



BlueCross BlueShield of Texas

# Texas Medicaid Behavioral Health Provider Orientation

Blue Cross and Blue Shield of Texas Medicaid STAR, CHIP, and STAR Kids



SKSCP-9073-112025

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BlueCross BlueShield of Texas

# Section 1

# Provider Compliance



# Section 1 – Provider Compliance

- Purpose
- Texas Health and Human Services HHSC
- Member Enrollment and Eligibility
- No Balance Billing
- Cultural Competency
- PCP Availability and Appointments
- Provider Demographics Updates

# 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.

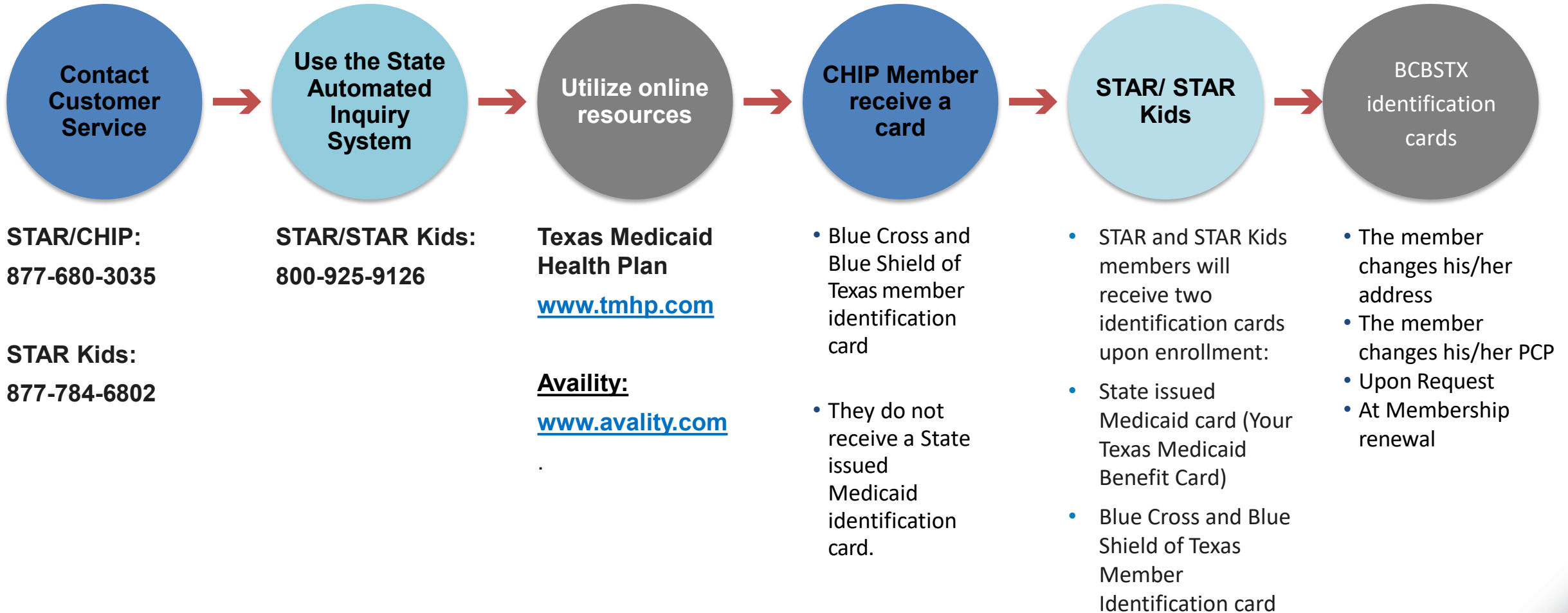
CHIP and CHIP Perinate eligible members **must enroll** in a CHIP HMO within 90 days. CHIP eligible members do not default into an HMO. If an HMO is not chosen, the CHIP eligible member will become ineligible.

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



# Various ways to Verify Member Eligibility

Our providers must verify eligibility before each service.



# 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** 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:

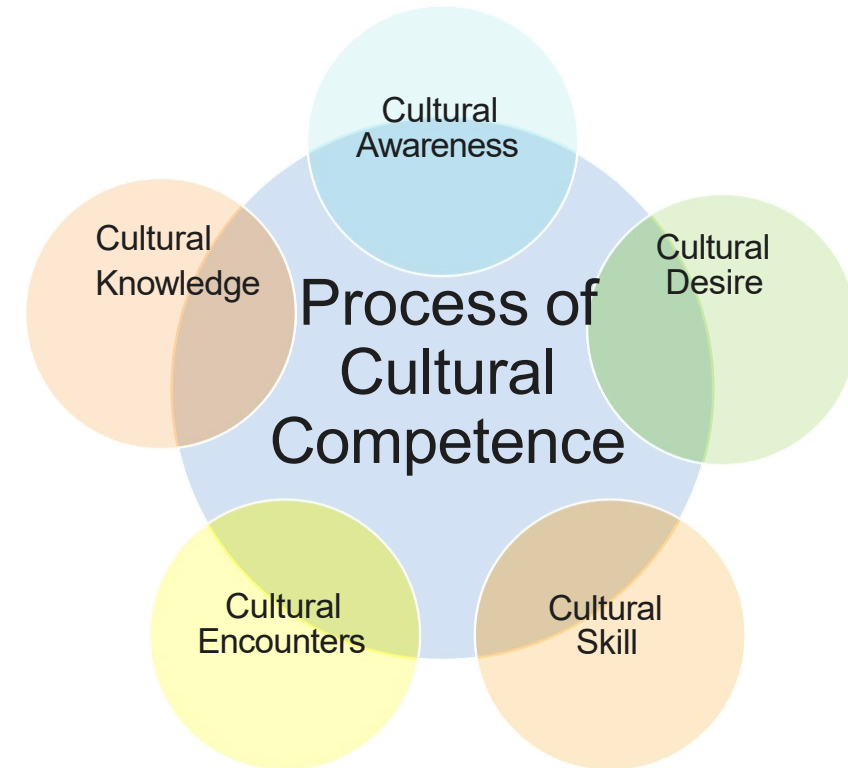
- **Advance health equity,**
- **Improve quality of care, and**
- **Help eliminate health care disparities to achieve the goal of improved health outcomes.**

