Magellan Providers of Texas, Inc.*

Provider Handbook Supplement for Blue Cross and Blue Shield of Texas (BCBSTX) Medicaid (STAR, STAR Kids) and CHIP Programs

November 2022

**Magellan Providers of Texas, Inc. is an affiliate of Magellan Health, Inc. (collectively "Magellan").*

Magellan HEALTHCARE®

Table of Contents

Magellan HEALTHCARE®

SECTION 1: INTRODUCTION

Welcome

Welcome to the Magellan Providers of Texas, Inc. (Magellan) Provider Handbook Supplement for Texas Medicaid State of Texas Access Reform (STAR) and Children's Health Insurance Program (CHIP). This handbook addresses policies and procedures specific to Texas providers for the Medicaid and CHIP Programs. The Provider Handbook Supplement for Texas Medicaid and CHIP Programs is to be used in conjunction with the Magellan National Provider Handbook. When information in the Texas Medicaid and CHIP Programs Supplement conflicts with the national handbook, or when specific information in the Texas Medicaid and CHIP Programs does not appear in the national handbook, policies and procedures in the Texas Medicaid and CHIP Programs Supplement prevail. Additional information may also be found in the Texas Medicaid Provider Procedures Manual on the TMHP website.

Covered Services

To meet the behavioral health needs of its members, Blue Cross and Blue Shield of Texas (BCBSTX) has contracted with Magellan Providers of Texas, Inc. to provide a continuum of services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.

Magellan offers a variety of behavioral health services to BCBSTX STAR and STAR Kids Medicaid and CHIP members in the Travis Service Area and to STAR Kids in the MRSA Central Service Area. These services include: *assessment and treatment planning, psychiatric services, medication management, inpatient services, intensive outpatient services, outpatient therapy* and *substance abuse services*. Effective Feb. 1, 2022, Magellan also manages autism benefits for STAR members in the Travis Service Area and STAR Kids members in the Travis and MRSA Central Service Areas.

For more detail on behavioral health and autism benefits, both providers and members may contact Magellan at the numbers listed below:

1-800-327-7390 STAR/CHIP

1-800-424-0324 STAR Kids

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

See the Magellan National Provider Handbook

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Initiating Care

Our Philosophy

Magellan joins with our members, providers, and customers to make sure members receive the most appropriate services and experience the most desirable treatment outcomes for their benefit dollar.

Our Policy

We assist members in optimizing their benefits by reviewing and authorizing the most appropriate services to meet their behavioral health care needs, and members may self-refer without a referral from their primary care physician. We do not pay incentives to employees, peer reviewers (i.e., physician advisors), or providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-authorization or under-utilization of behavioral health care services.

What You Need to Do

Your responsibility is to do the following when a member presents for care:

- Contact Magellan for an initial authorization, except in an emergency. Routine outpatient visits do not require authorization.
- Contact Magellan as soon as possible following the delivery of emergency services to coordinate care and discharge planning.
- Provide Magellan with a thorough assessment of the member, including, but not limited to, the following:
  - Symptoms
  - Precipitating event(s)
  - Potential for harm to self or others
  - Level of functioning and degree of impairment (as applicable)
  - Clinical history, including medical, behavioral health, and alcohol and other drug conditions or treatments
  - Current medications
  - Plan of care
  - Anticipated discharge and discharge plan (if appropriate).

Call Magellan if, during the course of treatment, you determine that services other than those authorized are required.

Contact Magellan up to 60 calendar days prior to the expiration of an existing authorization to request a renewal of the authorization.

What Magellan Will Do

Magellan's responsibility to you is to:

- Contact you directly to arrange an appointment for members needing emergent or urgent care.
- Refer members based upon the member's identified needs and preferences.
- Authorize medically necessary care.

- Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services.
- Communicate the authorization determination by telephone, online and/or in writing to you and the member.
- Offer you the opportunity to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested services.
- Authorize a second opinion if appropriate.
- Conduct retrospective audits of selected medication management cases for quality-of-care purposes.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Concurrent Review

Our Philosophy

Magellan believes in supporting the most appropriate services to improve health care outcomes for members. We look to our providers to notify us if additional services beyond those initially authorized are needed, including a second opinion for complex cases.

