BlueCross BlueShield of Texas

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

WELCOME!

Claims Billing Provider Training for CHIP, STAR, and STAR Kids 2025

SKSCP-9038-1225
Revised 122025
2073223_768615.1125

Agenda

Here are some of the topics we will discuss:

1. **Texas Medicaid Services**
2. **Provider Onboarding, Compliance, and File Maintenance**
3. **Utilization Management Overview**
4. **Claims Billing and Requirement Overview**
5. **Service Types Billing Requirements**
6. **Provider Relations**

Please Note: If you are newly contracted, please join us for a **New Provider Orientation!**

Visit our **website** to register for upcoming webinars.

Purpose

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

Rider 32

What is Rider 32?

This change follows the implementation of Rider 32, as required by the end of 2024-2025 General Appropriations Act, House Bill 1, 88th Texas Legislature, Regular Session, 2023 (Art. II, HHSC, Rider 32). The Texas Health and Human Service Commission transitioned Medicaid-only acute care services provided to dually eligible members from fee-for-service to managed care on Sept. 1, 2025.

Blue Cross and Blue Shield of Texas must cover, as Medicaid wrap-around services for dually eligible members, Medicaid-only acute care services that:

- Are not covered by Medicare; and
- BCBSTX covers for members who do not have Medicare

We will also begin covering non-risk, wrap-around drugs for dual eligible members.

Services provided via FFS for all Medicaid beneficiaries are not impacted by this transition.

Will both Medicaid and Medicare services be impacted? What does this mean for providers?

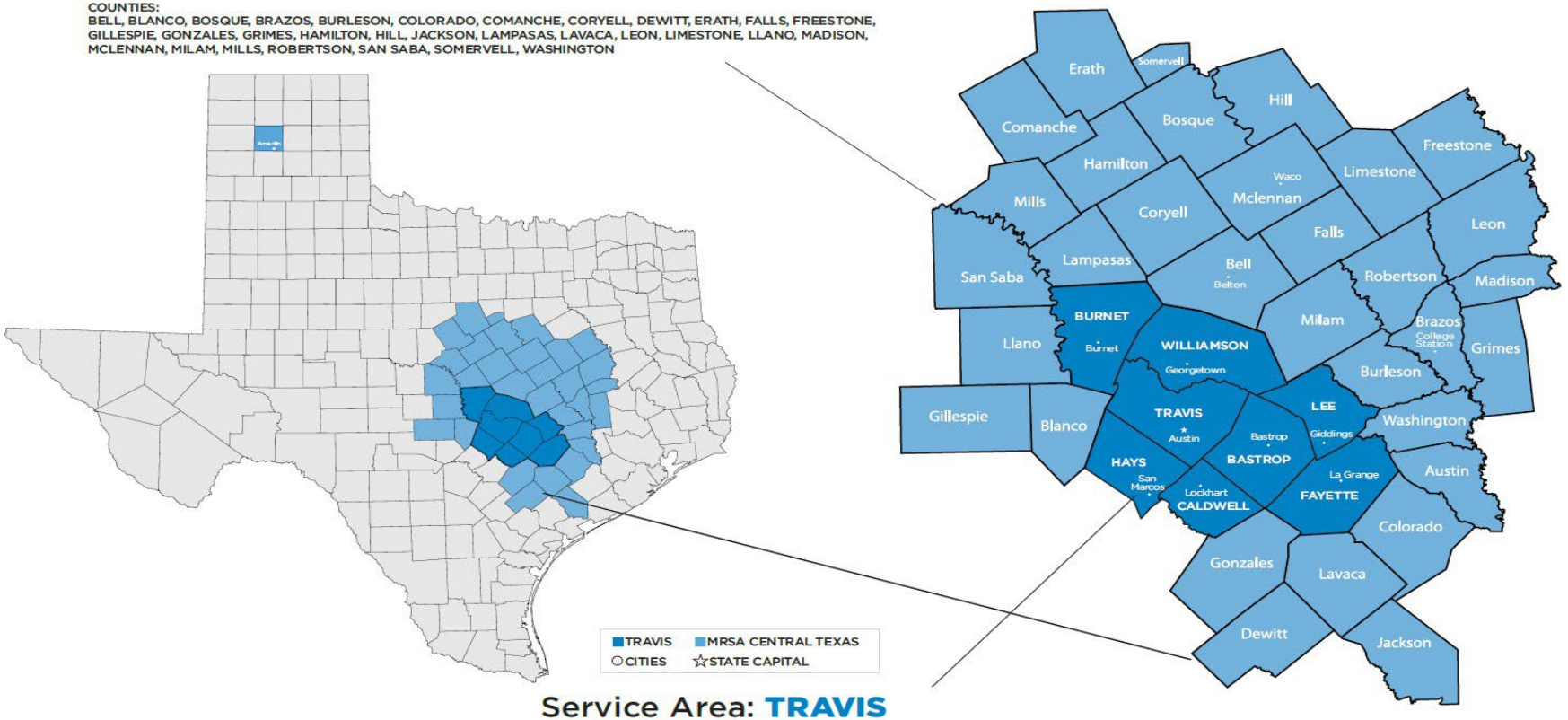
Rider 32 only affects the services that are Medicaid-only and currently covered by Medicaid FFS. Services that are covered by Medicare and their reimbursement schedule will not be impacted by this project.

1 Texas Medicaid 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

BlueCross BlueShield of Texas

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

TEXAS STAR Kids
Your Health Plan ★ Your Choice

TEXAS STAR
Your Health Plan ★ Your Choice

CHIP

STAR 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

Various ways to Verify Member Eligibility

Our providers must verify eligibility before each service.