## The link to CLAS 15 action steps:

[thinkculturalhealth.hhs.gov/clas/standards](http://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](http://www.bcbstx.com/provider/medicaid/training.html)



# PCP and Behavioral Health Availability and Appointment

- Blue Cross and Blue Shield of Texas 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 <b>STAR</b> , Preventive Covered Services including annual adult well checks	Within 90 days of request
For <b>STAR</b> , Preventive Covered Services for members younger than six months of age	Within 14 days of request
For <b>STAR</b> , Preventive Covered Services for members six months through age 20	Within 60 days of request
For <b>CHIP</b> , Preventive Care	Per the American Academy of Pediatrics Periodicity Schedule <sup>1</sup>
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. You can also contact TMHP directly at **800- 925- 9126** for assistance.

For additional information on how to update your demographic information, visit:

[www.bcbstx.com/provider/network/network/request-contract](http://www.bcbstx.com/provider/network/network/request-contract)





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## Section 2

# STAR, CHIP, and STAR Kids Benefits and Programs



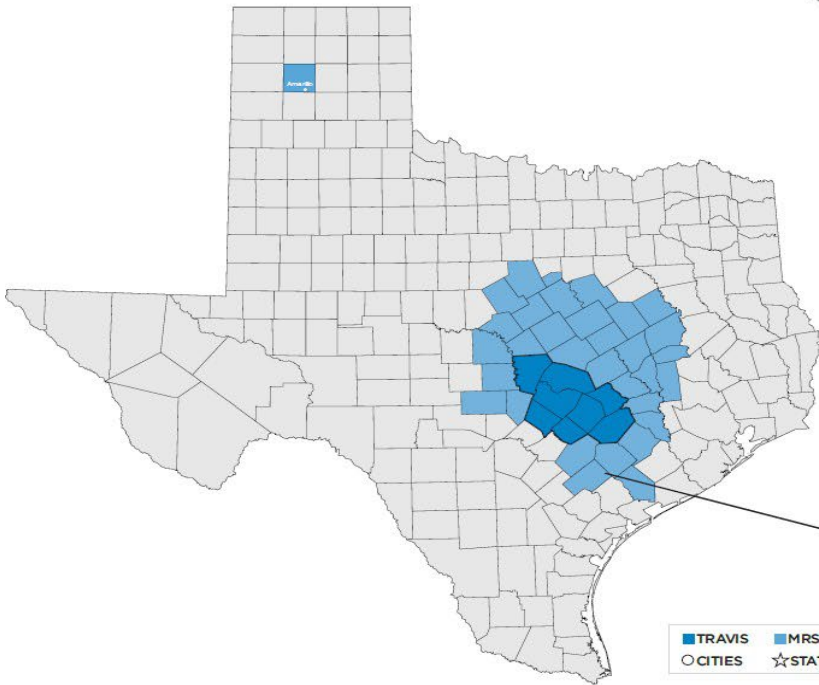
# Section 2 – STAR, CHIP, and STAR Kids Benefits and Programs Overview

- Where We Serve
- STAR Member Benefits and Services
- CHIP Member Benefits and Services
- STAR Kids Member Benefits and Services.
- Early Childhood Intervention
- Children of Migrant Farm Workers
- Healthy Texas Women
- Healthy Texas Women Plus
- Special Beginnings
- Children and Pregnant Women
- Benefit Limitations
- Value Added Services
- Pharmacy Program
- Vendor Services