Our Policy

Concurrent utilization management review is required for all services, depending on the benefits, including but not limited to:

- Inpatient and residential programs.
- Intermediate ambulatory services such as partial hospital programs (PHP), ambulatory detox programs, or intensive outpatient (IOP) programs.
- Psychological testing, outpatient ECT.
- Standard outpatient visits follow the Outpatient Care Model, as outlined in the next section.
- Mental health rehabilitative services and targeted case management

What You Need to Do

If after evaluating and treating the member, you determine that additional services are necessary:

- Contact the assigned Magellan care management team member up to 60 calendar days before end of the authorization period by telephone for inpatient and intermediate ambulatory services, including outpatient ECT and psychological testing.
- Be prepared to provide the Magellan care manager or physician advisor with an assessment of the member's clinical condition, including any changes since the previous clinical review.
- Request a second opinion if you believe it would be clinically beneficial.

What Magellan Will Do

Magellan's responsibility to you is to:

- Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for authorization of care.
- Promptly review your request for additional days or visits in accordance with the applicable medical necessity criteria.
- Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
- Respond in a timely manner to your request, verbally and in writing, for additional days or visits.
- Issue determinations, including adverse benefit determinations, within three business days after receipt of the request for authorization of services; within one business day for concurrent hospitalization decisions; one business day regarding a member who is hospitalized at the time of the request for services or equipment that will be necessary for the care of the member immediately after discharge; and within one hour for

post-stabilization or life-threatening conditions. (For emergency behavioral health conditions, no prior authorization is required.)

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Provider Claim Appeals

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

Our Philosophy	Magellan supports the right of the provider to appeal an unfavorable claim determination.
Our Policy	We will notify the member and provider by mail with an explanation of benefits and procedures for requesting a claim appeal.
What You Need to Do	Your responsibility is to: • File your Medicaid (STAR, STAR Kids) appeal within 120 calendar days from the date of the explanation of benefits. File your CHIP appeal within 180 calendar days from the date of the explanation of benefits. • Include any documentation you would like considered in the appeal request, including any documentation or information that was not considered in the initial determination. • Submit the request for appeal online at MagellanProvider.com (sign in required). Or, you may send the request for appeal to: Magellan Healthcare Attn: Appeals P.O. Box 1718 Maryland Heights, MO 63043
What Magellan Will Do	Magellan's responsibility to you is to: • Acknowledge the appeal within five business days of receipt. • Complete the appeal review within 30 calendar days of receipt. • Provide written notification of the appeal decision no later than 30 calendar days after Magellan's receipt of the request. • Refer you directly to BCBSTX if you are not satisfied with the appeal decision.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Appeals for BCBSTX Medicaid (STAR, STAR Kids) and CHIP Members

Our Philosophy

Magellan supports the right of the provider to appeal, on behalf of a member, an adverse benefit determination (unfavorable administrative or a medical necessity adverse determination) by complying with the requirements of BCBSTX Medicaid (STAR and STAR Kids) and CHIP administrative and medical necessity appeals processes.

Our Policy

To comply with our health plan delegation agreements and to inform Magellan-contracted providers of the processes by which to request appeals of administrative unfavorable determinations and medical necessity adverse benefit determinations.

What You Need to Do

Your responsibility is to:

- File your Medicaid (STAR and STAR Kids) appeal within 60 days from the date on the notice of the adverse benefit determination. File your CHIP appeal within 180 days from the date of your receipt of the adverse benefit determination. *
- Include any documentation you would like considered in the appeal request, including any documentation/information that was not considered in the initial determination.
- Request an extension on behalf of a Medicaid (STAR and STAR Kids) member of up to 14 calendar days, if appropriate. The timeframe may not be extended on a CHIP member's appeal.