Contact Customer Service

STAR/CHIP:

877-680-3035

STAR Kids:

877-784-6802

Use the State Automated Inquiry System

STAR/STAR Kids:

800-925-9126

Utilize online resources

Texas Medicaid Health Plan

www.tmhp.com

Availity:

www.availity.com

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CHIP Member receive a card

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

STAR/ STAR Kids

- STAR and STAR Kids members will receive two identification cards upon enrollment:
- State issued Medicaid card (Your Texas Medicaid Benefit Card)
- Blue Cross and Blue Shield of Texas Member Identification card

BCBSTX identification cards

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

BCBSTX Member ID Cards

The member ID cards contain the following information:

- Member Name
- Primary Care Provider (except CHIP Perinate mother)
- Prescription information
- Program eligibility
- BCBSTX contact Information

Copies of sample member ID cards can be found in the BCBSTX Provider Manual.

What is CHIP, STAR, and STAR Kids

Important Medicaid Programs: Texas Health Steps, often referred to as 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. Another program is Healthy Texas Women program dedicated to offering women's health and family planning at no cost to eligible women in Texas.

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

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

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

CHIP Member Benefits and Services

- Inpatient Acute and Rehabilitation Hospital Services*
- Outpatient and Ambulatory Health Services
- Physician/Physician Extender Professional Services PCP's and Specialists
- Pregnancy and Family Planning Services
- Audiology, Chiropractic & Podiatry,
- DME Supplies*
- Home Health
- Inpatient and Outpatient Mental Health Services*
- Substance Abuse Treatment Services*
- Rehabilitation Services*
- Hospice Care*
- Emergency Services, Hospitals, Physicians and Ambulances
- Physical Therapy, Occupational Therapy and Speech Therapy*
- Transplants*
- Vision
- Chiropractic
- Value Added Services **
- Lab X-Rays*

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.

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

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

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

***Some Benefits need Prior Authorization.**

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

STAR Member Benefits and Services

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

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.

The STAR program is for people who qualify for Medicaid and who are either a newborn, pregnant, have limited income,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**.

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 which includes but not limited to services such as:

- Adaptive Aids
- Community First Choice Services
- Personal Care Services
- Minor Home Modifications
- Applied Behavioral Analysis*

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.

2 Provider Onboarding, Compliance and File Maintenance

Attestation and Provider File Maintenance

- Claim will deny if provider has an unattested National Provider Identifier.
- Provider can check or apply for Attestation with Texas Medicaid and Healthcare Partnership at www.tmhp.com.
- Providers must revalidate or re-enroll with TMHP to avoid termination. Blue Cross and Blue Shield of Texas must be notified by the provider for any demographic changes including:
    - Address
    - Phone Number
    - Fax Number

Delayed claims payments will result if incorrect attestation of Tax Identifier Number or Demographics are submitted.

Provider Demographics Updates

Update immediately at BCBSTX via : bcbstx.com - Demographic Change Form concerning changes in:

- Address
- Phone
- Fax
- Office Hours
- Access and availability
- Panel Status
- Tax- Identification Number

Please remember to update your demographic information with Provider Enrollment and Management System. You can also contact Texas Medicaid and Health Care Partnership at www.tmhp.com or call directly at **800-925-9126.**

Cultural Competency

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

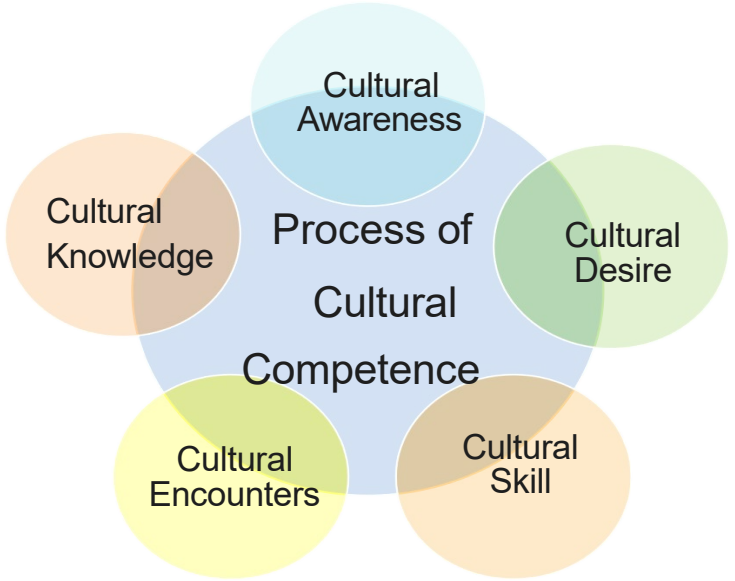
The purpose of the 15 action steps is threefold:

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

CLAS 15 action steps - thinkculturalhealth.hhs.gov/clas/standards

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

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



3 Utilization Management Overview

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

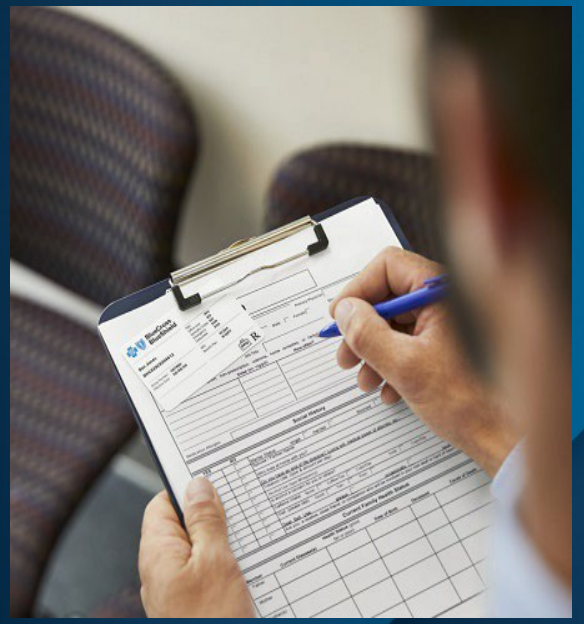
4 Claims Billing

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. Across the board Rate Reductions must be first approved by HHSC before being implemented. **Notification to HHSC must be done 90 days prior to rate reduction effective date**.