# Where We Serve

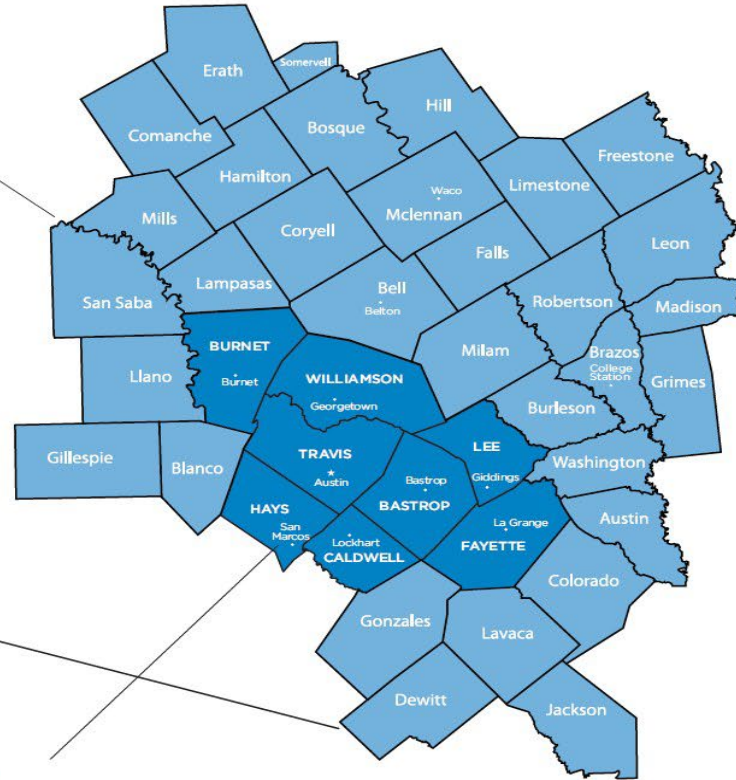
## Service Area: **MRSA CENTRAL TEXAS**

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, WASHINGTON



## Service Area: **TRAVIS**

COUNTIES:  
 BASTROP, BURNETT, CALDWELL, FAYETTE, HAYS, LEE, TRAVIS, WILLIAMSON



## STAR Kids

### 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, CHIP and STAR Kids

Service Area Travis Counties:  
 Bastrop, Burnett, Caldwell, Fayette, Hays, Lee, Travis and Williamson



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



# 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 our [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](http://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 our [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 our [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](http://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](http://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.



# CPW Case Management Overview

## What is CPW Case Management?

Blue Cross and Blue Shield of Texas defines case management services that are provided to help Medicaid eligible persons gain access to necessary medical, social, educational and other services.

### Case managers:

- Assess a person's need for these services and
- Develop a service plan to address those needs

Case Management for Children and Pregnant Women services are outlined in the Texas Administrative Code.



# CPW Case Management Overview

(Continued)

## Who can receive the services?

**CPW services are a benefit for children birth through 20 years of age who:**

Are Medicaid eligible in Texas

Have, or are at risk for, a health condition, illness, injury or disability that results in limitation of function, activities or social roles in comparison with healthy peers of the same age in the general areas of physical, cognitive, emotional or social growth and development

Need Case Management for Children and Pregnant Women services

Choose such service

**CPW services are a benefit for pregnant women of any age who:**

Are Medicaid eligible in Texas

Are pregnant and have a medical and/or psychosocial condition that places them and their fetus(es) at greater than average risk for complications, either during pregnancy, delivery or following birth

Need Case Management for Children and Pregnant Women services

Choose such services.



# Providers Who Are Eligible to Provide CPW Services

To be eligible to provide Case Management for Children and Pregnant Women services, a provider must be at least 18 years old, enrolled in Medicaid and approved by the Health and Human Services Commission. Additionally, providers must meet specific qualifications related to their professional background, such as:

- **APRN:** Must hold a license under Texas Occupations Code Chapter 301.
- **Registered Nurse:** Must hold a license under Texas Occupations Code Chapter 301 and have either a baccalaureate degree in nursing or an associate's degree with specific work or internship experience.
- **Social Worker:** Must hold a license, other than a provisional or temporary license, under Texas Occupations Code Chapter 505, appropriate for the individual's practice.
- **Community Health Worker:** Must be certified by the Department of State Health Services.
- **Doula:** Must be certified in alignment with nationally recognized standards and meet specific experience and training requirements.
- **FQHCs:** Must use their FQHC provider type, specialty code and taxonomy code, as well as their individual NPI, to deliver services. Use their own individual NPI.

# 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

## Pharmacy Services:

### Prime Services Therapeutics

Phone Numbers:

STAR: 855-457-0405

CHIP: 855-457-0403

STAR Kids: 855-457-0757  
(Travis Service area)

855-457-0758 (MRSA Central service  
Area)

Website: [www.dentaquest.com](http://www.dentaquest.com)

## Vision Service:

### Davis Vision

Phone Number: 800-773-2847

Website:

[www.davisvision.com/eye\\_care\\_professionals/](http://www.davisvision.com/eye_care_professionals/)

## Dental Services:

### DentaQuest

Phone Number: 800-516-0165

Website: [www.dentaquest.com](http://www.dentaquest.com)

### Managed Care of North America Dental

Phone Number: 800-494-6262

Website: [www.mcna.net](http://www.mcna.net)



BlueCross BlueShield of Texas

## Section 3

# Texas Health Steps Overview



## Section 3. Texas Health Steps Overview

- Texas Health Steps Introduction
- Medical Scope of Services – Texas Health Steps
- Behavioral Scope of Services – Texas Health Steps

## 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 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](http://www.tmhp.com/programs/thsteps)

## Scope of Texas Health Steps 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.

# Section 4

# Behavioral Health Services



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- Coordination of Care
- Behavioral Health Referral
- Provider Quality Meetings
- Collaborative Care Model

# Behavioral Health Services Hotlines

## Behavioral Health Services Hotlines

- **877-688-1811** – TX STAR Kids
- **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 Services
- Targeted Case Management Screening, Brief Intervention, and Referral to Treatment
- Coordination Specialty Care Services
- Other behavioral health outpatient services covered by Medicaid and CHIP.



