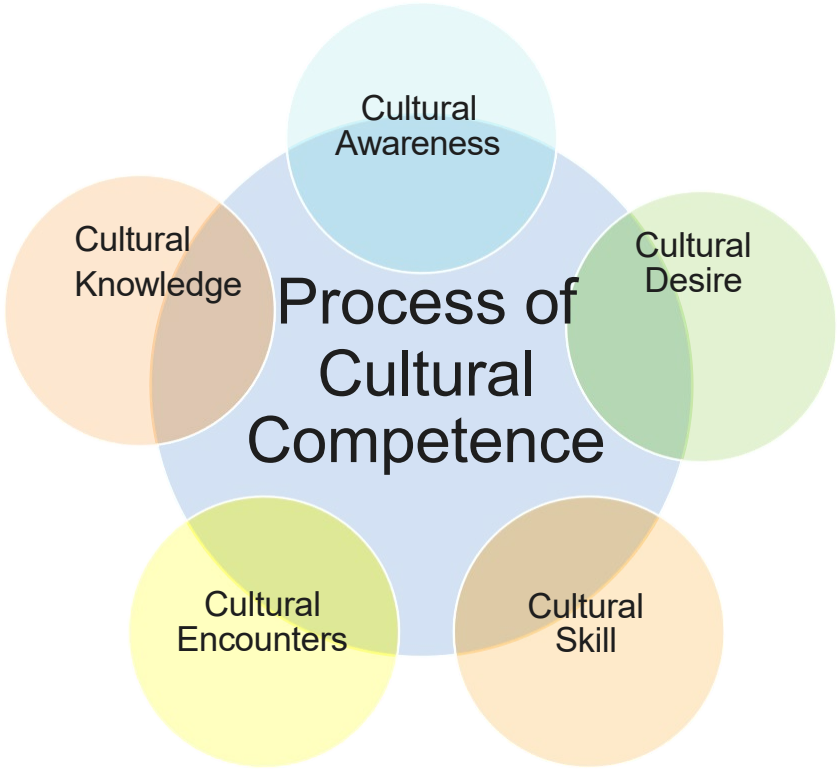
The purpose of the 15 action steps is threefold:

- **Advance health equity,**
- **Improve quality of care, and**
- **Help eliminate health care disparities to achieve the goal of improved health outcomes.**

The link to CLAS 15 action steps:
thinkculturalhealth.hhs.gov/clas/standards

Cultural Competency is the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic background and religions in a manner that recognize values, affirms and respects the worth of the individual and protects and preserves dignity.

Please register for the Culturally Competent Health Care Provider Training: www.bcbstx.com/provider/medicaid/training.html



PCP and Behavioral Health Availability and Appointment

- Blue Cross and Blue Shield of Texas (BCBSTX) Medicaid reminds all Primary Care Physicians and Behavioral Health Providers about Appointment Accessibility Standards.
- PCPs and BH providers will be surveyed throughout the year regarding Appointment Accessibility standards. The timeframe for PCP's and BH's appointment accessibility:

Appointment Accessibility Standards	
Primary Care Physician (PCP) Visit Type	Access Standards
Primary Routine Care	Within 14 days of request
For **STAR**, Preventive Covered Services including annual adult well checks	Within 90 days of request
For **STAR**, Preventive Covered Services for members younger than six months of age	Within 14 days of request
For **STAR**, Preventive Covered Services for members six months through age 20	Within 60 days of request
For **CHIP**, Preventive Care	Per the American Academy of Pediatrics Periodicity Schedule[1]
Medicaid members, Preventive Care	Per Texas Health Steps Periodicity Schedule
BCBSTX new members 20 years of age or younger, THSteps Check-up	Within 90 Days of enrollment
Behavioral Health Visit Type	Access Standards
Initial Outpatient Behavioral Health Visits*	Within 14 calendar days
Urgent- including urgent specialty care and Behavioral Health Services must be provided by licensed Behavioral Health Clinician.	Within 24 hours

*Does not apply to CHIP Perinate

Provider Demographics Updates

Update us immediately concerning changes in:

- Address
- Phone
- Fax
- Office Hours
- Access and availability
- Panel status
- Tax - identification Number

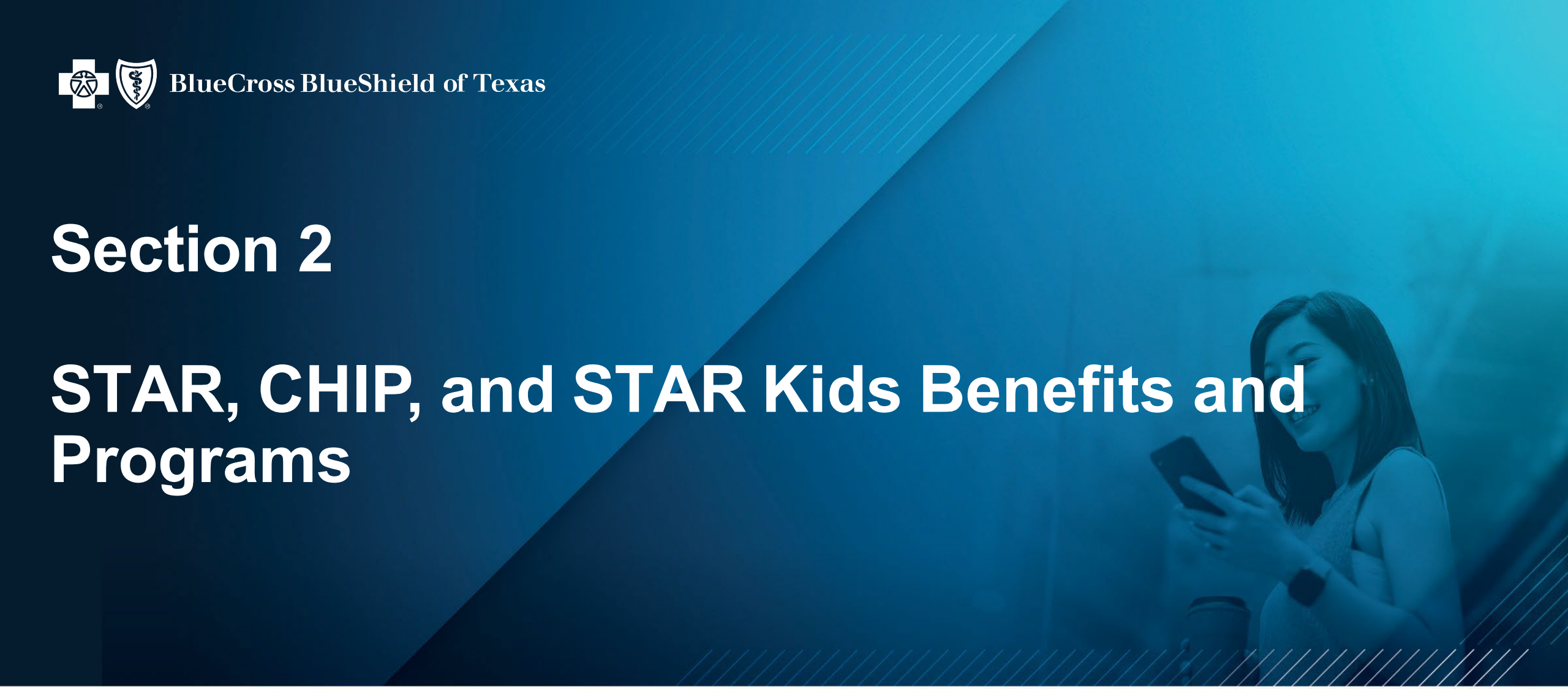
Please also remember to update your demographic information with Provider Enrollment and Management System (PEMS). You can also contact TMHP directly at **1-800-925-9126** for assistance.

For additional information on how to update your demographic information, visit: www.bcbstx.com/provider/network/network/request-contract

BlueCross BlueShield of Texas

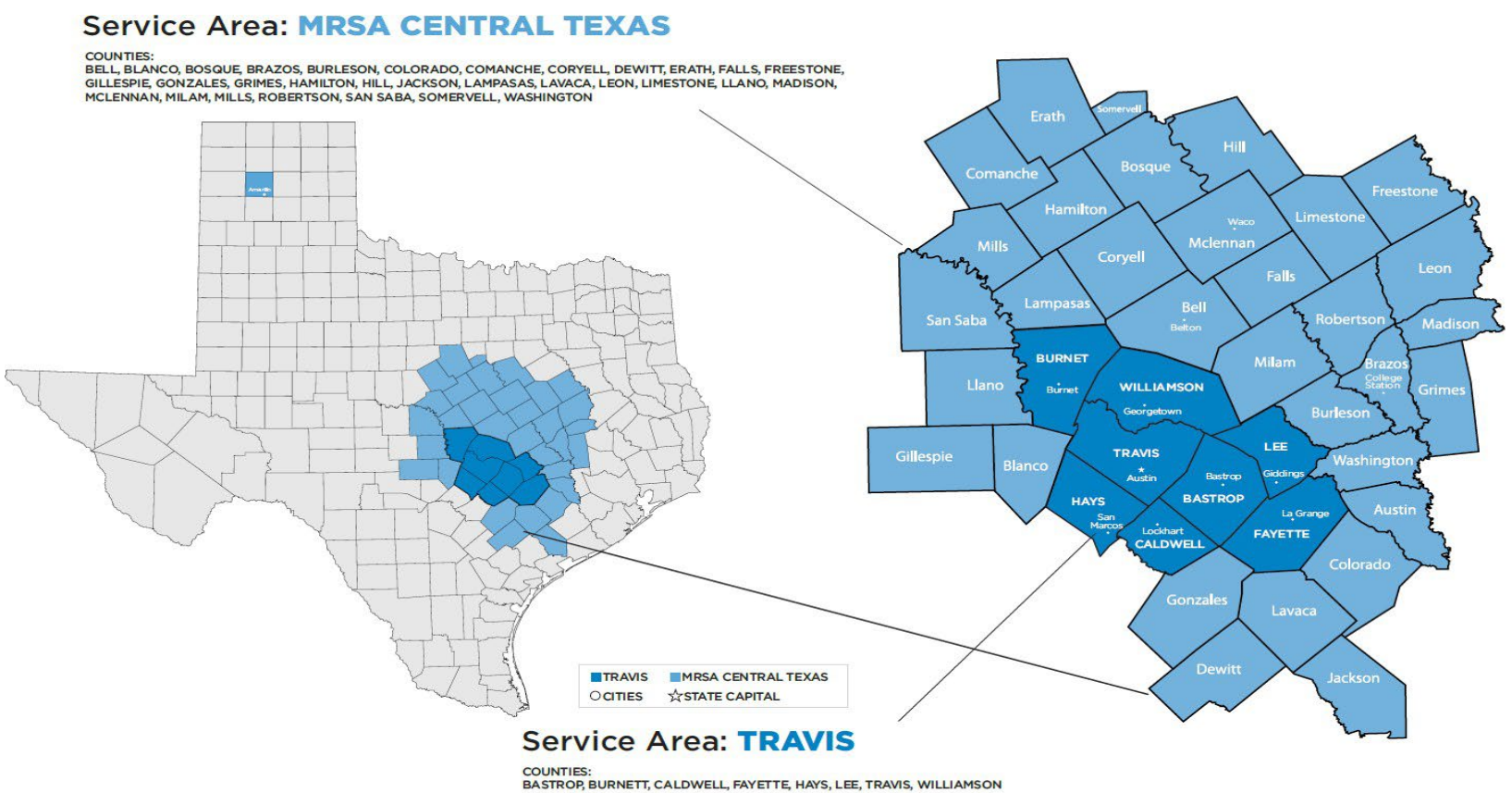
Section 2

STAR, CHIP, and STAR Kids Benefits and Programs



Section 2 – STAR, CHIP, and STAR Kids Benefits and Programs Overview

Where We Serve



BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, An Independent Licensee of the Blue Cross and Blue Shield Association

TEXAS STAR Kids
Your Health Plan ★ Your Choice

TEXAS STAR
Your Health Plan ★ Your Choice

CHIP

STAR and CHIP
Service Area Travis Counties:

Bastrop, Burnett, Caldwell, Fayette, Hays, Lee, Travis and Williamson

STAR Kids
Service Area Travis Counties:

Bastrop, Burnett, Caldwell, Fayette, Hays, Lee, Travis and Williamson

Service Area MRSA Central Texas Counties:

Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, Dewitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell and Washington

STAR Member Benefits and Services

- Applied Behavioral Analysis (ABA)*
- Inpatient and Outpatient Mental Health Service
- Inpatient and Residential Substance Use Disorder Services
- Outpatient Substance Use Disorder Services
- Physical Therapy, Occupational Therapy, and Speech Therapy*
- Emergency Ambulance
- Annual Adult Wellness Exams
- Audiology, Chiropractic & Podiatry
- DME/Orthotics and Prosthetics*
- Emergency Services
- Inpatient and Outpatient Hospital Services*
- Lab – X-Rays *
- OB/GYN and Pregnancy and Maternity Care
- Prescription Drugs*
- Rehabilitation Services*
- Texas Health Steps (EPSDT-Early and Periodic Screening, Diagnosis and Treatment Program Services)
- NEMT (Non-Emergency Medical Transportation
- Transplant Services*
- Value Added Services **

The STAR program is for people who qualify for Medicaid and who are either pregnant, have limited income, are newborns or receive cash assistance (Temporary Assistance for Needy Families or TANF).