If the member is a BCBSTX CHIP, STAR and STAR Kids member send appeal information to:

Blue Cross and Blue Shield of Texas Member Appeals
P.O. Box 660717
Dallas, TX 75266-0717

*This section does not apply to member or provider appeals for autism services.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Appeals for BCBSTX Medicaid (STAR, STAR Kids) Autism services

Our Philosophy

Magellan supports the right of the member or the provider l, on behalf of a member, to appeal adverse benefit determination (unfavorable administrative or a medical necessity adverse determination) by complying with the requirements of BCBSTX Medicaid (STAR and STAR Kids) administrative and medical necessity appeals processes.

Our Policy

To comply with our health plan delegation agreements and to inform Magellan-contracted providers of the processes by which to request appeals of administrative unfavorable determinations and medical necessity adverse benefit determinations.

What You Need to Do

Your responsibility is to:

- File your Medicaid (STAR and STAR Kids) appeal within 60 days from the date on the notice of the adverse benefit determination.
- Include any documentation you would like considered in the appeal request, including any documentation/information that was not considered in the initial determination.
- Request an extension on behalf of a Medicaid (STAR and STAR Kids) member of up to 14 calendar days, if appropriate. Send appeal information to:

Magellan Healthcare, Inc.
P.O. Box 1718
Maryland Heights, MO 63043

Or fax to 1-888-656-5712

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Member Access to Care

Our Philosophy

Magellan believes that members are to have timely access to appropriate mental health and substance abuse services from an in-network provider 24 hours a day, seven days a week.

Our Policy

We require in-network providers to be accessible within a timeframe that reflects the clinical urgency of the member's situation. Clinical urgency is categorized as Routine, Emergent and Urgent and defined by the State of Texas as follows:

Routine—When the member's condition is considered to be sufficiently stable and not to have a negative impact on the member's condition to allow for a face-to-face assessment to be available within 14 calendar days following the request for service.

Emergent—A medical situation that is not life threatening. A non-life-threatening emergency is a condition that requires rapid intervention (within 6 hours) to prevent acute deterioration of the member's clinical state or condition. Gross impairment of functioning usually exists and is likely to result in compromise of the member's safety.

Urgent—Health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician's or a provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health (within 24 hours)

Follow up to Routine Care—health care services to evaluate patient progress and other changes that have taken place since a previous visit. Prescriber appointments should be no longer than 90 days between visits; non-prescriber appointments should be no longer than 30 days between visits.

What You Need to Do

Your responsibility is to:

- Provide access to services 24 hours a day, seven days a week.
- Inform members of how to proceed, should they need services after business hours.

- Provide coverage for your practice when you are not available, including, but not limited to an answering service with emergency contact information.
- Respond to telephone messages in a timely manner.
- Provide comprehensive screening and appropriate triage for members who present at your office or emergency room experiencing a life-threatening emergency. (Pre-authorization is not required for these services.)
- Provide services within six hours of referral in an emergent situation that is not life threatening. Non-life-threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member's condition.
- Provide services within 24 hours of referral in an urgent clinical situation.
- Provide services within 14 calendar days of referral for routine clinical situations.
- Provide routine follow up services within 30 days of an initial evaluation.
- Provide services within seven days of a member's discharge from an inpatient stay.
- Contact Magellan immediately if member does not show for an appointment following an inpatient discharge so that Magellan can conduct appropriate follow up.
- Contact Magellan immediately if you are unable to see the member within the timeframes.
- Provide outpatient behavioral health services upon discharge from an inpatient psychiatric setting within seven days.

What Magellan Will Do

Magellan's responsibility to you is to:

- Communicate the clinical urgency of the member's situation when making referrals.
- Contact members who seek emergent or urgent services and are follow-up treatment compliant.
- Contact members who miss appointments and work with them to reschedule.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Local Mental Health Authority

Our Philosophy

Magellan will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities for treatment of members with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), as well as members committed by a court of law to a state psychiatric facility, to support and provide the most appropriate care.

Severe and persistent mental illness means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

Severe emotional disturbance means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

Our Policy

In coordination with the LMHA, Magellan will authorize additional behavioral health services for special populations and will assist our providers in meeting with these requirements.

What You Need to Do

Your responsibility is to:

- Understand Medicaid (STAR and STAR Kids) standards applicable to providers.
- Meet Medicaid (STAR and STAR Kids) standards.
- Refer members to LMHA, as appropriate, and accept referrals from LMHA.