For more information regarding covered Behavioral Health services, please refer to [the Tmppm Behavioral Health Manual](#).

# 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 treatment services delivered in a chemical dependency treatment facility.

## BCBSTX 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.

# Coordination Specialty Care Services

## **What is Coordination Specialty Care Services:**

It is designed to meet the needs of persons with an early onset of psychosis. Persons enrolled in CSC receive mental health services that are based on a comprehensive, recovery-oriented model of treatment for persons with first-episode psychosis. CSC utilizes a shared-decision making and team-based approach to develop a plan of care tailored to the individualized needs of the person. CSC services are for persons aged 15–30 who have a psychotic disorder diagnosed within the past two years and who live in the service area of a CSC provider.

## **Provider Qualifications:**

CSC services is considered a covered service when provided by providers who are Medicaid-enrolled Local Mental Health Authorities and Local Behavioral Health Authorities and part of the Advancing an Early Psychosis Intervention Network in Texas regional network.

CSC providers and programs must follow an industry standard CSC model such as NAVIGATGE, COMPASS and RAISE. Provider must conduct annual On Track NY Fidelity Assessment to meet fidelity requirements.

# Coordination Specialty Care Services

**Coordinated Specialty Care Core services include:**

- Psychiatric Diagnostic Interview Examination
- Routine Case Management
- Psychosocial Rehabilitation (Individual and group)
- Peer Support
- Pharmacological Management
- Administration of an Injection
- Medication Training and Support (individual and group)
- Family and Group Counseling (excluding multi-family counseling)
- Individual Psychotherapy
- Supported Housing
- Supported Employment
- Engagement Activities
- Flexible Funds

# Coordination Specialty Care Services

## **Adjunct services include:**

- Flexible Community Supports
- Screening, Brief Intervention and Referral to Treatment Services

Crisis Service Array: Authorized as medically necessary and available during a psychiatric crisis. Crisis services must be delivered in an outpatient setting to be included in the in-lieu-of service.

## Services that may not be covered by BCBSTX as part of a CSC include:

- Meals and transportation
- Room and board
- Services to Members receiving inpatient services, including Institutions of Mental Disease

# 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, outpatient hospital, extended care facility, 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.

# 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 Partnership 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 – 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.**

***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 – Psychiatric Diagnostic Evaluation Services

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

Psychiatric diagnostic evaluation can be with a medical service or without medical service.

## 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.

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

# Court-Ordered Services

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

# Court - Ordered Services

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. In these situations, the court order is considered the determination of medical necessity, when billed with modifier H9.

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.

# 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 Providers
- Local Mental Health Authority Providers
- Non-Local Mental Health Authority Providers
- Provider Credentials for Facilities Delivering MHTCM and Mental Health Rehabilitative Services
- Community Services Specialist
- Qualified Mental Health Professional – Community Services
- 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; the Texas Home Living Waiver; or an Intermediate Care Facility for Individuals with Intellectual Disabilities.

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

# Mental Health Targeted Case Management

Mental health targeted case management 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 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 and related conditions, or a single diagnosis of substance use disorder 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 - 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, 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 Rehabilitative and Targeted Case Management

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 Services

# Mental Health Rehabilitation 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, as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

**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 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 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 standardized assessment tool for persons who are 17 years of age and younger and the Adult Needs and Strengths Assessment 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 Services – Coordination of Care

**Mental Health Rehabilitative 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

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](#).

# Substance Use Disorder 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 euphorants), 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 Diagnostic Statistical Manual of Mental Disorders.

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 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.

# Substance Use Disorder 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. 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).

# Substance Use Disorder Treatment – Opioid Treatment Providers

Substance Abuse and Mental Health Services Administration certified opioid treatment providers that are also licensed as narcotic treatment programs in Texas are required to enroll in Medicare before enrolling with Texas Medicaid as OTPs.

A comprehensive assessment 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.

# Screening, Brief Intervention, and Referral to Treatment

# Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment 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

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.

# Peer Support Services

# Peer Support Services – Overview

Peer specialist services 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 – Enrollment criteria

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
- 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.

# Inpatient Psychiatric Services

**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](#).**

# 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, 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.

# 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 Advisory Group Quarterly Meetings

The Provider Advisory Group serves as a key advisory body to BCBSTX, representing a diverse group of providers from various specialties and practice settings. The PAG includes representatives from the STAR, CHIP, and STAR Kids programs in the Travis Service Delivery Area and Central service area. This group spans across primary care, specialty practices, small and large group practices, ancillary providers, private practices, and Federally Qualified Health Centers (FQHCs).