STAR Members do not have cost-sharing or co-pays for services.

Some Benefits need Prior Authorization

****Limitations on Value Added Services must be clearly stated in member materials**.

For more information regarding STAR Member Benefits including Value Added Services, please refer to your BCBSTX Provider Manual. In addition, refer to TMHP Provider Manual Covered Service limitations.

CHIP Member Benefits and Services

- Inpatient and Outpatient Mental Health Services*
- Inpatient and Residential Substance Use Disorder Services
- Case Management and Care Coordination Services
- Inpatient Acute and Rehabilitation Hospital Services*
- Outpatient and Ambulatory Health Services
- Pregnancy and Family Planning Services
- Audiology, Chiropractic & Podiatry,
- DME Supplies*
- Physician/Physician Extender Professional Services PCP's and Specialists
- Rehabilitation Services*
- Hospice Care*
- Emergency Services, Hospitals, Physicians and Ambulances
- Physical Therapy, Occupational Therapy and Speech Therapy*
- Transplants*
- Vision
- NEMT (Non-Emergency Medical Transportation
- Value Added Services **
- Lab X-Rays*
- Hone Health

The CHIP and CHIP Perinatal program is available to children ages 18 and younger and to pregnant women who do not qualify for Medicaid.

Per HHS, Member copays depends on their income and can be up to $35

www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/chip

****Some Benefits need Prior Authorization.***

*****Limitations on Value Added Services must be clearly stated in member materials*.**

For more information regarding CHIP Member Benefits including Value Added Services, please refer to your BCBSTX Provider Manual. In addition, refer to TMHP Provider Manual Covered Service limitations.

STAR Kids Member Benefits and Services

STAR Kids Members Benefits Modifications. Include **all the traditional benefits** offered in the STAR Program.

However, the STAR Kids program offers additional benefits in the form of Long-Term Services and Supports (LTSS) which includes but not limited to services such as:

- Adaptive Aids
- Community First Choice Services
- Personal Care Services
- Minor Home Modifications
- Applied Behavioral Analysis (ABA)*
- NEMT (Non-Emergency Medical Transportation

For more information regarding STAR Kids Member Benefits including Value Added Services, please refer to your BCBSTX Provider Manual. In addition, refer to TMHP Provider Manual Covered Service limitations.

The STAR Kids program provides Medicaid services for children and youth ages 20 and younger with disabilities.

STAR Kids Members do not have cost-sharing or co-pays for services.

Some Benefits need Prior Authorization

Limitations on Value Added Services must be clearly stated in member materials.

Early Childhood Intervention (ECI)

Early Childhood Intervention is a federally mandated program for children from birth up to 36 months of age with a developmental delays and/or disabilities or certain medical diagnoses that impact development.

How do they qualify for services? To be eligible for ECI services the child must meet one of the following three criteria:

- Medically Diagnosed Condition
- Deaf/Hard of Hearing or Blind/Visually Impaired
- Developmental Delay

How do they qualify for services? The child was evaluated using state approved evaluation tool to determine eligibility. If qualified, the team identifies the child's strengths and needs in family's daily routines.

ECI services supports families as they learn how to help their children grow and learn

For additional information on ECI visit: www.hhs.texas.gov/services/disability/early-childhood-intervention-services-eci

Children of Migrant Farm Workers

- Some of the barriers for Farm Workers to overcome: High mobility, language and cultural barriers, inaccessibility to health care service and lack of health insurance coverage.
- Special attention should be paid to **educating** traveling farm workers families on the importance of their children receiving timely or accelerated Texas Health Steps (THSteps) medical and dental checkups prior to the family traveling for work.
- Blue Cross and Blue Shield of Texas (BCBSTX) relies on you to identify these members and determine if there is a need to accelerate any THSteps medical or dental checkups.

THSteps checkups are made up of six primary components.

1. Comprehensive health and developmental history
2. Comprehensive unclothed physical examination
3. Appropriate immunizations
4. Appropriate laboratory test
5. Health education
6. Dental referral

Migrant farm worker is defined as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode.”

If you have questions about identifying children of Migrant Farm Workers or Texas Health Steps, please call Provider Network Representative: **1-855-212-1615.**

Healthy Texas Women

Healthy Texas Women provides a wide variety of women's health and core family planning services, eligible low-income women may receive the following services free with this program.

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services
- Breast and cervical cancer screenings
- Clinical breast examination
- Mammograms
- Screening and treatment for cholesterol, diabetes and high blood pressure
- HIV screening
- Long-acting reversible contraceptives
- Oral contraceptive pills
- Permanent sterilization
- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections
- Screening and treatment for postpartum depression

Healthy Texas Women is a program that provides primary healthcare services, including family planning services and health screenings, to eligible women under 1 Tex. Admin. Code Chapter 382, Subchapter A.

For additional information such as: Who can apply; How to apply; Additional Questions and Answers, please visit: www.healthytexaswomen.org/healthcare-programs/healthy-texas-women

Healthy Texas Women Plus

If a woman has been pregnant within the last 12 months? This program was developed and created for a postpartum care package through the Healthy Texas Women Plus program.

Women must be already enrolled in the Healthy Texas Women program to participate.

For additional information, please visit: https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women/htw-benefits

What services are covered?

- Some of the postpartum depression and other mental health conditions that are treated include: individual, family and group psychotherapy services and peer specialist services.
- Heart health services includes blood pressure monitoring, image studies and heart medications.
- Substance use disorder, including drug, alcohol and tobacco misuse, services include screenings, brief interventions, treatment referrals, outpatient substance use counseling, smoking cessation, medication–assisted treatment and peer specialist services.

Texas Health and Human Services (HHSC) launched a new postpartum services package for HTW clients call **Healthy Texas Women (HTW) Plus**. Benefits available through HTW Plus focus on treating health conditions that contribute to maternal morbidity and mortality, including postpartum depression, cardiovascular conditions, and substance use disorders.

Note: Only the services listed above are paid by this program.

Special Beginnings

When our members join this program, they receive the following:

- Two Pregnancy risk interviews: They may help our member find out if their pregnancy is high risk.
- Information and Materials about nutrition and healthy life choices before and after the birth.
- Personal phone calls from specially trained staff to talk to our members regarding how the pregnancy is going. Our Special Beginnings Care Coordinator will contact our member for six weeks after the birth.
- 24 - hour, toll–free access to a telephone hotline staffed by experienced registered nurses and maternity nurses (1-844-971-8906).

A Special Beginnings representative will call our member through the entire pregnancy to help with:

- Assess their health, lifestyle, and possible pregnancy problems.
- Teach them to avoid problems that can develop during pregnancy.
- Encourage them to make healthy changes.
- Talk to our member about their OB treatment plans.
- Help if they develop diabetes or high blood pressure while pregnant.
- Teach them about prenatal, postpartum, and newborn care.
- Complete depression screenings and refer to BH provider or BH supports if needed.

Special Beginnings is a maternity program that is there for our members and their needs. This program helps them better understand and manage their pregnancy.

Children and Pregnant Women (CPW)

What is CPW Case Management?

Blue Cross and Blue Shield of Texas (BCBSTX) defines case management for children and pregnant women as a Medicaid benefit that provides case management services to children from birth to 20 years of age with a health condition and to high-risk pregnant women of any case. Case managers help clients gain access to needed medical, social, educational and other covered services.

How Do CPW Case Manager Providers Connect Members to Services?

CPW Case Manager Providers will connect members to services such as:

- Assess behavioral health services and/or developmental testing.
- Coordinate Durable Medical Equipment, Home Health Nursing, Occupational, Physical, and Speech Therapy.
- Assist with the Special Education process for school issues.
- Help with transition planning.
- Address issues such as substance abuse, homelessness, or domestic violence.
- Finding other needs such as respite.

Children and Pregnant Women (CPW) Continued

How will BCBSTX Service Coordination Team Partner with CPW Case Manager Providers? BCBSTX Service Coordinators take a person-centered approach to service planning and discover others involved in the member's care (including CPW Providers) during the Individual Service Plan (ISP) process.

When a Service Coordinator receives an intake form from a CPW Provider, the service coordinator will verify if the member is already partaking in service coordination. The purpose is to determine there are no duplicative efforts of service coordination for the member. If it's determined that the member is missing services not already being coordinated with BCBSTX, the CPW Provider will assist with coordinating those services.

How Can a Member Request CPW Case Management Services?

BCBSTX Members may self-refer for CPW Case Management services. This can be done by reaching out to Service Coordinators at:

- **1-877-214-5630 -** STAR/CHIP SC Line
- **1-877-301-4394 -** STAR Kids SC Line:

Or requesting case management services from their Primary Care Provider. BCBSTX members who are established with a CPW Provider may continue to see their CPW Case Manager Provider.

BCBSTX will honor continuity of care and work with a member's current case manager to ensure all services are being met and/or not duplicative to ongoing services. If the CPW Provider is out-of-network, BCBSTX will work with a CPW Provider by administering a Single Case Agreement (SCA) until the CPW Provider is contracted with BCBSTX. Out of Network CPW Providers are required to submit prior authorization.

Benefit Limitations Overview

Unless otherwise specified, all services provided to BCBSTX Medicaid members must be medically necessary. Some services may be reimbursed without prior authorization within the set limitations.

In addition to services that always require prior authorization, providers may request prior authorizations for medically necessary services that exceed benefit limitations.

For more detailed listing of all benefit limitations, please refer to the TMHP Provider Manual.

If you need assistance with navigating or questions about benefit limitations, you may also contact your assigned Provider Relations Representative for more information.

Value-Added Services (VAS) – STAR, CHIP, and STAR Kids

A Value-Added Service is a service that is provided to Medicaid STAR, CHIP and STAR Kids members by Blue Cross and Blue Shield of Texas. BCBSTX Value-Added Services are used to promote preventive care and services, engage members in their own care, address gaps in care and services, and support our Quality Improvement Programs. Value-Added Services have restrictions and limitations.
New STAR, CHIP and STAR Kids members receive all Value-Added Services incentive forms in the new members' welcome packet.

STAR Value-Added Services
CHIP Value-Added Services
STAR Kids Value-Added Services

VAS include but not limited to:

- Learn to Live
- Incentive Gift Card for Getting Follow-up Care after a BH Inpatient Discharge
- Free rides to non-emergency doctor visits, therapy, pharmacy, WIC visits and classes
- 24-Hour Nurse Advice Line
- Well-Child Checkup Incentive Gift Card Incentive

VAS may have restrictions and limitations.

Collaborative Care Model (CoCM)

Collaborative Care Model (CoCM) Effected June 1, 2022

The CoCM is a benefit for Texas Medicaid for persons of all ages who have a mental health or substance use condition, to include preexisting or suspected mental health or substance use condition, as determined by the primary care provider (i.e., physician, physician assistant, or nurse practitioner.

The CoCM is an approach to bring behavioral health conditions (mental health treatments) together in the primary care provider's (PCP) setting. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility, and 'other location" settings.

You may reference: The Collaborative Care Model to Become a Benefit of Texas Medicaid June 1, 2022

Pharmacy Program

- The Texas Vendor Drug Program formulary and Preferred Drug List are available on our website: https://www.bcbstx.com/provider/medicaid/pharmacy/drug-list

- Prior authorization is required for:
  - Nonformulary drug requests
  - Brand-name medications when generics are available
  - High-cost injectable and specialty drugs
  - Any other drugs identified in the formulary as needing prior authorization

- Online pharmacy prior authorization:
- Phone: **1-855-457-0405** – STAR
- Phone: **1-855-457-0403** -- CHIP
- Phone: 1**-855-457-0758** – STAR Kids (MRSA Central)
- Phone: **1-855-457-0757** – STAR Kids (Travis Service Area)

- Epocrates is a free subscription drug information service that can be downloaded to a computer or handheld device. In addition to listing a drug's preferred status, Epocrates includes drug monographs, dosing information, and warnings. All prescribing providers are eligible to register for Epocrates online. Refer to the Outpatient Drug Services Handbook in the Texas Medicaid Provider Procedures Manual to learn more. Visit https://www.epocrates.com for additional information on the free subscription.