No Balance Billing Members

Blue Cross and Blue Shield of Texas 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 **855-212-1615**

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 manage 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**

Fraud, Waste, and Abuse

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

Examples of Fraud, Waste and Abuse:

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

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

- Call the Office of Inspector General (OIG) Hotline at **800-436-6184**
- Report Fraud, Waste, and Abuse online; or
- You can report directly to your health plan:
  Blue Cross and Blue Shield of Texas
  P.O. Box 660044
  Dallas, Texas 75266-9506

Post-Payment Claim Audit:

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

Other limitations may include the following scenarios:

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

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

Overpayments Identified by Providers:

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

5 Claims Requirements

National Drug Coding

National Drug Code required for all provider-administered medications

- Includes: Intrauterine devices, hormone patches, vaginal rings, subdermal implants, and intrauterine copper devices
- Exceptions: Vaccines from Texas Vaccines for Children Program, Durable Medical Equipment, Limited Home Health Supplies, and Radiopharmaceuticals

"How to Submit Claims for Physician Administered Drugs" located at http://www.bcbstx.com/provider/medicaid/submitting_ndc_claims.html

Conversion from 10 digits to 11 digits

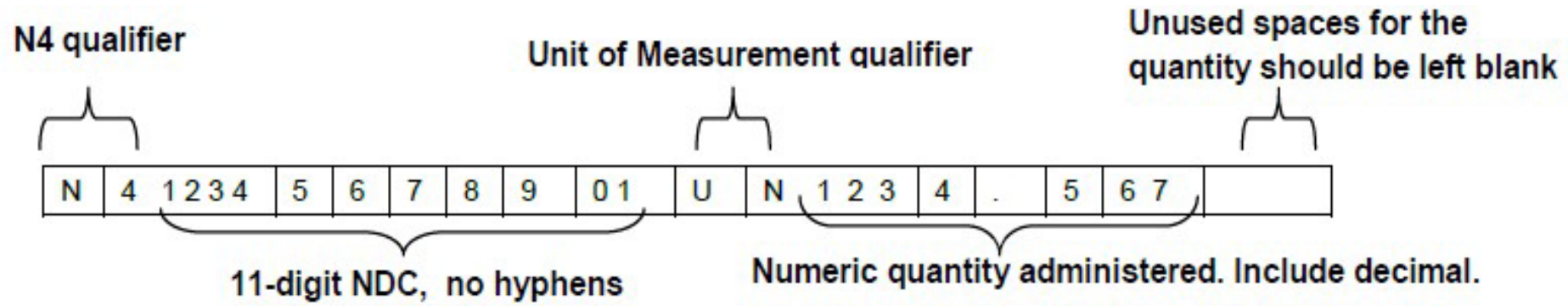
- Submitting Paper Claims
- Submitting Electronic Claims

If NDC information is missing or the NDC is not valid for the corresponding Healthcare Common Procedure Coding System code, BCBSTX will deny the entire claim for failing to comply with Clean Claim Standards.

National Drug Coding

- N4 qualifier
- 11-digits, no hyphens
- Unit of Measurement qualifier
- Quantity administered

Example:



Taxonomy Requirement

- Taxonomy code submitted *must match* the one submitted and approved by the State Medicaid Agency for the submitted National Provider Identifier/ Atypical Provider Identifier/ Tax ID.
- Confirm taxonomy and resubmit any rejected claims.
- Solo providers must use rendering NPI and taxonomy in both box 24J and 33a. **If** the taxonomy code is the same, it should only be in box 33B.

BCBSTX Medicaid STAR/CHIP & STAR Kids Claim Requirements	**Electronic Claim**	**CMS-1500 Claim Form**	**UB-04 Form Locator**
Billing Provider Taxonomy Code – required on all claims	2000A, PRV03	Box 33b w/ZZ qualifier preceding the taxonomy code	Box 81cc A w/ B3 qualifier
Rendering Provider Taxonomy Code – required on Professional claims when Rendering Provider information is submitted at the claim and/or service line level	2310B, PRV03 (claim level) 2420A, PRV03 (service line level)	Box 24J shaded area w/ ZZ qualifier in Box 24I	N/A
Attending Provider Taxonomy Code – required on Inpatient Institutional claims	2310A, PRV03	N/A	Box 76 w/ B3 qualifier

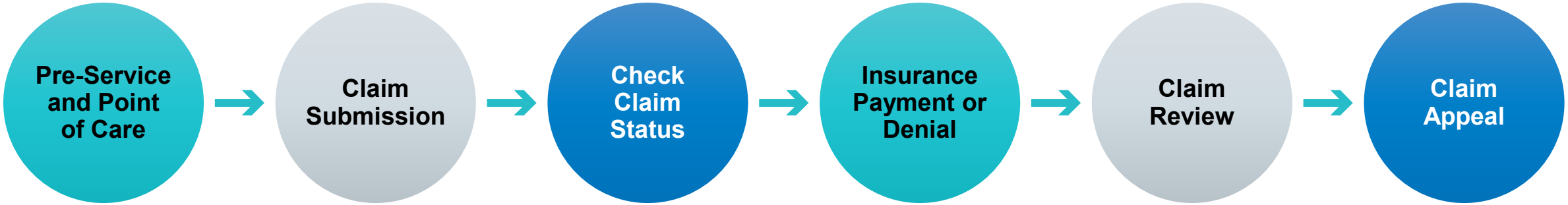
Claims PO Box Requirements

Rejected for the below reasons must be resubmitted with the necessary information