What Magellan Will Do

Magellan's responsibility to you is to:

- Operate a toll-free telephone hotline to respond to your questions, comments, and inquiries.
- Establish a multi-disciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
- Provide covered services to members with SPMI/SED when medically necessary.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Coordination with Texas Department of Family and Protective Services

Our Philosophy

Magellan will support all entities and stakeholders invested in the member's care.

Our Policy

Magellan collaborates with all state and legal entities involved in providing services to our members, including the Texas Department of Family and Protective Services (DFPS)—formerly the Department of Protective and Regulatory Services.

Magellan cooperates and coordinates with DFPS for a member receiving family-based services or for a member who is in DFPS conservatorship but is not enrolled in the STAR Health program.

Magellan will provide our delegated covered court-ordered behavioral health services to members.

Magellan may participate in the preparation of the medical and behavioral care plan prior to DFPS' submitting the health care plan to the court. Any modification or termination of court-ordered services will be presented and approved by the court having jurisdiction over the matter.

What You Need to Do

Your responsibility is to:

- Provide medical records to DFPS.
- Schedule behavioral health service appointments within 14 days unless requested earlier by DFPS.
- Contact DFPS to report any suspected abuse or neglect.
- Coordinate with the health plan care management team for services to members who have a DFPS service plan.

What Magellan Will Do

Magellan's responsibility to you is to:

- Support you, our provider, to ensure that you understand the intent of the court order and the services you are to provide.
- Not deny, reduce, or controvert the medical necessity of any behavioral health services included in a court order.
- Comply with all provisions related to Covered Services in the following documents:
  - A court order (Order) entered by a Court of Continuing Jurisdiction placing and child under protective custody of DFPS.
  - A DFPS Service Plan entered by a Court of Continuing Jurisdiction placing a child under the protective custody of DFPS.

- A DFPS Service Plan voluntarily entered into by parents or person having legal custody of a member and DFPS.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Referrals from Primary Care Physicians

Our Philosophy

Magellan believes that collaboration and communication among all providers participating in a member's treatment is essential for the delivery of integrated quality care.

Our Policy

Magellan supports communication between behavioral health providers and primary care physicians (PCPs) providing behavioral health services within the scope of his or her practice.

What You Need to Do

Your responsibility is to:

- Make a referral and/or collaborate with the member's PCP as clinically appropriate for ongoing or complex mental health, substance abuse problems, and/or maternal mental health (MMH) conditions.
- Talk directly to a Magellan care manager to facilitate care in an urgent situation.
- Inform Magellan of ongoing or complex mental health, substance abuse problems, and/or maternal mental health (MMH) conditions.

What Magellan Will Do

Magellan's responsibility to you is to:

- Encourage PCPs to make referrals to behavioral health specialists, as appropriate.
- Encourage behavioral health providers to communicate key health information with PCPs including:
  - Initial evaluation
  - Significant changes in treatment, medication, or clinical status
  - Termination of treatment.
- Encourage PCPs to obtain member authorization to communicate with behavioral health providers.
- Work with treatment providers to quickly and effectively respond to urgent care situations.
- Refer members with ongoing or complex mental health, substance abuse problems, or maternal mental health (MMH) conditions to a network behavioral health provider.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Advance Directives

Our Philosophy

Magellan believes in a member's right to self-determination in making health care decisions.

Our Policy

As appropriate, Magellan will inform adult members 18 years of age or older about their rights to refuse, withhold or withdraw medical and/or mental health treatment through advance directives. Magellan supports the state and federal regulations, which provide for adherence to a member's psychiatric advance directive.

What You Need to Do

Your responsibility is to:

- Understand and meet federal Medicaid standards regarding advance directives.
- Understand and meet state Medicaid (STAR and STAR Kids) standards regarding psychiatric advance directives.
- Maintain a copy of the psychiatric advance directive in the member's file, if applicable.
- Understand and follow a member's declaration of preferences or instructions regarding mental health treatment.
- Use professional judgment to provide care believed to be in the best interest of the member.