If BCBSTX cannot provide a response to the prior authorization request within 24 hours after receipt or the prescriber is not available to make a prior authorization request after prescriber's office hours and the dispense pharmacist determines it is an emergency situation, BCBSTX must allow the pharmacy to dispense a 72-hour emergency supply of medication.

Vendor Services

Dental Services:

DentaQuest

Phone Number:
1-800-516-0165
Website:
www.dentaquest.com

Managed Care of North America Dental (MCNA)

Phone Number:
1-800-494-6262

Website:
www.mcna.net

Vision Service:

Davis Vision
Phone Number:
1-800-773-2847

Website:
www.davisvision.com/eye-care-professionals/

Prime Pharmacy: Services Therapeutics

STAR Phone Number:
1-855-457-0405

CHIP Phone Number:
1-855-457-0403

STAR Kids Phone Numbers:
1-855-457-0757
(Travis service area)
1-855-457-0758
(MRSA Central service area)
Website:
www.myprime.com

BlueCross BlueShield of Texas

Section 3

Texas Health Steps Overview

Important Medicaid Programs:

Texas Health Steps often referred to (THSteps) is healthcare for children birth through age 20 who have Medicaid. THSteps gives your child free medical checkups starting at birth, and free dental checkups starting at 6 months of age

STAR

(*State of Texas Access Reform*) is the Medicaid Managed Care Program of Texas.

CHIP

(Children's Health Insurance Program) is the health insurance option for children.

STAR Kids

is the Medicaid managed care program that serves youth and children ages 20 and younger who receive disability related Medicaid.

Scope of Texas Health Steps (THSteps) Services

Texas Health Steps (THSteps) helps members with:

- Preventive care medical checkups and services
- Dental checkups and treatment services
- Comprehensive Care Program (CCP)
- Laboratory services
- Immunization services
- Electronic Visit Verification (EVV)

Providers can enroll to provide preventive care to kids and teens, by enrolling as a Texas Health Steps provider through Provider Enrollment on the Portal (PEP)

For additional information for THSteps: www.tmhp.com/programs/thsteps

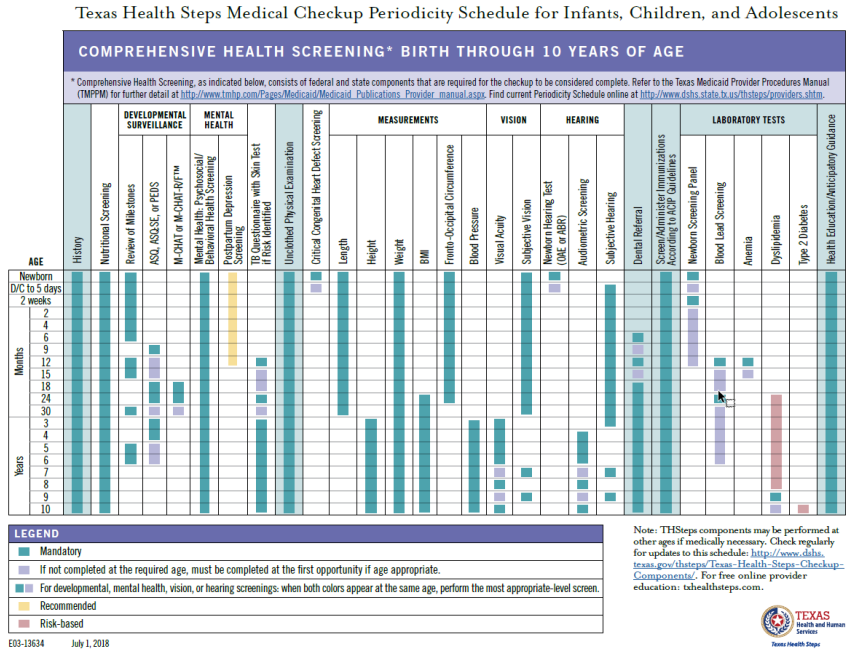
Texas Health Steps (THSteps) provides preventive health-care to 20-year-olds or younger.

Scope of Texas Health Steps (THSteps) Services – Behavioral Health

The THSteps Periodicity Schedule specifically requires the following:

- Ages & Stages Questionnaires (ASQ)
- Ages & Stages Questionnaires: Social-Emotional (ASQ:SE)
- Parents' Evaluation of Developmental Status (PEDS) assessments at ages 9 months, 18 months, 24 months, 30 months, 5 years, and 6 years.
- Additionally, Autism Spectrum Disorder Assessments M-CHAT or M-CHAT-R/F™ are required at ages 18 months and 24 months. The table below further details the components.

Texas Health Steps (THSteps) provides preventive health-care to 20-year-olds or younger.


Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.

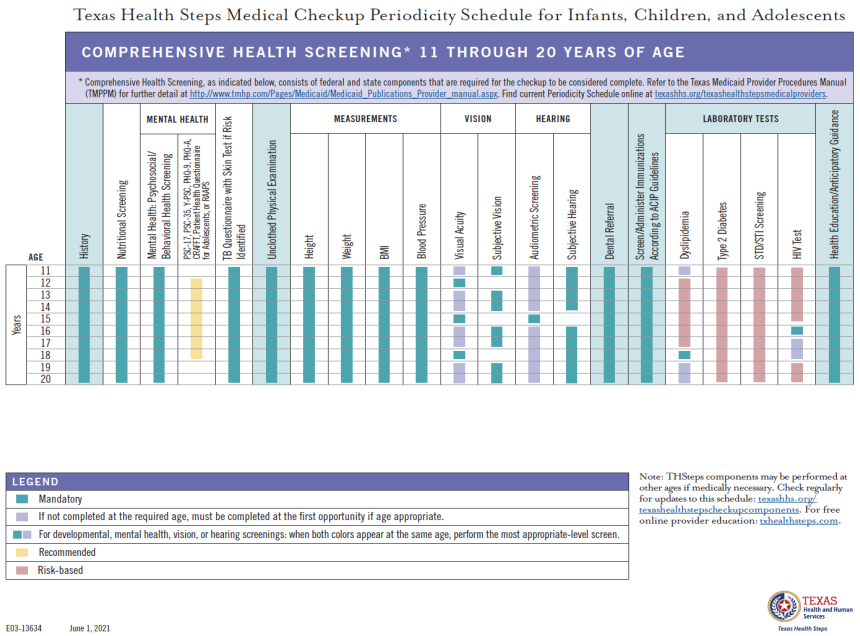
AGE | History | Nutritional Screening | DEVELOPMENTAL SURVEILLANCE: Review of Milestones; ASQ, ASQ:SE, or PEDS | MENTAL HEALTH: M-CHAT or M-CHAT-R/F™; Mental Health: Psychosocial/Behavioral Health Screening; Postpartum Depression Screening | TB Questionnaire with Skin Test if Risk Identified | Unclothed Physical Examination | Critical Congenital Heart Defect Screening | MEASUREMENTS: Length; Height; Weight; BMI; Fronto-Occipital Circumference; Blood Pressure | VISION: Visual Acuity; Subjective Vision | HEARING: Newborn Hearing Test (OAE or ABR); Audiometric Screening; Subjective Hearing | Dental Referral | Screen/Administer Immunizations According to ACIP Guidelines | LABORATORY TESTS: Newborn Screening Panel; Blood Lead Screening; Anemia; Dyslipidemia; Type 2 Diabetes | Health Education/Anticipatory Guidance

Newborn
D/C to 5 days
2 weeks
Months: 2, 4, 6, 9, 12, 15, 18, 24, 30
Years: 3, 4, 5, 6, 7, 8, 9, 10

LEGEND
- Mandatory
- If not completed at the required age, must be completed at the first opportunity if age appropriate.
- For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/. For free online provider education: txhealthsteps.com.

E03-13634 July 1, 2018


Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at texashhs.org/texashealthsteps medicalproviders.

AGE | History | Nutritional Screening | MENTAL HEALTH: Mental Health: Psychosocial/Behavioral Health Screening; PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, CRAFFT, or other Psychosocial Questionnaire for Adolescents, or BIMS | TB Questionnaire with Skin Test if Risk Identified | Unclothed Physical Examination | MEASUREMENTS: Height; Weight; BMI; Blood Pressure | VISION: Visual Acuity; Subjective Vision | HEARING: Audiometric Screening; Subjective Hearing | Dental Referral | Screen/Administer Immunizations According to ACIP Guidelines | LABORATORY TESTS: Dyslipidemia; Type 2 Diabetes; STD/STI Screening; HIV Test | Health Education/Anticipatory Guidance

Years: 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

LEGEND
- Mandatory
- If not completed at the required age, must be completed at the first opportunity if age appropriate.
- For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: texashhs.org/texashealthstepscheckupcomponents. For free online provider education: txhealthsteps.com.

E03-13634 June 1, 2021

BlueCross BlueShield of Texas

Section 4

Behavioral Health Services

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Behavioral Health Services Hotlines

Behavioral Health Services Hotlines

- **1-877-688-1811 –** TX STAR Kids
- **1-888-657-6061 –** TX STAR and CHIP

Our Behavioral Health Hotline is available to assist members in obtaining access to needed behavioral health care. Additionally, our BH clinicians are available 24-hours a day, 7 days a week to provide crisis intervention and coordinate stabilization services.

- **988 Suicide & Crisis Lifeline:** Gives support for those who are in distress and crisis.

- **National Maternal Mental Health Hotline:** Gives support before, during and after pregnancy for those who feel overwhelmed or depressed.

Behavioral Health Services

Blue Cross and Blue Shield of Texas offers a variety of network providers who provide intervention and treatment options that are designed to promote stability and help our members.

PCP providers must have valid screening instruments to identify and refer children to providers specializing in evaluations to determine whether a child or young adult has a developmental disability or is at risk for or has Serious Emotional Disorder or another type of mental illness.

Treatment options include but not limited to:

- Inpatient Mental Health and Substance Use (Detox)
- Substance Use Residential Services
- Partial Hospitalization
- Intensive Outpatient Services
- Opioid Treatment Programs
- Mental Health Rehabilitation (MHR) Services
- Targeted Case Management (TCM)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Other behavioral health outpatient services covered by Medicaid and CHIP.

In Lieu of Services

What is an In Lieu of Service?

In-lieu-of services are services offered by MCOs that substitute for Medicaid state plan services or settings, as allowed by 42 Code of Federal Regulations (CFR) § 438.3(e)(2).

As allowed by 42 C.F.R § 438.6(e) and 42 C.F.R. § 438.3(e)(2), BCBS provides services in the following HHSC-approved settings in lieu of an acute care inpatient hospital setting:

- Inpatient services for acute psychiatric conditions in a freestanding psychiatric hospital for up to 15 calendar days per month for members aged 21-64 only.
- Residential substance-use disorder (SUD) treatment services delivered in a chemical dependency treatment facility.

BCBS Process:

- BCBSTX will follow the service authorization notice requirements described in UMCM 3.21 and provide written notice to both the provider and the member when in-lieu-of-services are authorized, reduced, or denied.
- BCBSTX will not require members to use in-lieu-of services or settings instead of a covered service or setting. BCBSTX may offer members the option of these services or settings when medically appropriate and cost-effective. Members must agree to receive in-lieu-of services before we authorize the service. Provider contracts will require the provider to document member choice and consent to receive the ILOS and to provide this documentation to BCBSTX upon request.

Outpatient Mental Health Services

Outpatient Mental Health Treatment Services

Outpatient mental health services are used for the treatment of mental illness and emotional disturbances in which the clinician establishes a professional contract with the person and, utilizing therapeutic interventions, attempts to alleviate the symptoms of mental illness or emotional disturbance, and reverse, change, or ameliorate maladaptive patterns of behavior.

Outpatient mental health services include but are not limited to psychiatric diagnostic evaluation, psychotherapy (including individual, family, or group), psychological, neurobehavioral, or neuropsychological testing, pharmacological management, and electroconvulsive therapy (ECT).

Outpatient mental health services are benefits when provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations.

Outpatient mental health services are benefits of Texas Medicaid and a service through BCBSTX, when provided to persons who are experiencing a mental health condition that is causing distress, dysfunction, or maladaptive functioning because of a confirmed or suspected psychiatric condition as defined in the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM).

Outpatient Mental Health Services – Provider Enrollment*

Mental Health service providers includes:

- Physicians
- Physician Assistants
- Advanced Practice Registered Nurses
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists**
- Licensed Professional Counselors**
- Psychologists
- Licensed Psychological Associates
- Provisionally Licensed Psychologists
- Post –Doctoral Fellows
- Pre-doctoral Psychology Interns

Providers are required to attest with the Texas Medicaid and Healthcare aPrtnership to participate in Medicaid and BCBSTX.