BCBSTX Medicaid STAR/CHIP & STAR Kids Claim Requirements	Electronic Claims	CMS-1500 Claim Form	UB-04 Form Locator
Atypical Providers – If NPI is not submitted, provider must submit their assigned API number	Billing Provider Secondary Identification Loop 2010BB, REF01 (G2 qualifier) 2010BB, REF02 (API Number)	Box 19 w/G2 qualifier followed by API Number	Box 57 w/G2 qualifier followed by API Number
Billing Provider NPI – required on all claims (excluding Atypical Providers)	2010AA, NM109	Box 33a	Box 56
Rendering Provider NPI – required on Professional claims when the Rendering Provider is different from the Billing Provider	2310B, NM109 (claim level) 2420A, NM109 (service line level)	Box 24J Unshaded area	N/A
Attending Provider NPI – required on Inpatient Institutional claims	2310A, NM109	N/A	Box 76
Billing Provider Address – required on all claims. Should contain the physical address, not a P.O. Box or Lock Box	2010AA, N301/N302	Box 33	Box 1

6 Claims Overview

Life of a Claim



Provider to verify eligibility and benefits via **Availity® Essentials** prior to every scheduled appointment.

Obtain prior authorization if required.

Patient receives care.

Provider submits electronic claim via **Availity Essentials. or other vendors**.

Provider may also choose to mail a paper claim.

Provider to check status of a claim via **Availity Essentials** Claim Status Tool.

Provider receives payment, partial payment or denial via Electronic Remittance Advice or paper claim summary.

Provider receives payment via Electronic Funds Transfer or paper check.

Provider may contact customer service at **STAR/CHIP:**

877-680-3035

STAR Kids:

877-784-6802

for questions about how a claim has processed.

Provider may submit a formal request for reconsideration.

These can also be filed by providers on behalf of their patients.

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)**

Security & Accuracy → **Batch Submission** → **Decreased Processing Timelines** → **Expedited Payment**

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	2	3	4
• Register with Availity • Log into **Availity** • Select My Account Dashboard on the Availity homepage • Select Enrollments Center • Select Transaction Enrollment • Complete and submit	Providers can enroll with Availity to receive ERA/EFT as soon as they are showing as participating.	Providers can obtain enrollment status or ask questions regarding the Electronic Transaction Enrollment by emailing **Electronic Commerce Services**	Providers receive a confirmation letter in the mail with their confirmation date.

7 Post Processing Claim Inquires

Submitting Claims

Claims Status Inquiry and Follow up

- Claim Status Inquiry:

  www.availity.com or IVR for disposition

  Claim Status Tool

  - **Medicaid (STAR)/CHIP** Customer Service **877-560-8055**
  - **STAR Kids** Customer Service **877-784-6802**
  - Initiate follow-up action if no response after 30 business days
  - Provide a copy of the original claim submission and all supporting documents to the claims address
- Claim Status Real -Time Inquiry Payer ID (HCSV2)
  The customer service rep will perform the following:
  - Research the status of the claim
  - Advise of necessary follow-up action if any

Claims Forms On Medicaid Website

www.bcbstx.com/provider/medicaid/forms.html

- Provider Appeal Request Form
- Reconsideration Request Form
- Claims Status Request Form
- DME Request for Claims Status
- DME Review Request Form

Forms Submission and Process

- Complete the appropriate fields (*) on the forms
- Submit the claim form via email: TexasMedicaidNetworkDepartment@bcbstx.com

- Claim Forms Review Process:
  - Leadership reviews each claim form
  - Assigned and researched by staff
  - Denial reason is researched:
    - Educates how to correct the claim
    - Submits claim for reprocessing

Submitting Claims

Third Party Liability Coordination of Benefits

- If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party
- BCBSTX must receive COB claims within 95 days from the date on the other carrier's RA or denial letter
- Claims should be submitted on paper with TPL or COB attached:
  - Third Party Remittance Advice
  - Third party letter explaining the denial or coverage or reimbursement
  - THSteps claims are not required to be billed to other insurance. We pay these as primary.

Claims Information

- Providers are prohibited from balance-billing CHIP or STAR Medicaid members for covered services
- **Claim Filing With Wrong Plan** – if you file with the wrong plan and can provide documentation, you have 95 days from the date of the carrier's denial letter or Remittance Advice to resubmit for adjudication
- **Claim Payment** – your clean claim will be adjudicated within 30 days from date of receipt. If not, interest will be paid at 1.5% per month (18% per annum)

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

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 Independent Review Organization).

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: **877-886-2593**
Email: GPDTXMedicaidAG@bcbsnm.com.