The primary function of the PAG is to act as a sounding board for BCBSTX providers, offering valuable feedback on administrative, operational, and strategic initiatives. It serves as a crucial forum for gathering provider insights on various topics, including but not limited to:



PAG meetings are held quarterly, ensuring consistent and ongoing provider engagement, with each meeting designed to address the evolving needs and concerns of the provider community.



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## Section 5

# Applied Behavioral Analysis



## Section 5. Applied Behavioral Analysis

- Applied Behavioral Health Services Overview
- Applied Behavioral Analysis
- Applied Behavioral Analysis Billing

# Applied Behavior Analysis Overview

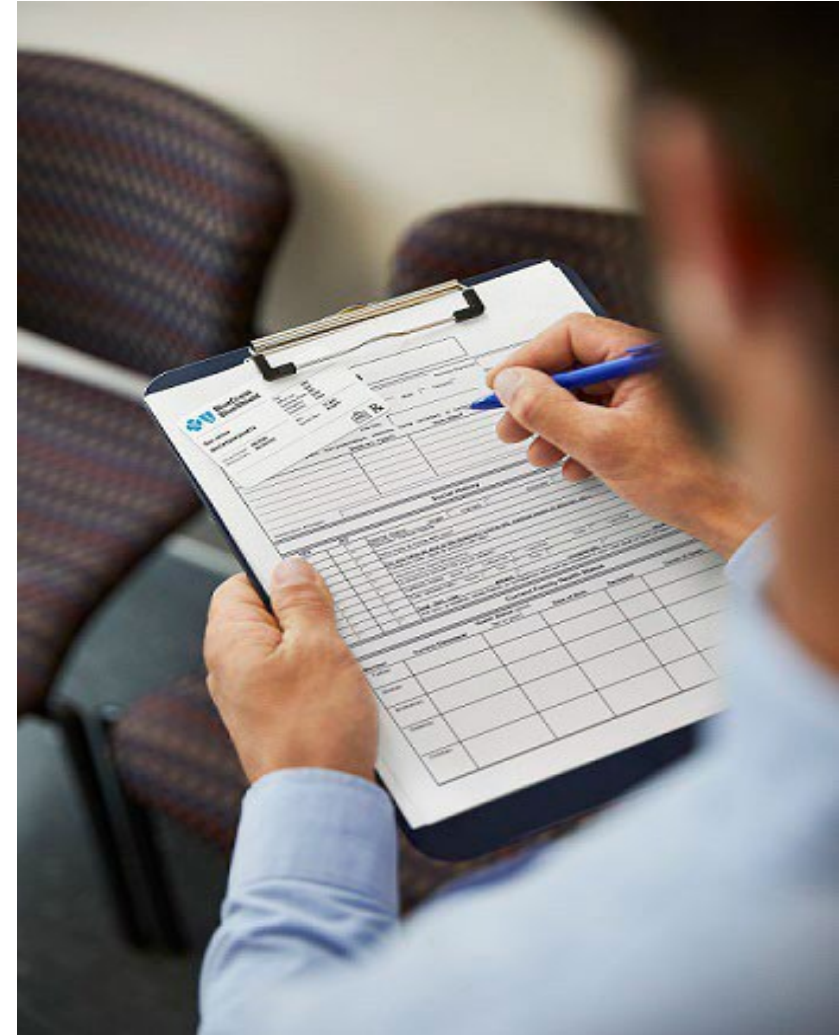
When submitting a prior authorization request for a Blue Cross and Blue Shield of Texas Medicaid member to receive Applied Behavioral Analysis services, clinical documentation must be included.

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** or electronically submitted through our provider portal.

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.



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## Section 6

# Utilization Management and Service Coordination



## Section 6. Utilization Management and Service Coordination

- Utilization Management
- Utilization Management Intake Department
- Time Frames for Prior Authorization
- 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.

Medical and 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 except for 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.

Medical and BH Providers may call Utilization Management toll-free for **STAR and CHIP at 877-560-8055 and STAR Kids at 877-784-6802** with questions and/or requests, including requests for urgent/expedited prior authorization and urgent concurrent/continued stay review. An on-call clinician 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**.

**Medical Provider** may fax Utilization Management for **STAR and CHIP to 855-653-8129 and STAR Kids to 866-644-5456.**

**BH Providers** may fax Utilization Management to **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](http://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 Medical and 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

# Required Information for Utilization Management Intake Department

## Required Information

Member name

Member identification number or Medicaid number

Member date of birth

Requesting provider name and national provider identifier

- Service requested-
  - Current Procedural Terminology (CPT®)
  - Healthcare Common Procedure Coding System
  - Current Dental Terminology
- Service requested start and end date (s)
- Quantity of service units requested based on the CPT, HCPCS or CDT requested

## Other information used to process requests include:

- Diagnosis code(s)
- Primary care physician, specialist and/or facility names
- Clinical justification for request
- Treatment and discharge plans (if known)

## If the required information above is missing the request:

- Will not be entered into the system
- Will be returned to requestor with an explanation of why it was returned
- Will include instruction to resubmit for reprocessing

# Time Frames:

- **One business day:** Concurrent hospitalization decisions

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- **Within one hour:** Post stabilization or life-threatening conditions

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- **Within one business day:**
  - Emergency medical and emergency behavioral health conditions do not require prior authorization; if member is admitted to the hospital, notification is required
  - For a member who is hospitalized at time of the request, notification is required of receiving the request for services or equipment that will be necessary for the care of the member immediately after discharge, including if the request is submitted by an out-of-network provider, provider of acute care inpatient services or a member

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- **Within three business days after receipt:** All other prior authorization requests

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



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# Service Coordination



# STAR, CHIP, and STAR Kids Services

Our Service Coordinator's works with you to develop a service plan that will coordinate services between the PCP, specialty care providers and any non-medical providers. If our members have special health care needs, we can help get access to those services.