What Magellan Will Do

Magellan's responsibility to you is to:

- Comply with state of Texas and federal advance directive laws.
- Document the execution of a member's psychiatric advance directive.
- Not discriminate against a member based on whether the member has executed an advance directive.
- Provide information regarding advance directives to the member's family or surrogate if the member is incapacitated and unable to articulate whether or not an advance directive has been executed.
- Follow up with the member to provide advance directives information once the member is no longer incapacitated.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Medical Necessity Review Guidelines

Our Philosophy

Magellan is committed to the philosophy of promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member's biopsychosocial needs. Medical necessity review is applied based on the member's individual needs including, but not limited to, clinical features and available behavioral health care services.

Our Policy

Magellan uses MCG Guidelines®, along with its proprietary clinical criteria, Magellan Healthcare Guidelines, as the primary decision support tools for our Utilization Management Program. Collectively, they are known as the Magellan Care Guidelines. Magellan also uses the American Society of Addiction Medicine (ASAM) criteria for all substance abuse treatment determinations. In addition, Magellan follows the Utilization Management Guidelines as those prescribed for use by Local Mental Health Authorities by Mental Health Mental Retardation (MHMR), for members receiving services from local community mental health centers.

For requests for applied behavior analysis, we use the medical necessity criteria as referenced by the Texas Medicaid Provider Procedures Manual.

What You Need to Do

Your responsibility is to:

- Be familiar with the medical necessity guidelines appropriate for the member's condition.

What Magellan Will Do

Magellan's responsibility to you is to:

- Communicate the specific guideline(s) used in rendering a determination.
- Make the guidelines available to you.
- Provide you with a specific clinical rationale and appeal procedures for any non-authorization determination.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Members with Special Needs

Our Philosophy	Magellan believes that members with Special Health Care Needs (MSHCN) should have direct access to in-network behavioral health specialists as appropriate to their condition and identified needs.
Our Policy	Magellan maintains systems and procedures for identifying MSHCN, including people with chronic or complex behavioral health conditions. For Children with Special Health Care Needs (CSHCN), Magellan refers to providers with expertise in treating children. It is our policy to review the request for services using Magellan's Medical Necessity Criteria.
What You Need to Do	Your responsibility is to: • Coordinate with the Health Plan Care Management team and/or the comprehensive treatment team if you are providing services to an MSHCN or CSHCN. • Collaborate with the Health Plan Care Management team and/or the appropriate community agencies involved in the member's care.
What Magellan Will Do	Magellan's responsibility to you is to: • Support those providing services to an MSHCN or CSHCN. • Collaborate with you and/or the appropriate community agencies involved in the member's care.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Texas Fraud, Waste, and Abuse

Our Philosophy

Magellan takes allegations of fraud, waste, and abuse very seriously. Magellan engages in considerable efforts and dedicates substantial resources to prevent these activities and to identify those committing violations. Magellan fully supports all state and federal laws and regulations pertaining to fraud, waste, and abuse in healthcare and will cooperate with enforcement of these laws and regulations.

Our Policy

Magellan does not tolerate fraud, waste, or abuse, either by providers, members, or staff. Accordingly, we have instituted extensive fraud, waste, and abuse programs to combat these problems. Magellan's programs are wide-ranging and multi-faceted, focusing on prevention, detection, and investigation of all types of fraud, waste, and abuse. Magellan will fully cooperate and assist HHSC and any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, waste, or abuse. Magellan will provide records and information, as requested.

What You Need to Do

Your responsibility is to:

- Report any enrollees you suspect of committing Medicaid (STAR, STAR Kids)/CHIP fraud, waste, or abuse to:
  - Magellan
  - The Attorney General's Office, or
  - Office of Inspector General.

- Cooperate with the Inspector General for the Texas Health and Human Services System or its authorized agent(s), the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, Texas Department of Insurance, or other units of state government free of charge by providing all requested information and access to premises within three business days of the request.