**LPCs and LMFT must registered with CMS.

****For more enrollment or licensure information please refer to the TMPPM Behavioral Health Manual Volume 2***

Outpatient Mental Health Services

Services provided by a psychologist, LPA, PLP, Psychology intern, or post-doctoral fellow must be billed with a modifier on each detail.

Psychological services provided by an LPA, PLP, psychology intern, or post-doctoral fellow must be billed under the supervising psychologist's NPI or the NPI of the legal entity employing the supervising psychologist.

Services performed by the LPA or PLP will be reimbursed at 70 percent and the psychology intern or post-doctoral fellow at 50 percent of the psychologist rate.

Claims submitted without a modifier or with two of these modifiers on the same detail will be denied. The following modifiers are to be used with procedure codes for licensed psychologist and delegated services:

Modifier	Description
AH	Identifies service provided by a clinical psychologist
UB	Identified service provided by a pre-doctoral psychology intern or post-doctoral psychology fellow
UC	Identifies service provided by an LPA
U9	Identifies service provided by a PLP

Note: Only the LCSW, LMFT, LPC, APRN, or PA performing the mental health service may bill Texas Medicaid. The LCSW, LMFT, LPC, APRN, or PA must not bill for services performed by people under his or her supervision.

Outpatient Mental Health Services – Procedure codes

The following procedure codes* may be reimbursed for outpatient mental health services:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90846	90847
90853	90870	90899	96116	96121	96130	96131	96132	96133	96136
96137									

****This is a limited list of the procedure codes associated with Outpatient Mental Health Services, please refer to the TMPPM Behavioral Manual Volume 2 for the full list of codes.***

Outpatient Mental Health Services – Psychotherapy

- **Individual Psychotherapy** is defined as therapy that focuses on a single person
- **Group psychotherapy** is defined as a type of psychotherapy that involves one or more therapists working with several persons at the same time.
- **Family psychotherapy** is defined as therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family's problem solving and communication skills.
- **Psychotherapy (individual, family, or group)** is limited to 4 hours per person, per day.
- **Psychotherapy is individual, group, or family psychotherapy visits per person**, per calendar year.

Providers must bill a modifier to identify a separate and distinct service when performing individual psychotherapy (procedure codes 90832, 90834, and 90837) and family psychotherapy (procedure codes 90846 or 90847) on the same day for the same person.

For more information regarding billing, telemedicine, Synchronous Audiovisual/Telephone and service limitations (and exclusions), please refer to the TMPPM Behavioral Health Volume 2.

Outpatient Mental Health Services – Family Psychotherapy

Family psychotherapy may be provided to Medicaid eligible persons 20 years of age and younger using procedure code 90846 or persons of any age using procedure code 90847.

Family psychotherapy is only reimbursable for one Medicaid eligible person per session regardless of the number of family members present per session.

Family psychotherapy for Medicaid eligible persons 20 years of age and younger may be provided to the child's parent(s), foster parent(s), or legal guardian without the child present, as clinically appropriate, using procedure code 90846. Parent- or guardian-only sessions may be indicated when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

For more information regarding billing and service limitations(and exclusions), please refer to the TMPPM Behavioral.v2.Section 4.2.

Outpatient Mental Health Services – Psychiatric Diagnostic Evaluation Services

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations.

Psychiatric diagnostic evaluation:

- With medical services also includes a medical assessment, other physical examination elements as indicated, and may also include prescription of medications, and laboratory or other diagnostic studies.
- Without medical services (procedure code 90791) may be reimbursed to physicians, psychologists, APRNs, PAs, LCSWs, LPCs, LMFTs, PLPs, psychology interns, and post-doctoral fellows.
- With medical services (procedure code 90792) may be reimbursed to physicians, APRNs, and PAs.

For more information regarding billing and service limitations (and exclusions), please refer to the TMPPM Behavioral Health Manual Volume 2.

Outpatient Mental Health Services – Psychological, Neurobehavioral, and Neuropsychological Testing Services

Psychological, neurobehavioral, and neuropsychological testing involves the use of formal tests and other assessment tools to measure and assess a person's emotional, and cognitive functioning to arrive at a diagnosis and guide treatment.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to eight hours per person, per calendar year. Additional hours require prior authorization when medically necessary.

Psychological, neurobehavioral, and neuropsychological testing will not be reimbursed to an APRN or a PA.

For more information regarding billing and service limitations (and exclusions), please refer to the TMPPM Behavioral Manual Volume 2.

Court-Ordered Services

Court-Ordered Services

The court-ordered services listed below for persons who are age 20 years of age and younger or 65 years of age and older are not subject to utilization management reviews that have the effect of denying, reducing, or controverting the court-ordered services including:

- Prior authorization
- Concurrent reviews
- Retrospective reviews

In these situations, the court order is considered the determination of medical necessity. When billed with modifier H9, court-ordered services are not subject to the 12-hour system limitation per provider, per day.

BCBSTX covers services that are court ordered, including substance use disorder treatment and inpatient/outpatient psychiatric services. Court-ordered services will not be clinically reviewed, reduced, limited or denied in any way that would controvert those court orders.

BCBSTX requests notification of admission to court-ordered care to ensure that claims will be paid appropriately, and proper coordination of care occurs. Providers may submit notification of admission and court order documents through fax or our provider portal.

For more information regarding Court – Ordered Services, please refer to the TMPPM Behavioral Health Manual Volume 2.

Intellectual Disability Service Coordination

Intellectual Disability Service Coordination, Mental Health Targeted Case Management, and Mental Health Rehabilitative Services

List of the various providers:

- Local Intellectual and Developmental Disability Authority (LIDDA) Providers
- Local Mental Health Authority (LMHA) Providers
- Non-Local Mental Health Authority (Non-LMHA) Providers
- Provider Credentials for Facilities Delivering MHTCM and Mental Health Rehabilitative Services
- Community Services Specialist (CSSP)
- Qualified Mental Health Professional – Community Services (QMHP-CS)
- Peer Provider
- Family Partner

Intellectual and Development Disabilities Service Coordination

Texas Medicaid provides the following:

Service coordination for persons who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community-based waiver (HCS); the Texas Home Living Waiver; or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

Service coordination funded by Medicaid as TCM is reimbursed by encounter.

There are two types of encounters:

Comprehensive encounter (Type A): A face-to-face contact with a person to provide service coordination. The comprehensive encounter is limited to one billable encounter per person per calendar month. HHSC will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per person per calendar month.

Supportive encounter (Type B): A face-to-face, telephone, or telemedicine contact with a person or with a collateral on the person's behalf to provide service coordination.

A LIDDA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

Mental Health Targeted Case Management (MHTCM)

Mental Health Targeted Case Management (MHTCM)

Mental health targeted case management (MHTCM) services are case management services provided to persons within targeted groups. The target population that may receive MHTCM as part of the Texas Medicaid Program are persons, regardless of age, with a diagnosis or diagnoses of mental illness or serious emotional disturbance (SED) as defined in the latest edition of the American Psychiatric Association's DSM, and who have been determined via a uniform assessment process to need MHTCM services.

Persons of any age with a single diagnosis of intellectual and developmental disabilities (IDD) and related conditions, or a single diagnosis of substance use disorder (SUD) are not eligible for MHTCM services.

MHTCM activities may be with the person, family members, LAR, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:

- Services are being furnished in accordance with the person's plan of care;
- Services in the plan of care are adequate in amount, scope, and duration to meet the needs of the
- person; and
- The plan of care and service arrangements are modified when the needs or status of the person
- changes.

Mental Health Targeted Case Management (MHTCM) - Eligibility

Under 20 Years of Age:

MHTCM is a benefit for persons who are 20 years of age and younger (child or youth) with a diagnosis or diagnoses of mental illness, or SED, as defined in the latest edition of the APA's DSM (excluding a single diagnosis of IDD and related disorders, or a single diagnosis of SUD) and who:

- ***Have been determined via the uniform assessment process to have a serious functional impairment and to need MTHCM services; or***
- ***Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or***
- ***Are enrolled in a school system's special education program because of SED.***

21 years and over:

MHTCM is a benefit for persons who are 21 years of age and older (adults) and who have serious mental illness (SMI), such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, or other severely disabling mental disorders (excluding a single diagnosis of IDD and related disorders or a single diagnosis of SUD) that require crisis resolution or ongoing and long-term support and treatment.

Mental Health Targeted Case Management (MHTCM) – Benefit Codes

MHTCM consists of intensive case management and routine case management. Intensive case management services are predominantly community-based case management activities provided to the child or youth or to the LAR on behalf of the child or youth (who may or may not be present) to assist a child or youth and caregiver or LAR in obtaining and coordinating access to necessary care and services appropriate to the child or youth's needs.

Routine case management services are 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.

Intensive case management and routine case management are benefits for persons who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day.

Routine case management is a benefit for persons who are 21 years of age and older.

Providers use procedure code T1017 and the appropriate modifier for MHTCM:

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

For more information regarding MHTCM including Telemedicine, Synchronous Audiovisual/Telephone, limitations (and exclusions), and billing. Please refer to the TPPM Behavioral Health Manual Volume 2.

Mental Health Rehabilitative and Targeted Case Management (MHTCM)

MHR and TCM services — including any limitations to these services — are described in the Texas Medicaid Provider Procedures Manual (TMPPM), and in the Behavioral Health, Rehabilitation, and Case Management Services Handbook). BCBSTX is not responsible for providing any services listed in those guidelines that are not covered services.

Providers of MHR and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment for adult members age 19 and 20, and the Child and Adolescent Needs and Strengths for members 18 and younger. Both are tools that can help assess a member's need for services and can recommend a level of care.

A provider entity must attest to BCBSTX that they or their organization has the ability to provide, either directly or through sub-contract, the full array of MHR and TCM services as outlined in the Texas Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

Texas HHSC has established qualifications and supervisory protocols for providers of MHR and TCM services. These requirements are located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

please visit Texas Medicaid & Healthcare Partnership website (Provider Manual: Behavioral Health and Case Management Services Chapter 7): **https://www.tmhp.com/resources/provider-manuals/tmppm**

Mental Health Rehabilitation (MHR) Services

Mental Health Rehabilitation (MHR) Services

Mental health rehabilitative services are defined as providing assistance in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goal as defined in their plan of care. Mental health rehabilitative services are provided to a person with a serious mental illness (SMI), as defined in the latest edition of the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental health rehabilitative services are age-appropriate, individualized, and designed to ameliorate functional impairments that negatively affect any of the following:

- Community integration
- Community tenure
- Behaviors resulting from SMI or severe emotional disturbance (SED) that interfere with a person's ability to remain in the community as a fully integrated and functioning member of that community.

Mental health rehabilitative services may include:

- Medication training and support services
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention services
- Day programs for acute needs

Mental Health Rehabilitation (MHR) Services – Eligibility

Certain mental health rehabilitative services (crisis intervention services, medication training and support, and skills training and development) are available to persons who are 20 years of age and younger with a diagnosis of mental illness or SED, as defined in the latest edition of APA's DSM and who:

- ***Have been determined via the uniform assessment process to have a serious functional impairment;***
- ***Are at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or***
- ***Are enrolled in a school system's special education program because of a SED.***

Functioning is assessed using the Child and Adolescent Needs and Strengths Assessment (CANS) standardized assessment tool for persons who are 17 years of age and younger and the Adult Needs and Strengths Assessment (ANSA) for persons who are 18 to 20 years of age, as well as any supplemental assessments, as needed.

Persons who are 21 years of age and older with SMI, determined to be medically necessary by a uniform assessment protocol, are eligible for mental health rehabilitative services if the adult is:

- ***A resident of the state of Texas;***
- ***Determined by a uniform assessment and clinician observation to require mental health rehabilitative services; and***
- ***An LPHA has determined that such services are medically necessary.***

Mental health rehabilitative services are available to persons who are 21 years of age and older who have an SMI and significant functional impairments which require crisis resolution or ongoing treatment. Functioning is assessed using the ANSA standardized assessment tool.

Mental Health Rehabilitation (MHR) Services – Benefit Codes

The following procedure codes are a benefit for mental health rehabilitation:

Service Category	Description	Modifiers
Day Program for Acute Needs	H2012	
Medication Training and Support	H0034	HQ: group services for adults HA/HQ: group services for child/youth
Crisis Intervention	H2011	HA: child/youth
Skills Training and Development	H2014	HQ: group services for adults HA: individual services for child/youth HA/HQ: group services for child/youth
Psychosocial Rehabilitation Services	H2017	TD: individual services provided by RN HQ: group services HQ/TD: group services provided by RN ET: individual crisis services

For more information regarding billing, service limitations, and additional services including telehealth, synchronous audiovisual/telephone under MHR Services, please refer to the TMPPM Behavioral Manual Volume 2.