1

## All Plans

A service coordinator is dedicated to helping our members find the right doctor, physical and behavioral health care services, and community support.

2

## All Plans

A disease manager focuses on making our members total health better.

3

## All Plans

Our Maternity nurses provide pregnancy support

4

## All Plans

A Behavioral health specialists helps coordinate mental health and substance use services. BH care does not require a referral from the PCP.

5

## STAR Kids ONLY:

A Transition specialist helps our member's plan for changes to providers and benefits as the child ages. Planning starts at age 15 until member turns 21.

# Service Coordination Duties

1

## **All Plans**

Develop care plans, answers questions and discuss services or resources available to help reach the member's health goals

2

## **All Plans**

Coordinate care with PCPs, specialists, and community-based services

3

## **All Plans**

Assist members, their family and caregiver to better understand their health condition(s), medications and treatments

4

## **STAR Kids Only:**

Provide adult transition planning

5

## **STAR Kids Only:**

Complete the Child's STAR Kids Screening and Assessment and Individual Service Plan

**Contact Information:** STAR and CHIP: **1-877-214-5630** or STAR Kids: **1-877-301-4394**

# 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 provide 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: 877-214-5630

Fax: 1-866-644-5456

Email: [TX\\_Medicaid\\_HC@bcbstx.com](mailto:TX_Medicaid_HC@bcbstx.com)

## **STAR Kids**

Phone: 877-301-4394

Fax: 1-866-644-5456

Email: [TX\\_Medicaid\\_HC@bcbstx.com](mailto:TX_Medicaid_HC@bcbstx.com)



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# Section 7

# Provider Requirements



## Section 7. Provider Requirements

- No Balance Billing Members
- Fraud, Waste, or Abuse
- Abuse, Neglect, and Exploitation
- Provider Compensation
- How to Submit a Claim
- Life of a Claim
- Electronic Claim Submission
- Claim Submission
- Claims Status
- Manage My Organization via Availity Essentials
- Electronic Funds Transfer/Electronic Remittance Advise
- Durable Medical Equipment

# 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).

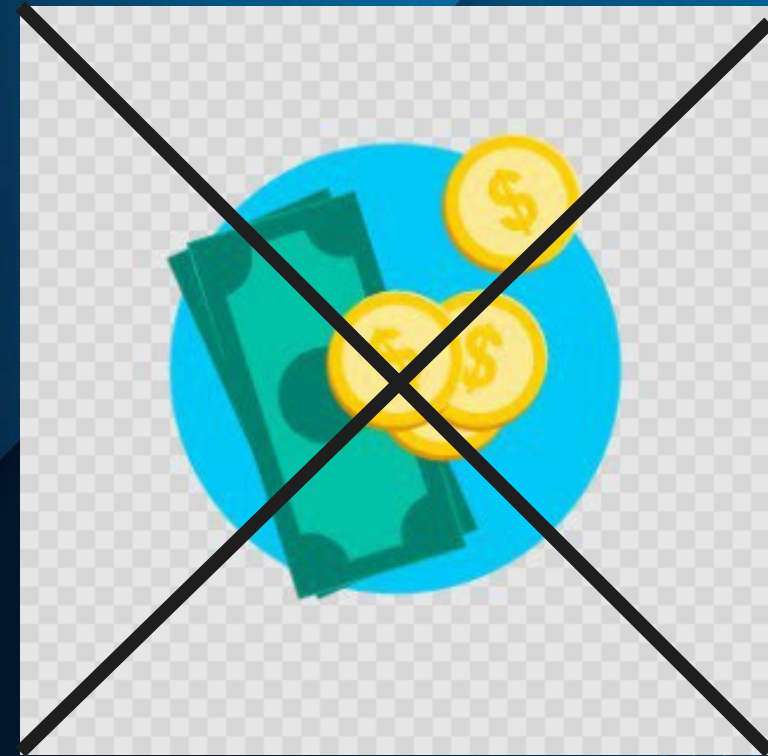
## What is Balance Billing?

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 - Continued

## 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.

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

# Abuse, Neglect, and Exploitation

Blue Cross and Blue Shield of Texas and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and support to the appropriate entity. The managed care contracts include BCBSTX, and provider responsibilities related to identification and reporting ANE. Providers must provide the BCBSTX with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services. Also, the provider is responsible for reporting individual remediation on confirmed allegation to us.

## 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  
**855-212-1615**

# 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.





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# How to Submit a Claim?