What Magellan Will Do

Magellan's responsibility to you is to implement and regularly conduct fraud, waste, abuse, and overpayment prevention activities, in compliance with applicable federal and state regulations and contractual obligations, that include:

- Providing you with contact information or file the information for you with the appropriate regulatory body.
- Monitoring and auditing provider utilization and claims to detect fraud, waste, abuse, and overpayment.
- Investigating and pursuing fraud and abuse and other alleged illegal, unethical, or unprofessional conduct.

- Reporting suspected fraud, waste, and abuse and related data to federal customers and/or state agencies.
- Cooperating with law enforcement authorities in the prosecution of health care and insurance fraud cases.
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded health care programs.
- Training employees annually on Magellan's Corporate Compliance Handbook.
- Making the Magellan Provider Handbook available to network providers.

How to report suspected cases of fraud, waste and abuse:

Reports made to Magellan can be submitted via one of the following methods:

- Special Investigations Unit via the hotline: 1-800-755-0850 or email: SIU@MagellanHealth.com
- Corporate Compliance via the hotline: 1-800-915-2108 or email: Compliance@MagellanHealth.com

Additionally, you may also report suspected fraud, waste, or abuse by recipients or providers in Texas Health and Human services programs via:

- Texas HHS OIG toll free hotline 1-800-436-6184 or
- Submitting an online form https://oig.hhsc.state.tx.us/wafrep/

Refer to Magellan's national provider handbook for additional information on this section.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Court-Ordered Commitments

Our Philosophy

Magellan is subject to all state and federal laws and regulations relating to court-ordered commitments, and will provide services to CHIP, STAR and STAR Kids members within regulatory requirements.

Our Policy

Related to court-ordered commitments, Magellan will provide inpatient psychiatric covered services to members birth through age 20, and ages 65 and older, up to the annual limit, who have been ordered to receive the services: a)by a court of competent jurisdiction, including services ordered under the provisions of Chapters 573 (Subchapters B and C) and 574 (Subchapters A through G) of the Texas Health and Safety Code and the Chapter 55, Subchapter D of the Texas Family Code, or b) as a condition of probation if the member receives those services at an acute care hospital.

Exception: when the member is incarcerated.

For members between the ages of 21 and 64, Magellan may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.

Magellan will provide covered substance abuse disorder treatment services, including residential treatment, as required: a) as a court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or b) as a condition of probation.

Exception: when the member is incarcerated.

What You Need to Do

To comply with this policy, your responsibility is to:

- Contact the assigned Magellan care management team member by telephone if you are aware of a court-ordered commitment.
- Submit the court-ordered commitment documents to Magellan at the time of the authorization request.
- Be prepared to provide the Magellan care manager or physician advisor with an assessment of the member's clinical condition.

What Magellan Will Do

Magellan's responsibility is to:

- Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for authorization of care.
- Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
- Respond in a timely manner verbally and in writing to your request:
    - Within three business days after receipt of the request for authorization of services,

  - Within one business day for concurrent hospitalization decisions, and
  - Within one hour for post-stabilization or life-threatening conditions (for emergency behavioral health conditions, no prior authorization is required).
- Not deny, reduce, or controvert the medical necessity of inpatient psychiatric services provided, pursuant to court-ordered commitments for members, birth through age 20, or ages 65 and older.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Texas Medicaid Autism Services

Our Philosophy

Magellan believes that members who are 20 years of age or younger with a diagnosis of an autism spectrum disorder (ASD) should have access to services that are medically necessary and appropriate to their diagnosis and needs.

Our Policy

Magellan has adopted the Texas Medicaid Autism Services Policy for guidance and oversight of Medicaid members accessing applied behavior analysis (ABA). Magellan will perform oversight on compliance with this policy as required by state and federal laws and regulations.

What You Need to Do

Your responsibility is to:

- Enroll licensed behavior analysts with Texas Medicaid & Healthcare Partnership (TMHP).
- Sign and return Magellan contract documents for these services.
- Review the Medicaid Autism Services Policy on the TMHP website and autism information in the Texas Medicaid Provider Procedures Manual (TMPPM).
- Confirm diagnosis was made by one of the eligible providers as identified in the Medicaid Autism Services Policy within the specified timeframe.
- Obtain a referral for ABA services from the prescribing provider.
- Submit request for the initial services and any subsequent services within a timely manner.
- Coordinate with the prescribing provider for referrals and frequency and duration of treatment.
- Maintain accurate attendance logs and submit them with each request for an extension or recertification.
- Participate in interdisciplinary meetings with the required licensed professionals.
- File claims accurately and timely.