Mental Health Rehabilitation (MHR) Services – Coordination of Care

Mental Health Rehabilitative (MHR) Services include training and services that help the member maintain independence in the home and community. Services include:

- **Medication training and support**: Curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of their mental illness or emotional disturbance and the role of medications in ensuring symptom reduction and increased tenure in the community

- **Psychosocial rehabilitative services**: Social, educational, vocational, behavioral or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development

- **Skills training and development**: Skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors and other skills necessary for independent living or functioning effectively with family, peers and teachers

- **Crisis intervention**: Intensive, community-based, one-to-one service provided to members who require services to control acute symptoms. These symptoms would otherwise place the member at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting.

Substance Use Disorder (SUD)

Substance Use Disorder (SUD) Services

SUDs are chronic, relapsing medical illnesses that require an array of best practice medical and psychosocial interventions of sufficient intensity and duration to achieve and maintain remission and support progress toward recovery. SUD may include problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, “club” drugs, other synthetic euphoriants), and other substances that may be identified in the future.

Treatment for SUD is a benefit of Texas Medicaid for persons who meet the criteria for a substance related disorder, as outlined in the current edition of the American Psychiatric Association’s (APA’s) Diagnostic Statistical Manual of Mental Disorders (DSM).
SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat a person’s problematic use of alcohol or other drugs, including prescription medication.

SUD services include:
- Withdrawal management services.
- Individual and group SUD counseling in an outpatient setting.
- Residential treatment services.
- Medication assisted treatment.
- Evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.

Substance Use Disorder (SUD) Treatment - Continued

SUD outpatient or residential treatment services may only be delivered in a licensed chemical dependency treatment facility (CDTF).

Withdrawal management, formerly known as detoxification, is the medical and behavioral treatment of persons experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use. Withdrawal management may be performed in an outpatient setting for persons experiencing mild to moderate withdrawal symptoms that can be successfully, as well as safely, managed outside of a residential setting or an inpatient hospital.

Withdrawal management in a residential setting may be required for persons whose multidimensional assessment indicates one or more of the following circumstances that would make outpatient withdrawal management unsafe or unsuccessful.

Residential treatment programs provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate. The frequency and duration of services should be based on meeting the person's needs and achieving the person's treatment goals.

Counseling for SUDs is designed to assist persons in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist persons in accordance with the plan. Counseling may be done individually or in a group setting with multiple members. Group counseling sessions are limited to a total of 16 persons per session.

Outpatient treatment services must be billed with ***procedure codes H0004 or H0005***.

Substance Use Disorder (SUD) Treatment – Medication Assisted Treatment Services

MAT is the use of FDA-approved medications in combination with psychosocial treatment to treat SUDs, particularly alcohol and opioid use disorders (OUD). Determination of which MAT medication to use is also an individualized treatment decision based on provider assessment and the person's needs and treatment goals. Providers are encouraged to offer as many treatment options as possible (within the parameters of their licensing and scope of practice) to maximize the person's choice and access to care.

MAT may be utilized as appropriate, as part of the service array delivered by outpatient providers or residential treatment services programs at CDTFs.

CDTFs, physicians, NPs, and PAs may prescribe and provide for the administration of long-acting injectable naltrexone (Vivitrol) to treat cravings associated with either OUD or AUD.

Physicians, PAs, and APRNs who are recognized by the Texas Board of Nursing as either NPs, CNSs, APRNs, or CNMs who have received a federal waiver to dispense buprenorphine may choose to incorporate this form of MAT into their medical practice while also providing or referring for other types of treatment services (also referred to as OBOT).

The following MAT procedure codes may be separately reimbursed from withdrawal management and treatment services in the outpatient or residential setting:

Procedure Codes						
H0020	H0033	J0570	J0576	J2315	Q9991	Q9992

Substance Use Disorder (SUD) Treatment – Opioid Treatment Providers

Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) opioid treatment providers (OTPs) that are also licensed as narcotic treatment programs in Texas are required to enroll in Medicare before enrolling with Texas Medicaid as OTPs. Providers billing claims for persons who have dual eligibility for Medicaid and Medicare must first submit their claims to Medicare.

The following procedure codes may be reimbursed to Opioid Treatment Providers:

Procedure Codes				
H0001	H0004	H0005	H0020	H0033
J0570	J0576	J2315	Q9991	Q9992

CDTFs cannot bill for OTP services through Medicare, as CDTFs are not Substance Abuse and Mental Health Services Administration certified (SAMHSA-certified) OTPs.

A comprehensive assessment (procedure code H0001) is limited to once per day, any provider. An assessment is also limited to once per episode of care and should be performed at the start of each new episode of care.

For more information regarding billing, service limitations, and additional services including telehealth, synchronous audiovisual/telephone under SUD Services, please refer to the TMPPM Behavioral Manual Volume 2.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment. These services are available to our members who meet the following criteria:

- 10 years of age and older and who have alcohol or substance use disorders;
- or are at risk of developing such disorders. SBIRT is used for intervention directed to a person and not
- for group intervention.

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

A person may have a maximum of two screening only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer the person to treatment if the screening results reveal severe risk of alcohol or substance use.

SBIRT is widely utilized tool for assisting persons who are experiencing substance use disorders including not limited to opioid treatment, alcoholism, and substance use disorders.

Providers who perform SBIRT must be training in the correct practice and required to complete at minimum 4 hours of training. For information on how to get trained in SBIRT please visit the following website: **http://www.samhsa.gov/**

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The SBIRT process consists of the following:

Screening: This process consist of utilizing an appropriate screening tool that allows for a provider to assess the severity of a member's substance use and to determine what level of treatment of service is appropriate. Screening must be conducted using a standardized screening tool.

Brief Intervention: Brief intervention is performed following a positive screen or a finding of at least a mild to moderate risk for alcohol or substance use. The session is also focused on motivating the person toward behavioral change. Subsequent screening and brief intervention sessions within the allowable annual limitations may be indicated to assess for behavior change and further explore a person's readiness to make behavioral changes related to their alcohol or substance use.

Referral to Treatment: The provider determines that the person is in need of more extensive treatment or has a severe risk for alcohol or substance use, the person must be referred to an appropriate substance use treatment provider. Referral is an essential component of the SBIRT intervention because it ensures that all persons who are screened have access to the appropriate level of care.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – Billing

SBIRT services are limited to persons who are 10 years of age and older. SBIRT services are limited to up to two screening sessions per rolling year. Procedure code 99408 or G2011 should be used when a brief intervention follows an SBIRT screening.

Procedure code 99408 is limited to once per day. SBIRT services are limited to four sessions per rolling year when it constitutes a screening followed by a brief intervention. If a person requires more than four combined screening and brief intervention sessions per rolling year, the person must be referred for substance use disorder treatment.

Procedure codes 99408, G2011, and H0049 will be denied if billed for the same date of service as any of the following procedure codes:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90847	90853
90865	90870	96130	96131	96132	96133	96136	96137		

For more information regarding billing, service limitations, and additional services including telehealth, synchronous audiovisual/telephone under SBRIT Services, please refer to the TMPPM Behavioral Manual Volume 2.

Peer Support Services

Peer Support Services – Enrollment criteria

In order to be eligible to become a Peer Support specialist, the peer specialist must meet all the following criteria:

- At least 18 years of age
- Have lived experience with a mental health condition, substance use disorder, or both
- Have a high school diploma or General Equivalency Diploma (GED)
- Willing to appropriately share his or her own recovery story with clients
- Demonstrate current self-directed recovery
- Pass criminal history and registry checks as described in 1 TAC §354.3201

To be certified as a peer specialist as specified in 1 TAC §354.3155, a candidate must complete the following training:

- Required orientation
- Self-assessment activities
- Core training delivered by a certified training entity
- Supplemental training in one of two specialty areas:
    - Mental health peer specialist
    - Recovery support peer specialist

The candidate can apply for initial certification after successful completion of core and one supplemental training and a knowledge assessment.

Peer Support Services – Overview

Peer specialist services (procedure code H0038) for a mental health or substance use condition, or both, are a benefit of Texas Medicaid for persons who are 21 years of age and older, and who have peer specialist services included as a component of their person-centered recovery plan. Peer specialist services are recovery-oriented, person-centered, relationship-focused, voluntary, and trauma-informed.

Peer specialist services are based on a mutual relationship between the peer specialist and the Medicaid eligible person. A peer specialist uses his or her lived experience to support the person with the following:

- Achieving the goals and objectives of the person's individualized recovery plan
- Skill development
- Problem solving strategies
- Coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder

A peer specialist ***must not*** perform the following services:

- Practice psychotherapy.
- Make clinical or diagnostic assessments.
- Dispense expert opinions.
- Engage in any service that requires a license.
- Falsify any documentation related to application, training, testing, certification, or services provided.

Peer specialist services can be delivered individually or in a group setting

Peer Support Services – Overview Continued

Peer specialist services may be delivered as part of a coordinated, comprehensive, and individualized approach to treating a person's mental health or substance use condition, or both, if the peer specialist is employed by one of the following Medicaid-enrolled provider types:

Only clinic/group practices or behavioral health care individual providers (M.D., D.O., NP, CNS, and PA) with a behavioral health focus may be reimbursed for peer specialist services. Peer specialists coordinate with all behavioral health service providers involved in the person's care and utilize a person-centered, recovery-oriented approach to treatment planning and service delivery.

For more information regarding billing, service limitations, and additional services including telehealth, synchronous audiovisual/telephone under Peer Support Services, please refer to the TMPPM Behavioral Manual Volume 2.

Inpatient Psychiatric Services

Inpatient Psychiatric Services

Inpatient psychiatric services admissions to acute hospitals are a benefit of Texas Medicaid for persons of all ages in a fee-for-service Medicaid or MCO.

Admissions to psychiatric facilities, i.e. Institutions for Mental Disease (IMD), for inpatient psychiatric services are a benefit of Texas Medicaid for:

- For persons 20 years and younger or 65 and older in fee-for-service Medicaid.
- Persons 21 through 64 years of age receiving services agree to an IMD as setting for inpatient psychiatric services and enrolled in managed care as an in lieu of service. The benefit is for a maximum of 15 calendar days per month, not per stay.

For more information regarding billing, service limitations, and additional services including telehealth, synchronous audiovisual/telephone under Inpatient Psychiatric Services, please refer to the TMPPM Behavioral Manual Volume 2.

Coordination of Care, Collaborative Care Model, Referrals, and Quality Programs

Coordination of Care

BCBSTX requires that behavioral health providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the consent of the member or the member's legal guardian. Behavioral health providers may provide physical health care services only if they are licensed to do so.

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information helps improve both behavioral and medical health care.

To support PCPs as they identify and manage a member's mental health and behavioral health needs, BCBSTX provides a variety of behavioral health tips and hosts behavioral health education webinars. More information is on our website.

Coordination of Care - Continued

- Both the PCP and behavioral health provider should coordinate medical and behavioral health services with the Local Mental Health Authority and state psychiatric facilities regarding admission and discharge planning for members with Serious Emotional Disorders (SED) and Serious Mental Illness (SMI), if applicable.
- Both the PCP and behavioral health provider should complete and send the member's consent for information release to the collaborating provider.
- Both the PCP and behavioral health provider should share information — per conditions of the patient release — to help coordinate care for the member.
- Both the PCP and behavioral health provider should note contacts and collaboration in the member's chart.
- Both the PCP and behavioral health provider should respond to requests for collaboration within one week, or immediately if an emergency is indicated.
- The behavioral health provider should send a completed coordination of care/treatment summary form to the member's PCP when they have seen a member.
- The behavioral health provider should send to the member's PCP an initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status.
- The behavioral health provider should contact the PCP when making a change in the behavioral health treatment plan.
- The PCP should contact the behavioral health provider when the PCP determines the member's medical condition could be expected to affect the member's mental health treatment planning or outcome. The PCP should document the information on the coordination of care/treatment summary.

Volunteer Participation in Provider Quality Meetings

Providers could participate in BCBSTX Medicaid Provider Advisory Group (PAG) meetings, which is held quarterly.

During these meetings BCBSTX works with all provider types to help promote a way to share information between BH, PCP, and other specialty providers.

The purpose of this meeting is to help create space where providers express techniques or helpful best clinical practice guidelines for coordination of care with our members.

These meeting also create the opportunity for BH providers to share feedback on our clinical policies and UM practices to improve the quality of care and experience for the BH providers and members.

BlueCross BlueShield of Texas

Section 5

Applied Behavioral Analysis

Applied Behavior Analysis (ABA) Overview

When submitting a prior authorization request for a Blue Cross and Blue Shield of Texas Medicaid member to receive Applied Behavioral Analysis services, clinical documentation must be included.