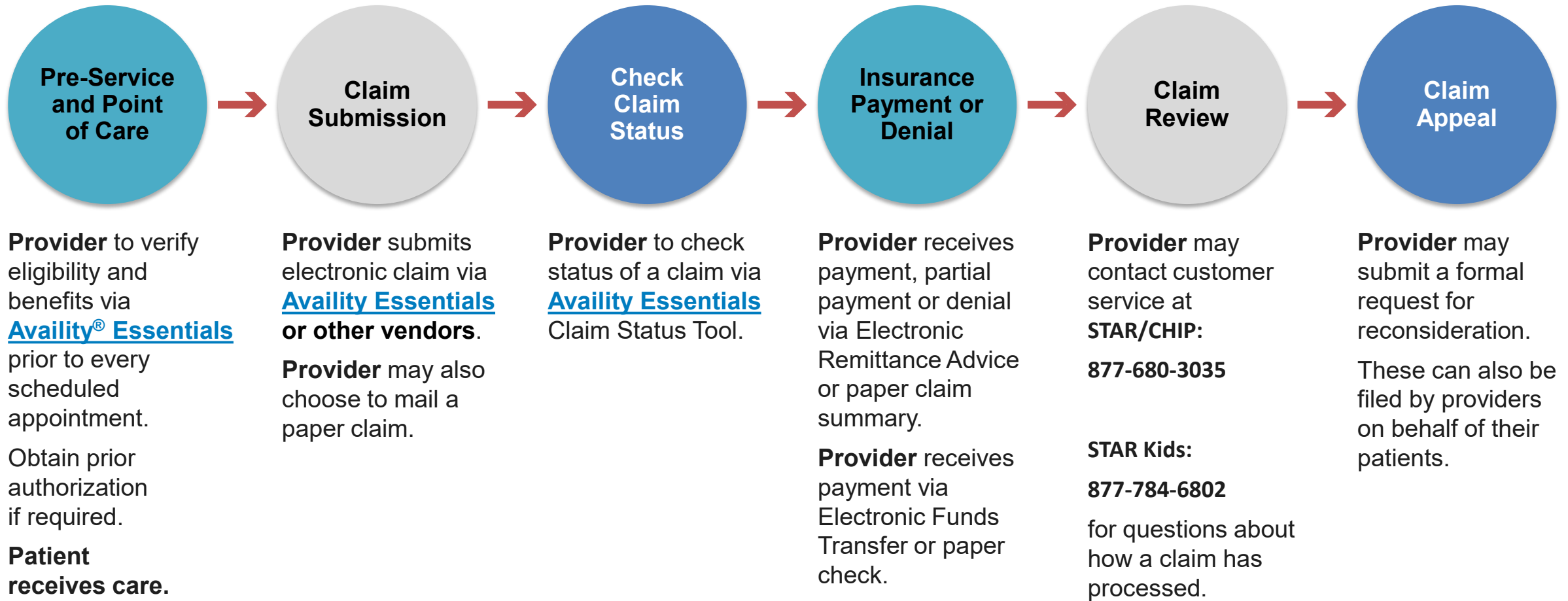
## Availity

[www.availity.com](http://www.availity.com)

Claims Submission  
Claims Status



# Life of a Claim



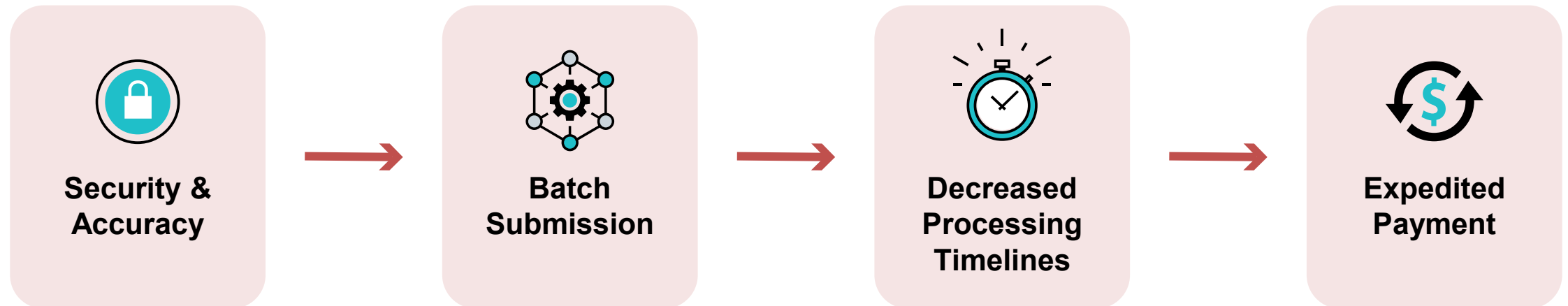
# Electronic Claim Submission



**Professional and facility claims** can be submitted electronically via a third-party vendor, such as [Availity Essentials](#).

Visit the Electronic Commerce section of the provider website for more information on electronic vendor options.

Payer ID: **66002 (MEDICAID)**



# Claim Submission

Visit the [provider website](#) to view a quick claims submission introduction. Timely Filing (Professional) is 95 days.

We encourage providers to file claims electronically; however, we will accept paper claim submissions.

Paper claims can be mailed to: BCBSTX, PO Box 650712, Dallas, TX 75265-0712.