What Magellan Will Do

Magellan's responsibility is to:

- Review requests for authorization of ABA services and enter authorizations as appropriate.
- Provide feedback to you regarding any questions or concerns identified in the course of treatment.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM)

Our Philosophy

Magellan believes that members should have access to mental health rehabilitative (MHR) services and targeted case management (TCM) as appropriate to their condition and identified needs.

Our Policy

Magellan has established policies and procedures for monitoring mental health rehabilitative services and targeted case management and will perform oversight on compliance with these as required by state and federal laws and regulations.

What You Need to Do

As required in the Texas Administrative Code, Title 1, Part 15, Chapters 353 and 354 regarding Medicaid Managed Care, providers of these services must:

- Complete the Magellan credentialing application, attesting to all requirements.
- Credential staff in accordance with § 353.1415.
- Meet the information systems and medical record systems of § 353.1407.
- Demonstrate adherence to patient safety, rights, and protections as outlined in § 353.1409.
- Provide access to mental health services as defined by § 353.1411.
- Assure staff member credentialing and competence as outlined in §§ 353.1413, 353.1415, 353.1417, and 353.1419.
- Perform criminal history background checks on each staff member and applicant offered employment in accordance with § 354.2613.
- Assess member eligibility and continued eligibility as outlined in §§ 354.2651, 354.2653, 354.2701, and 354.2703.
- Perform assessments and service authorizations according to § 354.2607.
- Perform treatment planning, plan review, and discharge summaries as required in § 354.2609.
- Provide mental health rehabilitation and mental health targeted case management services as outlined in §§ 354.2611, 354.2655, 354.2705, 354.2707, and 354.2711.
- Adhere to required documentation as outlined in § 354.2657.
- Be aware of the exclusions listed in §§ 354.2659 and 354.2717.
- Provide medication training and support services listed in § 354.2709.

- Offer appropriate skills training and development services outlined in § 354.2713.
- Provide access to day programs for acute needs according to § 354.2715.

Understand the meanings of the terms and words in § 354.2603.

As specified in the Health and Human Services Commission (HHSC) Uniform Managed Care Manual (UMCM), Chapter 15.3 version 2.2, providers must attest annually as having completed trainings that include the following:

- Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-17 years and the Adult Needs and Strength Assessment (ANSA) for members 18 and older.
- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).
- Attest to Magellan that you have the ability to provide services to members with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC established qualification and supervisory protocols.
- For more information on trainings and how to attest, please contact:

1-800-327-7390 STAR
1-800-424-0324 STAR Kids

What Magellan Will Do

Magellan's responsibility is to:

- Audit Comprehensive Provider Agencies to assure strict compliance with the standards as written.
- Provide feedback and a corrective action plan on the audit requirements out of compliance and audit again as needed.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Peer Support Services

Our Philosophy

Magellan includes in its network, specialists who, under clinical supervision, provide peer support services to members recovering from behavioral health conditions. Peer support specialists have experienced mental health and/or substance use challenges themselves and are trained and certified to help others in similar situations.

Our Policy

Magellan complies with Texas Medicaid benefits for mental health and substance abuse services in the area of peer support. Peer support specialists provide services including recovery planning, assistance with finding appropriate community resources and services, and member advocacy in urgent situations.

What You Need to Do

Your responsibility is to:

- Review the eligibility requirements for peer specialists.
- Complete criminal history and registry checks as described in 1 TAC § 354.3201.
- Assure that any individual providing peer support services has completed all the training and certification requirements as outlined in 1 TAC § 354.3155.
- Provide supervision as required.
- Follow the prior authorization as required and bill with the appropriate HCPC codes, including modifiers.
- Ensure proper documentation of all peer specialists services that are rendered, including supervisory sessions and documentation in the personnel file.