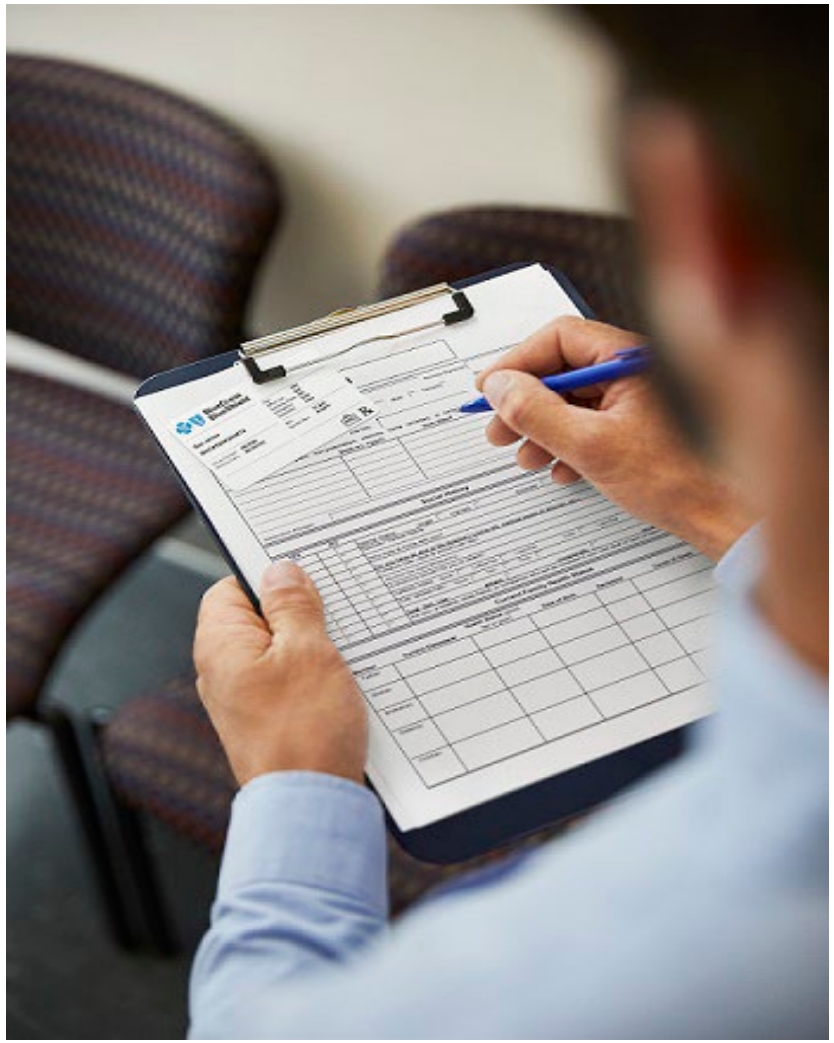
The clinical documentation should be sent via fax **1-888-530-9809** or electronically submitted through our provider portal.

Before submitting the prior authorization request, please ensure all the following items are included for each request type:

- ABA Initial Evaluation
- ABA Initial Treatment
- ABA Initial Extension
- ABA Re Evaluation & Recertification
- The LBA must submit documentation attesting

Please submit the Applied Behavioral Request form to **1-888-530-9809.**

For further information and requirements please visit our **ABA website page.**



Applied Behavior Analysis (ABA) - Billing

What are the ABA billing codes?

If services billed exceed the limitations outlined in this section, the claim will be denied, and may be appealed.

Autism services are reimbursed in accordance with Title 1 Texas Administrative Code § 355

Direct treatment for the child or youth is limited to a total of 8 hours per day, inclusive of procedure codes 97153, 97154, 97155, and 97158.

The following modifiers may be required for ABA services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavioral analyst
HM	Behavior technician
95	Telehealth

For clients who are 20 years old and younger, the limitations listed below may be exceeded with evidence of medical necessity. The following procedure codes will be authorized for a 30-day authorization period for ABA evaluation or re-evaluation:

ABA Initial Evaluation		
Procedure Code	Limitations	Modifier Options
9751	Limit to 6 hours	HO only

ABA Initial Evaluation		
Procedure Code	Limitations	Modifier Options
9751	Limit to 6 hours	HO only

The following procedure codes may be reimbursed for ABA individual treatment:

ABA Services	
Procedure Code	Modifier Options
97153	No modifier required
97155	HO and/or HN

The following procedure codes may be reimbursed for ABA group treatment services:

ABA Services	
Procedure Code	Modifier Options
97154	No modifier required
97158	HO and/or HN

The following procedure codes may be reimbursed for ABA parent or caregiver, family education, and training services:

ABA Services	
Procedure Code	Modifier Options
97156	HO and/or HN

The following procedure codes may be reimbursed for interdisciplinary team meetings attended by qualified nonphysician health-care providers:

Interdisciplinary Team Meeting	
Procedure Code	Modifier Options
99366	No modifier required

Applied Behavior Analysis (ABA) – Billing Continued

Each claim submitted with procedure code 97151 requires the following modifier:

Evaluation and Re-evaluation	
Modifier	Description
HO	Licensed behavior analyst

Each claim submitted with procedure codes 97155, 97156, and 97158 requires one of the following modifiers:

ABA Services	
Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst

Claims submitted with procedure codes 97153 and 97154 may include the following modifiers for information purposes:

Behavior Technician Level Services	
Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician

The following procedure codes may be delivered via telehealth::

Procedure Codes	Required Modifier to Designate Remote Delivery
97151	95
97155	95
97156	95
97158	95
99366	95

The following billing codes does not include all code types, units, and limitations. Please visit the TMHP Children's Services Handbook for additional details for ABA billing.

In addition, BCBSTX reimburses all ABA services at the Texas Medicaid Fee Schedule.

BlueCross BlueShield of Texas

Section 6

Utilization Management and Service Coordination

Utilization Management

BCBSTX Utilization Management (UM) Team collaborates with providers to promote and document the appropriate use of health care resources.

Utilization Management takes a multidisciplinary approach to help provide access to health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

Behavioral Health authorization is based on medical necessity and will be contingent upon eligibility and benefits. It is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications with the exception of Texas Health Steps Service for children from birth through 20 years of age.
For these services, medical necessity is based on the clinical documentation received by the utilization management department when requesting a BH prior authorization.

BH Providers may call Utilization Management toll-free for **STAR and CHIP** at **1-877-560-8055 and STAR Kids at 1-877-784-6802** with questions and/or requests, including requests for urgent/expedited prior authorization and urgent concurrent/continued stay review. An on-call clinicians will provide assistances for any urgent after hours needs.

Utilization Management attempts to return calls the same day they are received during normal business hours. Calls received after normal business hours will be returned the next business day. All routine requests will be responded to within **24 hours**.

BH Providers may fax Utilization Management a t **1-888-530-9809** for **STAR, CHIP and STAR Kids** with requests for urgent/expedited and non-urgent prior authorization and concurrent/continued stay review. Faxes are accepted during normal business hours as well as after hours.

Faxes received after hours will be processed the **next business day**.

Eligibility verification, benefits, and network information may be available after normal business hours at **www.availity.com**.

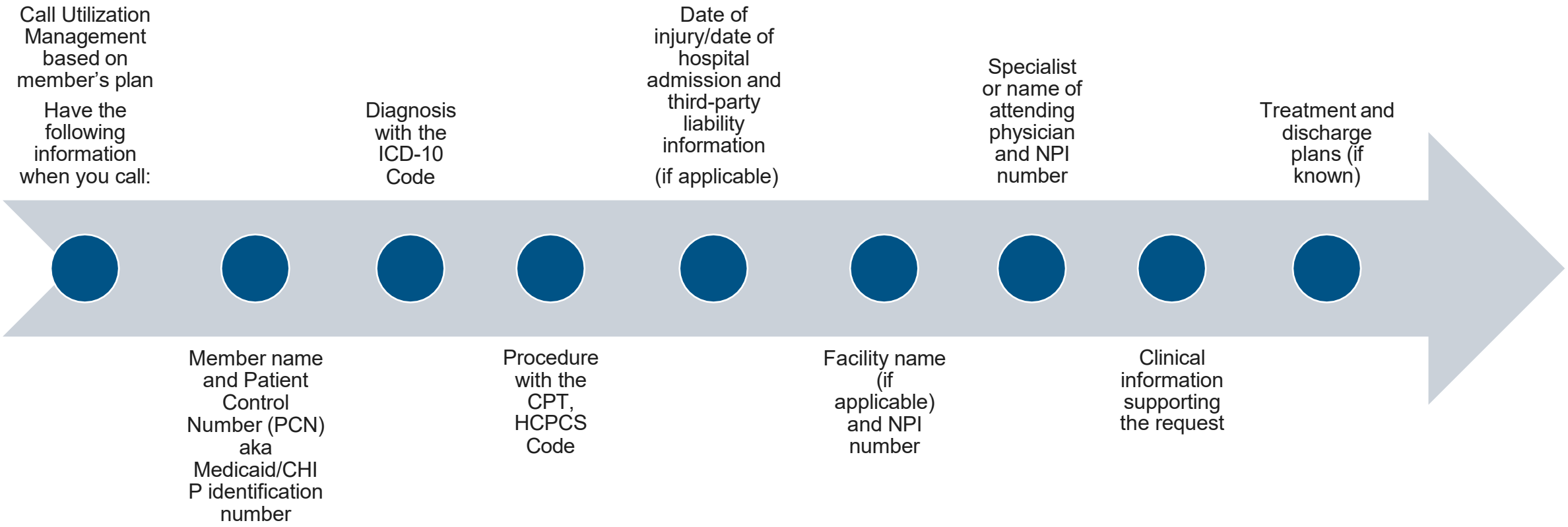
BCBSTX Utilization Management (UM) Team has the responsibility for ensuring medical reviews such medical necessity, fraud waste and abuse, pre-payment reviews, audits and other monitoring.

In coordination with BCSTX Quality Team, BH providers must adhere to the rules and regulations of applicable Texas Medicaid laws.

As a BH provider for BCBSTX, you may be subject to the following activities:

- Medical Record Reviews (utilizing HEDIS)
- Provider Surveys
- Member Surveys
- Random audits of medical records
- Claims and Encounter Data Review

Submitting a Prior Authorization Request



Submitting Prior Authorization Time Frames:

One Business Day

- Concurrent Stay requests (when a member is currently in a hospital bed) = **Urgent Concurrent**
- Urgent prior authorization requests are initiated before outpatient services have been provided and are reviewed within this time frame.*
- Within one hour of receiving a request for post-stabilization or life-threatening conditions, **except** for Emergency Medical Conditions and Emergency Behavioral Health Conditions, BCBSTX does not require prior authorization.

Three Business Days

Prior authorization routine requests (before outpatient service has been provided or prior to an elective admission)

***URGENT Prior Authorization is defined as a condition that a delay in service could result in harm to a member.**

BlueCross BlueShield of Texas

Service Coordination

Service Coordination Team - STAR and CHIP

Service Coordination is a benefit provided to STAR and CHIP members to help manage their health care needs. You can help coordinate care for our members and improve their health by working directly with them and their family. Our Blue Cross and Blue Shield Service Coordinator will look at the member's medical, behavioral, social and educational needs and work with other specially trained team members of the BCBSTX Service Coordination team to design a care plan.

Make care plans, answer questions and talk to our members about ideas to reach their health goals	Help set up care with your doctor and specialists	Help our members, their family and caregiver better understand their health condition(s), medications and treatments	Get the community support and services our members need: Behavioral Health Treatment Durable Medical Equipment (DME) Home health nursing Medical supplies Physical, Occupational, & Speech Therapy Transportation

IF our member is eligible for these services, and the service is medically necessary, **providers** have a **responsibility** to provide or coordinate these services. The BCBSTX dedicated Service Coordinator will help you coordinate these services. Please refer to Provider Manual for in-depth information regarding Service Coordination including roles and types of service coordination services.

Service Coordination Team - STAR Kids

Service Coordination is a STAR Kids benefit that helps our members choose services and plan so that our members can live in the most independent setting possible.
A BCBSTX service coordinator will work directly with the members, their family and you to meet health care and long-term services or support needs.

Make home visits and find out what our members needs are	Complete the Child's STAR Kids assessment tool and Individual Service Plan	Help answer questions and talk to our members about ideas they have about how to reach their health goal	Get the right care with the right doctor	Provider Adult transition planning and Discharge Planning	Get the community support and services our members need: Behavioral Health Treatment Durable Medical Equipment (DME) Home health nursing Medical supplies Physical, Occupational, & Speech therapy Transportation

IF our members are eligible for these services, and the service is medically necessary, **providers** have a **responsibility** to provide or coordinate these services. **Please note**, for members who may need access to **IDD supports and HCBS Waiver services**, please ensure appropriate evaluation and psychometric testing is performed, this is **required** prior to approval of services.