Paper claim forms can be obtained by contacting the following:

- [National Uniform Claim Committee](#) – For Professional CMS 1500 Claim Form  
– (Billing NPI - Box 33A, Rendering NPI – Box 24J)
- National Uniform Billing Committee – For Facility UB-04 Claim Form  
– (Billing NPI – Box 50, Attending NPI – Box 76)

**Please Note:** We do not advise how to bill or code claims. If you need assistance, contact [Texas Medicaid Provider Procedures Manual](#)

## Helpful Hint

When filing claims electronically as secondary, please make sure to include all primary insurance payment information. If filing on paper, make sure to attach a copy of the primary insurance Explanation of Benefits.

# Claim Status



After submitting a claim, you can check the status online to verify if your claim has been received, pended or finalized. You can also verify the descriptions for any claim denials.



[Claim Status Tool](#) in Availity Essentials can be used to check the status of a claim online.



Availity is no cost to the provider.  
[Register online.](#)



[Claim Status Tool user guide](#)

# Manage My Organization via Availity Essentials

Manage My Organization in Availity Essentials allows administrators and users to add provider(s) within your organization(s) or edit existing ones, for easy data entry when submitting transactions. Adding providers to Manage My Organization should be completed prior to utilizing the Availity self-service applications, as this ensures providers in your organization are available in the **Select a Provider** drop-down listing in each tool.

**Please Note:** Only administrators can view and edit business information for existing organization(s) in Manage My Organization.



For navigational assistance, refer to the [Manage My Organization User Guide](#)



If you are not yet registered with Availity, [sign up](#) today at no charge.



If you need registration assistance, contact Availity Client Services at **800-282-4548**.

# Electronic Funds Transfer/ Electronic Remittance Advice

**Electronic Funds Transfer** is a direct deposit of your claim payment from BCBSTX to your designated bank account. Additional information regarding EFT and ERA transactions is available on our [Availity EFT & ERA Enrollment User Guide](#).

**Electronic Remittance Advice** is a HIPAA-compliant method of receiving claim payment and remittance details. The ERA can be automatically posted to your patient account system. Approximately six weeks after enrolling in ERA, provider will no longer receive a paper claim summary.

**Remittance Viewer** – To access your ERA in Availity. Approximately six weeks after enrolling in ERA, provider will no longer receive a paper claim summary: [Remittance Viewer User Guide](#)

**Provider Claim Summary** – To access your Provider Claim Summary in Availity: [Provider Claim Summary User Guide](#)



## Please Note

The EFT Transaction Enrollment option is only available to Availity administrators and/or registered Availity users who have been granted access.

If you are already enrolled in EFT or ERA or both and you add a new network to your contract, you must submit a new request to enroll in EFT/ERA for the new network.

# Electronic Funds Transfer/ Electronic Remittance Advice (Cont.)

## How to Enroll:

1

- Register with Availity
- Log into [Availity](#)
- Select My Account Dashboard on the Availity homepage
- Select Enrollments Center
- Select Transaction Enrollment
- Complete and submit

2

Providers can enroll with Availity to receive ERA/EFT as soon as they are showing as participating.

3

Providers can obtain enrollment status or ask questions regarding the Electronic Transaction Enrollment by emailing [Electronic Commerce Services](#)

4

Providers receive a confirmation letter in the mail with their confirmation date.



BlueCross BlueShield of Texas

## Section 8

# Submitting Complaints, Appeals and Reconsiderations



## **Section 8. Complaints, Appeals and Reconsideration**

- Submitting Appeals & Claims Reconsideration
- Submitting Fair Hearing
- Submitting Member Complaints
- Submitting Provider Complaints

# Submitting Appeals

## Filing a Standard Appeal: Provider Appeal Form

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 **888-657-6061 (711)** as first option

A Member Advocate at **877-375-9097 (711)**

# Submitting Claims Reconsideration

## Filing a Claims Reconsideration: Reconsideration Form

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](mailto:TexasMedicaidNetworkDepartment@bcbstx.com)

# 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](mailto: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](http://www.bcbstx.com/starkids)

[www.bcbstx.com/chip](http://www.bcbstx.com/chip)

[www.bcbstx.com/star](http://www.bcbstx.com/star)

# 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 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:  
**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](mailto: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](mailto:ConsumerProtection@tdi.texas.gov)



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## Section 9

# Customer Service Information Texas Medicaid Website Disclaimers



## Section 9. Complaints, Appeals and Reconsideration

- Customer Service and Important Contact Numbers
- BCBSTX Medicaid Provider Website
- Disclaimer
- Questions

# Customer Service and Important Contact Numbers

## STAR and CHIP Customer Service

Provider: **1-877-560-8055**

Member: **1-888-657-6061**

TTY: 711

**Telephone Support available Monday to Friday  
8 a.m. to 5 p.m. CST**

Web Support Available through Availity: [www.availity.com](http://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](http://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/](http://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.



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# Questions?

Please contact:  
BCBSTX Network Representatives

Phone: **1-855-212-1615**

[TexasMedicaidNetworkDepartment@bcbstx.com](mailto:TexasMedicaidNetworkDepartment@bcbstx.com)