Find plan specific complaints, appeals, State Fair Hearing and External Medical Review forms at the respective member site.
www.bcbstx.com/starkids
www.bcbstx.com/chip
www.bcbstx.com/star

Submitting 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 a minor 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
888-657-6061 STAR and CHIP
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.
P.O. Box 660717
Dallas, TX 75266-0717
Fax: **877-886-2593**

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: **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
877-560-8055 STAR and CHIP
877-784-6802 STAR Kids
submit in writing to:

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

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

CHIP care providers:
Texas Department of Insurance

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149104
Austin, TX 78714 -9104
Complaints may also be emailed
ConsumerProtection@tdi.state.tx.us

Physician and Mid-Level Billing

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

Type of Billed Services

CMS-1500 Professional Services

- Physician and Mid-level services
- Specific Ancillary Services
  - Ambulance
  - Audiology
  - Dietician
  - Durable Medical Equipment
  - Federally Qualified Health Centers
  - Free Standing ASCs
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy

Type of Billed Services

CMS-1450 Institutional Providers

- Community Mental Health Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Critical Access Hospitals
- ESRD Providers
- Histocompatibility Laboratories
- Home Health Agencies
- Hospice Organizations
- Hospitals
- Indian Health Service
- Facilities
- Opioid Treatment Programs
- Organ Procurement Organizations
- Outpatient Physical Therapy
  - Occupational Therapy / Speech-Language
  - Pathology Services
- Religious Non-Medical Health Care Institutions
- Rural Emergency Hospitals
- Rural Health Clinics
- Skilled Nursing Facilities

Texas Health Steps

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

Frew et al vs. Traylor et al
Consent Decree and Corrective Actions

Class action lawsuit that alleged Texas Medicaid failed to ensure children access to Early and Periodic Screening, Diagnostic and Treatment through Texas Health Steps services.

Some of the Requirements:

- TX Health Steps Benefits
- Medical Checkup Periodicity Schedule
- Immunization Schedule
- Texas Health Steps Provider Outreach Referral Form (website: https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/forms)
  - Scheduling a follow-up visit
  - Rescheduling a missed appointment
  - Scheduling transportation to an appointment
  - With other outreach services
- Children of traveling farm workers

Texas Health Steps

THSteps is a program that includes both preventive and comprehensive care services.

For preventive, use the following guidelines: For acute care services and THSteps and CHIP preventive visits performed on the same day:

- Claims must be billed separately
- Modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit
- Modifier 25 be billed on the acute care visit and not the THSteps visit
- Rendering NPI number is not required for THSteps check-ups
- Billing primary coverage is not required for THSteps and CHIP preventive claims
- Include Benefit Code “EP1” on Texas Health Steps claims
- If the EP1 benefit code is in box field 11c, then box 11 must be empty. Note provider may place the EP1 benefit code in box 11 rather than 11c. (Benefit Code is not required for CHIP preventive claims)

Texas Health Steps Quick Reference Guide

- Diagnosis codes: Z0000, Z0001, Z00110, Z0011, Z00121, Z00129
- Diagnosis code: Z23 for Immunizations

Texas Health Steps Timely Checkups

- Newly enrolled children on STAR should be seen **within 90 days** of joining the plan for a timely Texas Health Steps Checkup.
- Roster List of Members provided Monthly.
- Existing Members birth through 35 months should receive a THSteps Checkup **within 60 days** beyond the periodic due date based on the Member's birth date.
- Existing Members ages three years and older are due annually, considered timely if THSteps Checkup occurs no later than 364 calendar days after the child's birthday.
- Providers should bill as an exception to periodicity.
- Exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup.
- Modifier 32 Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier "32" to the basic procedure or service.

Texas Health Steps – Mental Health Screening Procedure Codes

Mental Health Screening in adolescents two codes:

- 96160
- 96161

Required once for all clients ages 12-18.

Only one procedure code reimbursed per client per calendar year.

Postpartum Depression Screening:

- G8431
- G8510

Only one procedure reimbursed per client.

Texas Health Steps – Comprehensive Care Program

- Medical Supplies and Durable Medical Equipment (Pharmacy may provide these services)
- Mental Services
- Outpatient Rehabilitation
- Private Duty Nursing
- Therapies

Texas Health Steps – Benefit Codes

- Benefit Code is an additional data element used to identify various state programs.
- Claims will deny if Benefit Code is not included.
- For CHIP, STAR and STAR Kids use the appropriate Benefit Code:
  - HCFA-1500 paper claim: Box 11.
  - Electronic claims: SRB Loop 2000B, SBR03 qualifier field.
- Providers who participate in the following programs will use the associated Benefit Code when submitting claims:
  - EC1-Early Childhood Intervention Providers.
  - EP1-Texas Health Steps Medical Provider.

Texas Health Steps – Vaccines for Children

- Providers who administer vaccines to children 0-18 years of age may enroll
- Providers who administer vaccines to children 0-18 years of age must be enrolled in Texas Health Steps
- To enroll, visit the TMHP website: Immunization
- BCBSTX will only reimburse the administration fee for any vaccine available through the TVFC program
- Only time a provider is reimbursed for use of private stock is when TVFC posts no stock currently available message on website
- Claim should be billed with U1 to indicate private stock
- Bill with the appropriate vaccine and administration codes

Children and Pregnant Women Billing

For full list of billing information refer to Behavioral Health and Case Management Services Handbook

Children and Pregnant Women

Children and Pregnant Women Contracted Case Managers will not require authorizations for procedure code G9012 and the following modifiers used for all CPW services. Modifiers are used to identify which service component is provided. Please refer to the table below for coding requirements:

Services	Coding Requirements
Comprehensive Visit (in person)	G9012 with modifiers U2 and U5
Comprehensive Visit (synchronous audio-visual)	G9012 with modifiers U2, U5, and 95
Follow-up visit (in person)	G9012 with modifiers U5 and TS
Follow -up visit (synchronous audio-visuals)	G9012 with modifiers U5, TS, and 95
Follow-up visit telephone (audio-only)	G9012 with modifiers TS and 93
Reminder: Billable services are defined in program rule 25 TAC 27.11.	