The BCBSTX dedicated Service Coordinator will help you coordinate these services. Please refer to Provider Manual for in-depth information regarding services. ng Service Coordination including roles and types of service coordination services.

Coordination of Care: Health Home

Health Home is described as a designated provider including a provider that operates in coordination with a team of health care professionals or a Health Team selected by a member with chronic conditions to provider health home services.

Health Homes Services is described as a comprehensive and timely high-quality services that are provided by a Designated Provider, a Team of Health Care Professionals operating with such a provider or a Health Team. Health Home Services include: Comprehensive Care Management; Care Coordination and health promotion; comprehensive transitional care; including appropriate follow up from inpatient to other settings; member and family support (including authorized representatives); referral to community and social support services and; if relevant use of health information technology to link services as feasible and appropriate.

Providers play a crucial role with maintaining and developing a Health Home. We encourage provider to work with the service coordination team and monitor member's progress. Please contact your member’s service coordinator for more information about Health Home.

Contacting Service Coordination

Providers are encouraged to reach out to service coordination when services such as OT, PT, DME, Behavioral Health, etc. are identified or member expresses need for such services. In addition, providers can refer members for other services like disease management.

If at anytime you have questions or concerns related to service coordination feel free to contact our service delivery team.

Contact Information:

STAR/CHIP
Phone: 1-877-214-5630
Fax: 1-866-644-5456
Email: TX_Medicaid_HC@bcbstx.com

STAR Kids
Phone: 1-877-301-4394
Fax: 1-866-644-5456
Email: TX_Medicaid_HC@bcbstx.com

BlueCross BlueShield of Texas

Section 7

Claims Submission

Provider Compensation

BCBSTX or Payer will pay Physician for Covered Services rendered to Members less any applicable Member Copayments, Coinsurance or Deductible amounts (refer to your provider contract).

General Information :

- Physician shall accept such compensation, and any applicable Member Copayment, Coinsurance or Deductible as Physician’s only compensation for Covered Services.
- BCBSTX or Payer shall make such payment for services within thirty (30) days of receipt of Clean Claims regardless of submission format. If Medicaid is a secondary insurer, then a claim must include the amount paid as a covered claim by the primary insurer to be a Clean Claim.
- Rates are determined by the Texas Medicaid Fee Schedule unless previously negotiated.
- In the event of reimbursement rate reduction across all BCBSTX providers. BCBSTX will notify the provider and Health Human Services Commission (HHSC). Across the board Rate Reductions must be first approved by HHSC before being implemented. Notification to HHSC must be done 90 days prior to rate reduction effective date.

No Balance Billing Members

Blue Cross and Blue Shield of Texas (BCBSTX) Medicaid reminds all Medicaid doctors or hospitals who accept Medicaid – STAR, STAR Kids, and CHIP plans are **prohibited** from balance billing our members for services that Medicaid covers. (**Note**: CHIP members are responsible for their co-payments, co-insurance, and deductibles as applicable).

What is Balance Billing?

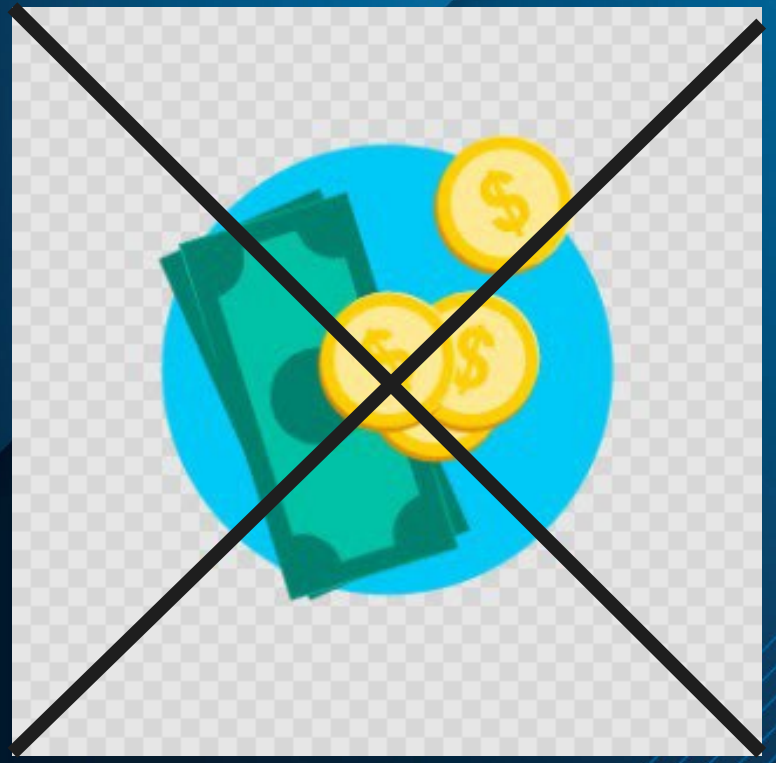
Balance billing is the practice in which providers bill Medicaid and CHIP eligible members for covered services. A member cannot be billed for charges beyond reimbursement paid under Texas Medicaid for covered services.

Act Now

•Verify member's eligibility prior to every service. Providers who are registered with Medicaid may visit the TMHP website to verify members' eligibility if our member forgot their insurance card.

•Availity is an application your office can register with at no cost to verify member coverage.

Please contact your BCBSTX Network Representative at **1-855-212-1615**



Fraud, Waste, or Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care provider or a person getting Medicaid benefits is doing something wrong. Doing something wrong could be fraud, waste or abuse, which is against the law.

Examples of Fraud, Waste and Abuse:

- A health care professional getting paid for services that weren't given or needed
- Altering medical records
- Use of unlicensed staff
- Drug diversion (e.g., dispensing controlled substances with no legitimate medical purpose)
- Kickbacks and bribery
- Providing unnecessary services to members.

To report fraud, waste, or abuse, choose one of the following:

- Call the Office of Inspector General (OIG) Hotline at **1-800-436-6184**
- Report Waste, Abuse and Fraud online ; or
- You can report directly to your health plan:

  Blue Cross and Blue Shield of Texas
  P.O. Box 660044
  Dallas, Texas 75266-9506

Post-Payment Claim Audit:

Post-payment review strategies are among the most effective cost avoidance and waste prevention activity. BCBSTX reserves the right to complete audits of a provider claim no later than 3 years after the receipt of a clean claim. The 3 year look back period does not apply in cases of provider Fraud, Waste, and Abuse.

Other limitations may include the following scenarios:

- 3 year limitation does not apply when HHSC has recovered capitation from BCBSTX based on member's eligibility.
- 3 year limitation does not apply when conducting Prior Authorization examination, audits or inspection, even if its more than 3 years after BCBSTX received the claim.

If during any audit, BCBSTX identifies that a provider is owed an additional payment, BCBSTX will submit the payment no later than 30 days after completion of the audit. If audit determines a refund payment is owed to BCBSTX, provider will receive written notice from BCBSTX explaining in detail the reason for refund. Please note, a provider has the right to appeal such findings. BCBSTX will not recover any payment until the provider has exhausted all appeal rights.

Overpayments Identified by Providers:

Providers must notify BCBSTX in writing within 30 days of discovery of the overpayment. There are multiple ways to BCBSTX can remediated overpayments by refund or recoupment. BCBSTX will work with provider to determine best course of action.

Fraud, Waste, or Abuse - Continued

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  P.O. Box 660044
  Dallas, Texas 75266-9506

BlueCross BlueShield of Texas

How to Submit a Claim?

Availity

www.availity.com

Claims Submission
Claims Status

How to get claims paid quickly

Benefits of Electronic Data Interchange (EDI) and Claims Portals

Timely Filing Limit: 95 calendar days from the date of service or per provider agreement or contract

- Convenient expedited claims processing
- Able to confirm, correct errors, and resubmit batch status electronically
- Portals/EDI Vendors
- TMHP Claims Portal
- Availity® Essentials
- HIPAA compliant and meet federal requirements

Paper Claims Submission

- Paper Claims
- CMS - 1500 = Professional
- CMS - 1450 = Institutional
- **Paper Claims Address**:
- Blue Cross and Blue Shield of Texas
  PO Box 650712
  Dallas, TX 75265-0712

Electronic Claim Submission

- Electronic Data Interchange (EDI)
- Electronic Payor ID: 66002

Using Availity® Essentials for Claims Submission and Status

For electronic claim submissions, providers can submit and review claim status through the Availity® Essentials

The Availity® Essentials is HIPAA-compliant method of receiving claim payment and remittance details from BCBSTX.

For more information on how to register with Availity® Essentials, please visit:

www.availity.com/Essentials-Portal-Registration

Electronic Claim Submission via Availity Provider Portal

Availity Provider Portal

Availity's Claim Submission tool allows providers to quickly submit electronic Professional (ANSI 837P) and facility, or Institutional (ANSI 837I) claims or encounters to Blue Cross and Blue Shield of Texas (BCBSTX), at no cost. Use this online tool to submit a single claim or add to batch and send multiple claims to BCBSTX at the same time. Once submitted, you can confirm BCBSTX's receipt of the claim(s) and check claim status in real-time, all within the Availity Portal.

You must be registered with Availity to use the Claim Submission tool for electronic professional. You can sign up today at Availity, at no charge. For registration assistance, call Availity Client Services at **1-800-282-4548.** This Availity Portal option does not require the use of a separate clearinghouse or practice management system.

How to access and use Availity's Claim Submission tool:

1. Log in to Availity
2. Select **Claims & Payments** from the navigation menu
3. Select **Professional Claim** or **Facility Claim**
4. Within the tool, select your **Organization, Transaction Type and Payer**
5. Complete the required fields

For additional details, refer to the **Electronic Professional Claim Submission User Guide**

Claims Status Tool via Availity Provider Portal

Availity Provider Portal

The Availity Claim Status Tool is the recommended electronic method for providers to acquire detailed claim status for claims processed by Blue Cross and Blue Shield of Texas (BCBSTX) for the following members:
Government Programs – including Texas Medicaid Providers can improve their accounts receivable and increase administrative efficiencies by utilizing the Claim Status tool to check status online for all your BCBSTX patients. Results are available in real-time and provide more detailed information than the HIPAA-standard claim status (276/277 transaction).

Quick Reference for Availity's Claim Status Tool:
Quick Reference:
→ Refer to page 7 to view claim status results for government programs claims
→ Refer to page 8 and 9 to view basic HIPAA-standard claim status results (276/277 transaction)
For additional details, refer to the **Electronic Professional Claim Status User Guide**

Texas Health Steps (THSteps) Claims

The Current Procedural Terminology (CPT®) codes are available in the Texas Medicaid Provider Procedure Manual (TMPPM).

Providers, including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) should contact: The appropriate medical or dental managed care plan, or TMHP for patients with fee-for-service coverage.

For more information regarding the Texas Health Steps Program or billing, please visit our Texas Health Steps (THSteps) Toolkit:

www.bcbstx.com/provider/medicaid/education-and-reference/texas-health-steps

Durable Medical Equipment (DME) Required Documentation

Durable Medical Equipment (DME) providers must disclose the following records to the Texas Health and Human Services Commission (HHSC) or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until the audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these service is subject to retrospective review.

Durable medical equipment providers must retain the following documents:

Required DME Documents
Home Health Services (Title XIX) DME/ Medical Supplies Physician Order forms:

- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms
- Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms
- Ordering Physicians must maintain copies of the completed, originally signed and dated forms in their records.

Required DME Documents
Delivery Slips

- Providers must retain individual delivery slips or invoices for each DOS that shows the date of delivery of all supplies provided to the client.
- Documentation of delivery must include one of the following:
  - Delivery slip or corresponding invoice signed and dated by client or caregiver.
  - A dated carrier tracking document with shipping date and delivery date must be printed from the carrier's website as confirmation. The dated carrier tracking document must be attached.
- The following must be included in the dated delivery slip:
  - Client's full name
  - Address where supplies were delivered
  - Itemized list of goods (includes descriptions and numerical quantities)
  - Corresponding tracking number from carrier.

Required DME Documents
Claims Submission

- All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on the Home Health Services (Title XIX) forms.
- The number of units by which each product is measured must be included.
- Must be one dated delivery slip or invoice for each claim submitted for each client.
- All claims submitted for medical supplies must reflect either one business day before or after the date of service as documented on the delivery slip or corresponding invoice and the same information covered by the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
- The DME Certification and Receipt Form is still required for all equipment delivered.

BlueCross BlueShield of Texas

Section 8

Submitting Complaints, Appeals and Reconsiderations

Submitting a Member Complaint

A Complaint is defined as any expression of dissatisfaction about any matter related to BCBSTX except for an action or an adverse determination (i.e. any denial, reduction, or termination of benefits in whole or in part denial of services).

A member or provider or authorized representative can file a complaint.

A complaint can be **filed anytime**.

Within 30 Calendar days of receipt of complaint, it must be resolved.

Note: If the member is minor or is incompetent or incapacitated, the parent, guardian, conservator, relative or other designee of the member, as appropriate, may submit the complaint.

Ways to Submit Complaints :
Call a Customer Advocate at
1- 888-657-6061 STAR and CHIP
1-877-688-1811 STAR Kids
submit in writing to:

Call a BCBSTX Member Advocate toll free at 1-877-375-9097 (711).

Return the **Complaints form** to:
Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Dept.
PO Box 660717
Dallas, TX 75266-0717
Fax: 1-855-235-1055

Call the Managed Care Help Line: 1-866-566-8989 (toll free).

Texas Health and Human Services Commission
Office of the Ombudsman,
MC H-700
P.O. Box 13247
Austin, TX 78711-3247
Fax: 1-888-780-8099 (toll-free)

Note: For more information on how a member can submit a complaint: **HHSC Member Complaints**.

Submitting a Provider Complaint

Physician and other professional provider complaints and appeals are classified into categories for processing by BCBSTX as follows:

Complaints relating to the operations of BCBSTX.

Physician and other professional provider appeals related to Adverse Determinations.

Physician and other professional provider appeals of non-medical necessity claims determinations.

Ways to Submit Complaints :
Calling Customer Service at
1- 877-560-8055 STAR and CHIP
1-877-784-6802 STAR Kids
submit in writing to:

Texas Health and Human Services Commission Provider Complaints
Health Plan Operations, H320
P.O. Box 85200
Austin, TX 78708

Complaints may also be emailed to:
HPM_complaints@hhsc.state.tx

CHIP care providers: Texas Department of Insurance (TDI)
Texas Department of Insurance
Consumer Protection
(MC: CO-CP)
P.O. Box 12030
Austin, TX 78711 -2030
Complaints may also be emailed to:
ConsumerProtection@tdi.texas.gov

Submitting Appeals

Filing a Standard Appeal:

An Appeal is defined as a request for review of an action or adverse determination, which is any denial, reduction, or termination of benefits in whole or in part.

Within **60 Calendar** days of the notice date on an action letter advising of the adverse determination, a Member or Provider may file an appeal.

Appeals and Resolved Dates:
Within **5 Business** days Acknowledgement letter sent to providers
Within **30 Calendar** days (standard appeal) unless extension is needed
Within **72 hours** (emergency appeals)
Within **1 working day** (if a request for continued stay)

Submit an Appeal, State Fair Hearing or External Medical Review request by calling:
A Customer Advocate at **1-888-657-6061 (711)** as first option
A Member Advocate at **1-877-375-9097 (711)**

Provider Appeal Request Form

BlueCross BlueShield of Texas

Provider Appeal Request Form

- Please complete one form per member to request an appeal of an adjudicated/paid claim.
- Fields with an asterisk (*) are required.
- Be specific when completing the "Description of Appeal" and "Expected Outcome."
- Please provider all **supporting documents** with submitted appeal.
- Appeals received **incomplete appeals form or missing documents will be returned for your completion**
- Appeals must be submitted within 120 days of the remittance date.
- Mail or Fax the completed form to:

Blue Cross and Blue Shield of Texas
Attn: Complaint and Appeal Department
P.O. Box 660717
Dallas, Texas 75266
Fax: (855) 235-1055

Line of Business Type*:(Check One): ☐ **CHIP** ☐ **STAR** ☐ **STAR Kids**
Provider Name*: _____
National Provider Identifier (NPI) Number: _____ Texas Provider Identifier _____
Tax ID Number: _____
Street Address*: _____
City*: _____ S _____
Provider Type: ☐ PCP - Primary Care Physician ☐ ☐ Hospital
☐ DME -Durable Medical Equipm
☐ FQHC/RHC

SAMPLE

CLAIM INFORMATION
Member Name*: _____ rth: _____
Subscriber ID Number or Medicai _____
Original Claim ID Number(s)/Correc r(s): _____
Service "From/To" Dates* (dates of se _____/_____
Original Claim Amount Billed: _____ Original Claim Amount Paid: _____
Appeal Reason*: ☐ Eligibility ☐ Coordination of Benefits ☐ Authorization ☐ Claim Payment Incorrectly ☐ Timely Filing
☐ Medical Necessity ☐ Other
_____
_____
_____
_____
Expected Outcome*: _____
Contact Name (please print)*: _____ Title: _____
Phone Number*: _____ Fax Number: _____
Signature: _____ Date: _____

☐ **Check here if medical records are attached.** ☐ **Check here if additional information is attached.**
For Health Plan Use Only Appeal Number: _____

Provider appeals acknowledgement receipt will be sent to organization first (5) days and resolved within (30) days of receipt.
- This is not a claims reconsideration form. Please use the claims reconsideration located at www.bcbstx.com/provider/medicaid/

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
SKSCP-9158-19

Submitting Fair Hearing

State Fair Hearings and External Medical Reviews:
A STAR or STAR Kids member who is not satisfied with the decision made on the appeal can request a State Fair Hearing with or without an External Medical Review. A request must be submitted within 120 days from the notice of adverse determination (CHIP members can request an IRO).
Appeals, State Fair Hearings and External Medical Review request forms can be submitted to: Blue Cross and Blue Shield of Texas Attention: Appeal Department P.O. Box 660717 Dallas, TX 75266-0717 Fax: **1-855-235-1055** Email: **GPDTXMedicaidAG@bcbsnm.com.**
Find plan specific complaints, appeals, State Fair Hearing and External Medical Review forms at the respective member site. **www.bcbstx.com/starkids** **www.bcbstx.com/chip** **www.bcbstx.com/star**

Submitting Claims Reconsideration

Claims reconsideration is review of a claim for payment reconsideration. Claims are either rejected at the EDI gateway, or the claims is adjudicated in our claim system for payment reconsideration.

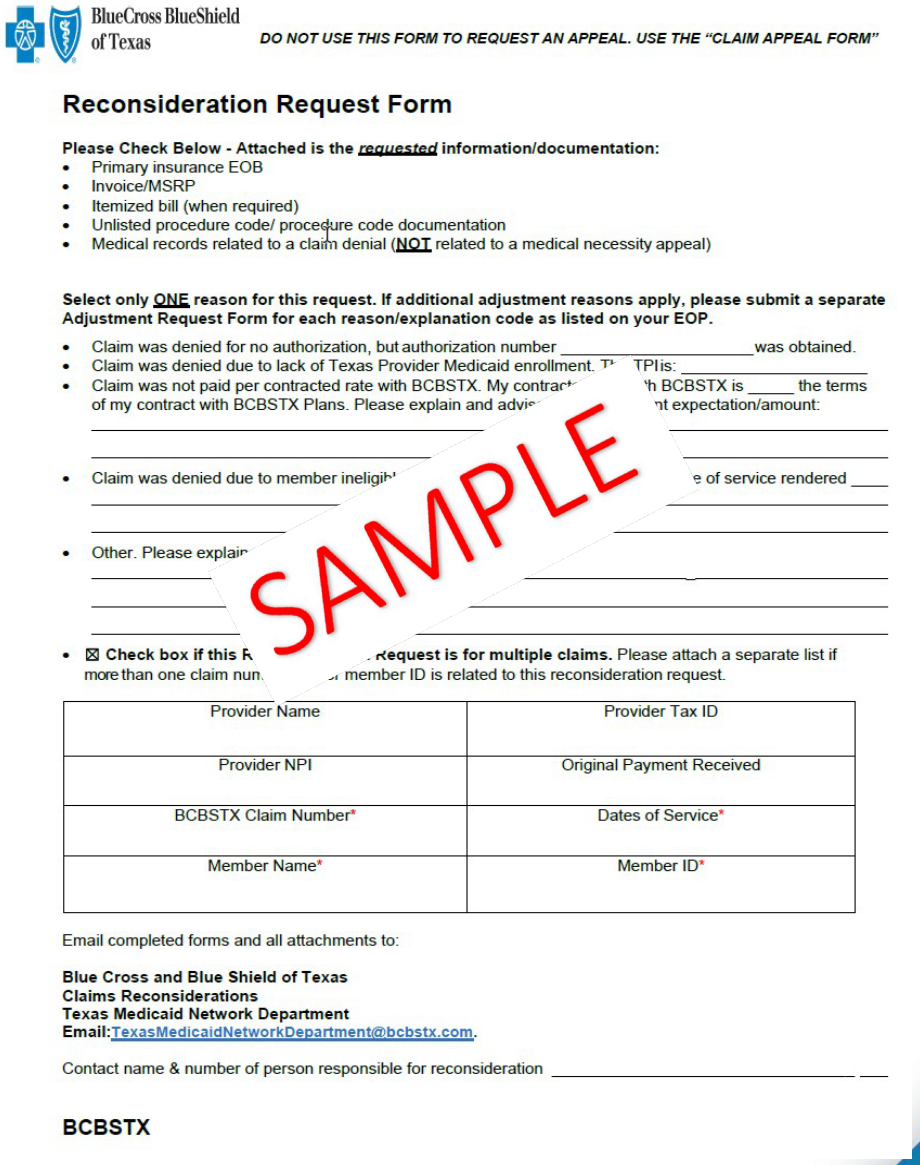
Provider or authorized representative can file a claims reconsideration.

Deadlines:
95 days from initial timely filing
120-day claims reconsideration deadline from date of first denial

What must be included with submission
Certain claims must be sent with accompanying documentation for a claim to be reconsidered:
- Reconsideration Request Form
- Primary Insurance EOB
- Sterilization forms
- Invoice/MSRP
- Itemized bill
- Unlisted procedure code/procedure code documentation
- Medical records related to a claim denial

Email completed form and all attachments to:
Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email: TexasMedicaidNetworkDepartment@bcbstx.com

Claims Reconsideration Request Form



BlueCross BlueShield of Texas

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:
- Primary insurance EOB
- Invoice/MSRP
- Itemized bill (when required)
- Unlisted procedure code/ procedure code documentation
- Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.
- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. TPI is: _____
- Claim was not paid per contracted rate with BCBSTX. My contract with BCBSTX is _____ the terms of my contract with BCBSTX Plans. Please explain and advise of expectation/amount:
- Claim was denied due to member ineligibility. Date of service rendered ____
- Other. Please explain:
- ☒ **Check box if this Request is for multiple claims.** Please attach a separate list if more than one claim number or member ID is related to this reconsideration request.

SAMPLE

Provider Name	Provider Tax ID
Provider NPI	Original Payment Received
BCBSTX Claim Number*	Dates of Service*
Member Name*	Member ID*

Email completed forms and all attachments to:

Blue Cross and Blue Shield of Texas
Claims Reconsiderations
Texas Medicaid Network Department
Email: TexasMedicaidNetworkDepartment@bcbstx.com.

Contact name & number of person responsible for reconsideration _____

BCBSTX

BlueCross BlueShield of Texas

Section 9

Customer Service Information
Texas Medicaid Website Disclaimers

Customer Service and Important Contact Numbers

STAR and CHIP Customer Service
Provider: **1-877-560-8055**
Member: **1-888-657-6061**
TYY: 711
Telephone Support available Monday to Friday 8 a.m. to 5 p.m. CST
Web Support Available through Availity: **www.availity.com**
STAR Kids Customer Service
Provider: **1-877-784-6802**
Member: **1-877-688-1811**
TTY: 771
Telephone Support available Monday to Friday 8 a.m. to 5 p.m. CST
Web Support available through Availity: **www.availity.com**
Nurse Advise Line: STAR, CHIP, and STAR Kids
STAR and CHIP: **1-844-971-8906**
STAR Kids: **1-855-802-4614**
Available 24 hours a day, 7 days a week

Interpreter Services

Language Assistance is available at no cost

- Member
  - Call Customer Service at 1-**888-657-6061** STAR & CHIP **1-877-688-1811** STAR Kids to request interpreter services
  - Request: Please request service three business days in advance
  - Cancellation: Please provide 24 business hours notice
- Provider
  - **1-877-560-8055** STAR & CHIP
  - **1-877-784-6802** STAR Kids
  - Request: Please request service three business days in advance
  - Cancellation: Please provide 24 business hours notice
  - BCBSTX Provider Website **www.bcbstx.com/provider/medicaid/**

BCBSTX Medicaid Provider Website

Website link:

https://www.bcbstx.com/provider/medicaid

Disclaimers

- Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.
- CPT Copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. For inactive CPT or Healthcare Common Procedure Coding System (HCPCS) codes that have been replaced by a new code(s), the new code(s) is required to be submitted.

BlueCross BlueShield of Texas

Questions?

Please contact:
BCBSTX Network Representatives
Phone: **1-855-212-1615**
TexasMedicaidNetworkDepartment@bcbstx.com