OB/GYN Billing

For full list of billing information refer to Gynecological, Obstetrics, and Family Planning Title XIX Services Handboo

OB/GYN Billing

- CHIP Perinate Mothers are entitled to a maximum of 2 postpartum visits within 60 days of the end of the pregnancy.

  www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-pregnant-women-chip-perinatal

- CHIP Perinate Mothers' eligibility terms at the end of the month the baby was born.
- If a Provider checks benefits after the month of the baby’s birth, they will be advised the CHIP Perinate mother is not eligible.

Billing OB/GYN Claims CHIP Perinate

- Delivery codes should be billed with the appropriate CPT codes:

59409	•Vaginal Delivery only
59410	•Vaginal Delivery only (including postpartum)
59612	•Vaginal Delivery only, after previous cesarean delivery
59514	•C-Section only
59515	•Cesarean Delivery only (including postpartum care)
59614	•Vaginal Delivery only, after previous cesarean delivery (including postpartum care)
59620	•C-Section only, following attempted vaginal delivery after previous cesarean delivery
59622	•C-Section only, following attempted vaginal delivery after previous cesarean delivery (including postpartum care)
59430	•Vaginal Delivery, Antepartum and Postpartum Care

For full list of billing information refer to Behavioral Health and Case Management Services Handbook

Billing Maternity Claims

The following modifiers must be included for all deliveries		
U1 Medically necessary delivery prior to 39 weeks of gestation* STAR claims must include a medically necessary diagnosis from the list of approved diagnoses	U2 Delivery at 39 weeks of gestation or later*	U3 Non-medically necessary delivery prior to 39 weeks of gestation*

Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria will be subject to recoupment. Recoupment may apply to both physician services and hospital fees.

Billing Maternity Claims

- BCBSTX reimburses only one delivery or cesarean procedure per member in a seven-month period.
- Reimbursement includes multiple births
- Delivering physicians who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery.
- Itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and received within 95 days from the date of service.
- Use modifier **TH,** obstetrical treatment or service, prenatal or postpartum, with all antepartum codes.

Billing Maternity Claims

If a member is admitted to the hospital during her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.

If high risk, the high-risk diagnosis must be documented on the claim form.

Global codes cannot be used for billing BCBSTX.

Billing OB/GYN Claims

- 17P (Alpha Hydroxyprogesterone Caproate) is a Texas Medicaid Benefit for pregnant clients who have a history of preterm delivery before 37 weeks of gestation.
- Prior Authorization is required for both the compounded and the trademarked drug.
- Limited to a maximum of 21 doses per pregnancy
- When submitting claims use the following code:
  - J1725 U1 with NDC – Compounded Version
  - J1725 with NDC – Trademarked Version (Makena)
  - Diagnosis Codes: O09211, O09212, O09213, O09219

For additional codes: Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook

Sterilization

- Use the CMS-1500 claim form and follow appropriate coding guidelines.
- Attach a copy of the completed Sterilization Consent Form available at www.tmhp.com/resources/forms.

  Sterilization Consent Form (English)
  Sterilization Consent Form (Spanish)
  Sterilization Consent Form Instructions

- Claims will deny if form is not included with the claim.

Ancillary service

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

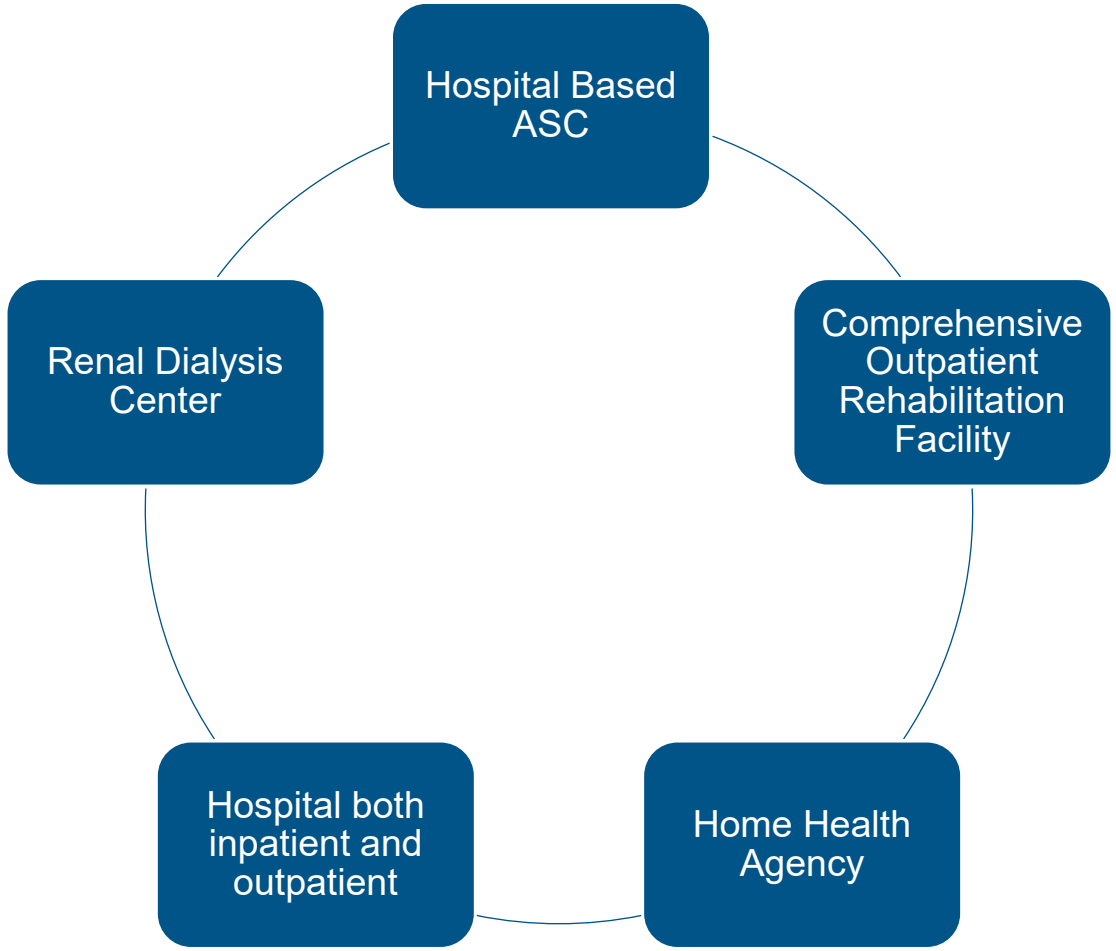
Ancillary Services

Providers who will use CMS-1500 include:

- Ambulance
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Durable Medical Equipment
- Early Childhood Intervention Providers
- Freestanding Ambulatory Surgical Center
- Laboratory
- Physical, Occupational, and Speech Therapists
- Podiatry
- Radiology

Ancillary Services

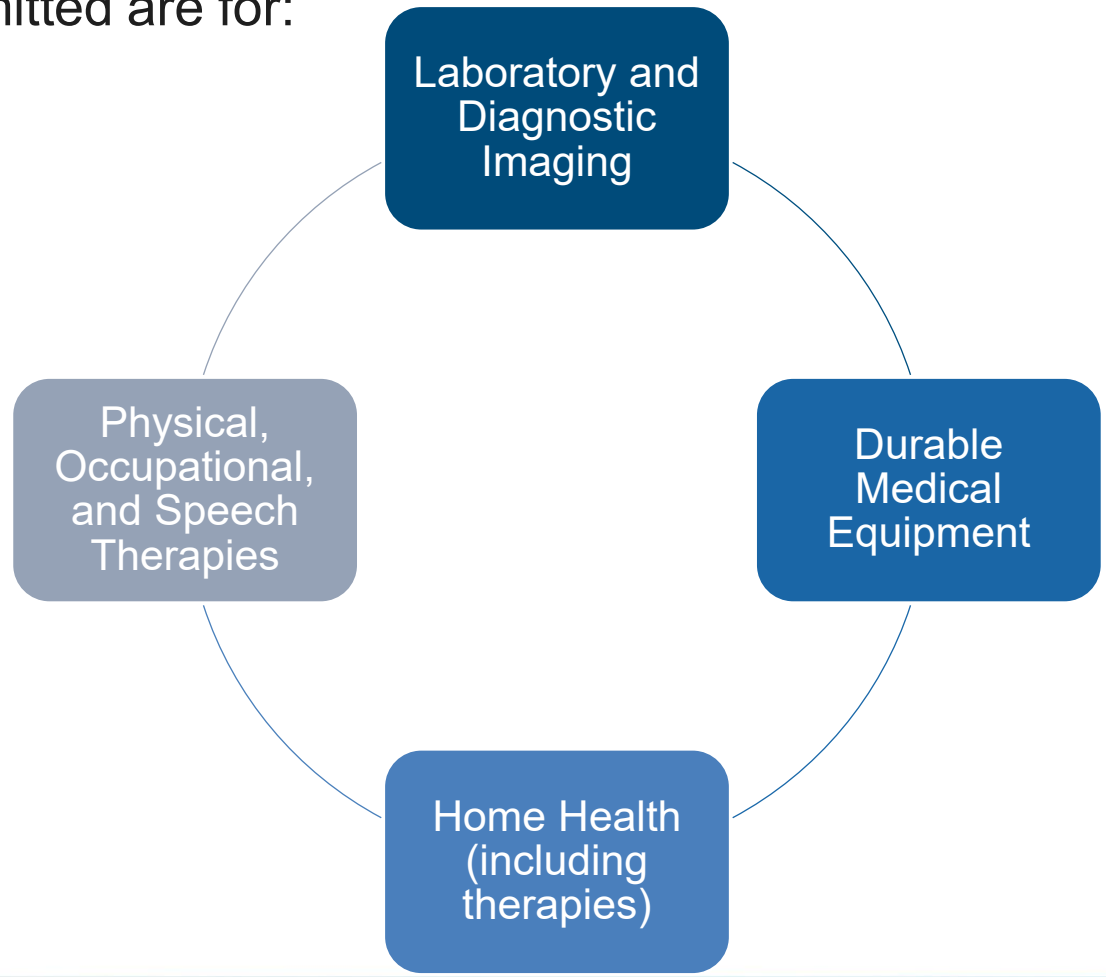
Providers who will use CMS-1450 (UB-04) include:



Ancillary Services

In general, no additional documentation or attachments are required for services that do not require prior authorization

Most Ancillary claims submitted are for:



Ancillary Services – Lab and Radiology

- Routine Lab and X-ray do not require prior authorization
- When billing for Lab or Radiology, all required information must be included on the claim.
- Superbills, or itemized statements are not accepted as claims supplements.
- Attested NPI numbers for STAR, STAR Kids and CHIP must be included on the claim.
- Any services requiring prior authorization must include the authorization number on the claim form.

Ancillary Services – Durable Medical Equipment

- Durable Medical Equipment is covered when prescribed to preserve bodily functions or prevent disability.
- All custom-made DME must be prior-authorized.
- When billing for DME services, follow the general billing guidelines:
  - Use HCPCS codes for DME or supply invoices for Average Wholesale Price/ Manufacture Suggested Retail Price pricing.

Ancillary Services – Home Health

- Home Health Agencies bill on a CMS-1450 UB-04, except for DME
- DME provided during a Home Health visit must be billed on a CMS-1500
- Home Health services include:
  - Skilled Nursing
  - Home Health Aides
  - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy and GO for Occupational Therapy must be billed for these services)
- Additional modifiers should also be billed with the Therapy Codes UB/U5 to denote the provider type billing service.

Ancillary Services – PT/OT/ST

- Home Health Agencies bill on a CMS-1450 UB-04, except for DME
- DME provided during a Home Health visit must be billed on a CMS-1500
- Home Health services include:
  - Skilled Nursing
  - Home Health Aides
  - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy and GO for Occupational Therapy must be billed for these services)
- Additional modifiers should also be billed with the Therapy Codes UB/U5 to denote the provider type billing service.

Ancillary Services – PT/OT/ST

- Home Health Agencies bill on a CMS-1450 UB-04, except for DME
- DME provided during a Home Health visit must be billed on a CMS-1500
- Home Health services include:
  - Skilled Nursing
  - Home Health Aides
  - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy and GO for Occupational Therapy must be billed for these services)
- Additional modifiers should also be billed with the Therapy Codes UB/U5 to denote the provider type billing service.

Behavioral Health Overview

For full list of billing information refer to Behavioral Health and Case Management Services Handbook

Provider Responsibilities for Behavioral Health

Precertification is required for mental health and substance abuse services for STAR, STAR Kids and CHIP

Direct referral – no PCP referral required to access mental health and substance abuse services

Mental health and substance abuse providers contact BCBSTX for initial authorization except in an emergency

Contact BCBSTX as soon as possible following the delivery of emergency service to coordinate care and discharge planning

Contact BCBSTX if during the course of treatment, you determine that services other than those authorized are required

Provide us with a thorough assessment of the member

Outpatient Mental Health Services – Procedure codes

The following procedure codes* may be reimbursed for Outpatient Mental Health Services:

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

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

Outpatient Mental Health Services – Psychiatric Diagnostic Evaluation Services

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

Psychiatric diagnostic evaluation:

- With medical services also includes a medical assessment, other physical examination elements as indicated, and may also include prescription of medications, and laboratory or other diagnostic studies.
- Without medical services (procedure code 90791) may be reimbursed to physicians, psychologists, advanced practice registered nurses, physician assistants, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, provisionally licensed psychologists, psychology interns, and post-doctoral fellows.
- With medical services (procedure code 90792) may be reimbursed to physicians, APRNs, and PAs.

In Lieu of Services Billing

In Lieu of Services Submission of Claims

Authorization will be required for claims payment for both PHP and IOP. If an urgent need for BH services, Providers will not be penalized for obtaining authorization after initiation of services.

Claims Codes and Modifiers

BCBSTX chosen procedure and modifier code combinations will be unique to each in-lieu-of service.

- S9480 - Intensive Outpatient Program Psychiatric
- H0015 - Intensive Outpatient Program Alcohol and/or drug services
- H0035 - Partial Hospital Services Psychiatric
- S0201 - Partial Hospital Services Alcohol and/or drug services

Behavioral Health – Psychologist Modifiers

Services provided by a psychologist, Licensed Psychological Associates, Provisionally Licensed Psychologists, Psychology intern, or post-doctoral fellow must be billed with a modifier on each detail.

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

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

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

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

Outpatient Mental Health Services – Psychological Neurobehavioral, and Neuropsychological

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

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

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

Applied Behavior Analysis - 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
97151	Limit to 6 hours	HO only

ABA Re-Evaluation		
Procedure Code	Limitations	Modifier Options
97151	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

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

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.

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

Therapy Billing

For full list of billing information refer to Texas Medicaid Provider Procedures Manual

Claim Form Requirements

CMS-1500 Claim Form:

- Individual Therapy Providers and Non-Outpatient Rehabilitation Facilities /Comprehensive Outpatient Rehabilitation Facilities Therapy Clinics
- Physical Therapy
- Occupational Therapy
- Speech Therapy

CMS-1450 (UB-04) Claim Form:

- Outpatient Hospital Therapy Clinics
- Comprehensive Outpatient Rehabilitation Facilities
- Outpatient Rehabilitation Facilities
- Home Health Agencies

Therapy Policy and Billing Guidelines

Medicaid reimbursement provided for therapy services:

- The Physical Therapy, Occupational Therapy, and Speech Therapy Handbooks are currently published on the TMHP website www.tmhp.com and contains information regarding benefit limits, therapy policies and guidelines.
- Accepted coding principles followed.
- Additional information and resources located in Blue Cross and Blue Shield of Texas Medicaid STAR, CHIP and Star Kids Provider Manual www.bcbstx.com/provider/medicaid/education-and-reference/education-reference

Common Denial Reasons

- Provider sanction status
- Missing or invalid modifier
- Incorrect place of service and modifier placement for Telehealth Claims
- Missing or invalid authorization
- Invalid Diagnosis Code

Provider Relations

Provider Relations Representatives

- Education and Training
- Assistance with problem claim resolution and locate forms on our website
- Claims Resolutions forms: www.bcbstx.com/provider/medicaid/forms.html
- Assistance with provider attestation issues
- Answer questions regarding program guidelines and claims filing

Contact:

- Call **855-212-1615**
- Email: TexasMedicaidNetworkDepartment@bcbstx.com.
- Website: www.bcbstx.com/provider/medicaid/network-participation/network-participation

Questions

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

BlueCross BlueShield of Texas

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Thank you!

Questions?

Contact information