What Magellan Will Do

Magellan's responsibility is to:

- Review requests for peer specialists' services and authorize services based on medical necessity.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

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

Our Philosophy

Magellan believes in early intervention and treatment services for client with or at risk for substance use disorders.

Our Policy

Magellan makes the determination for the most appropriate level of care based on clinical appropriateness, eligibility, benefits, and coverage at the time of the referral.

What You Need to Do

Your responsibility is to:

- Complete at least four (4) hours of SBIRT Training and maintain poof of training in your place of service.
- Notify Magellan of your interest in providing this service and complete Magellan attestation as documentation of training.
- Use standardized tools to complete screening.
- Provide brief intervention as appropriate, using motivational interviewing techniques.
- Follow the guidelines in Section 8 of the Behavioral Health and Case Management Services Handbook.
- If it is determined that the client needs more intensive treatment or is at severe risk for alcohol or substance abuse, contact Magellan at the number listed below:
  - 1-800-327-7390 STAR
  - 1-800-424-0324 STAR Kids

What Magellan Will Do

Magellan's responsibility to you is to:

- Provide you with access to the training attestation.
- Provide you with the member's benefit and participating network information to assist you in making a referral to another provider if you are not able to treat this member.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Substance Use Referrals for STAR, STAR Kids and CHIP Members

Our Philosophy

Magellan believes in referring members to the appropriate level of care when it is identified that a member has a substance use disorder.

Our Policy

Magellan makes the determination for the most appropriate level of care based on clinical appropriateness, eligibility, benefits and coverage at the time of the referral.

What You Need to Do

Your responsibility is to:

- Contact Magellan when, while assessment or treatment, you have determined additional treatment for the member's substance use disorder is needed, such as inpatient, residential, partial hospitalization, intensive outpatient treatment (IOP), or medication-assisted treatment (MAT).
- Provide Magellan with a thorough assessment of the member, including, but not limited to, the following:
  - Symptoms
  - Precipitating event(s)
  - Potential for harm to self or others
  - Level of functioning and degree of impairment (as applicable)
  - Clinical history, including medical, behavioral health, and alcohol and other drug conditions or treatments
  - Current medications
  - The DSM diagnosis in effect at the time of service
- Contact Magellan at the number listed below:
  - 1-800-327-7390 STAR/CHIP
  - 1-800-424-0324 STAR Kids

What Magellan Will Do

Magellan's responsibility to you is to:

- Make the determination regarding the most appropriate level of care.
- Provide you with the member's benefit and participating network information to assist you in making a referral to another provider if you are not able to treat this member.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Health and Human Services Commission's MTP for STAR and STAR Kids

The Medical Transportation Program (MTP) is provided by Texas Health and Human Services Commission (HHSC) so that STAR Kids members can receive transportation assistance to get to and from a provider, hospital or drug store. HHSC will do one of the following:

- Pay for a bus ride or ride sharing service.
- Pay a friend or relative by the mile for the round trip.
- Provide gas money directly to the member/parent/guardian.
- If a member must travel out of town for services, HHSC may pay for lodging and meals for the member and the member's parent/guardian.

To be approved for transportation the member must not have any other way to get to the Medicaid-related health visit. There are two steps to arranging transportation that need to be completed.

1. Requests within the county should be made at least two (2) business days in advance. If the travel distance to the provider is outside of the county, arrangements should be made at least five (5) business days in advance. Requests made on the same day as the service are not guaranteed.
2. At the time the request for transportation is made the following information should be supplied: Medicaid ID number, address where the member should be picked up along with telephone number, the name and address of the provider where the member will be seeking treatment and/or service, the date and time of the visit, any special needs of the members.

To request services, please call ModivCare directly toll-free between 8 a.m. and 5 p.m., Central Time, Monday through Friday at **1-866-824-1565 (TTY: 711).**

SECTION 4: THE QUALITY PARTNERSHIP

Complaint and Complaint Appeal Process for Members and Providers

Our Philosophy

Magellan believes that members and providers have the right to express comments related to care, service or confidentiality, to have those concerns thoroughly investigated, to receive a timely, comprehensive and professional response to concerns, and to have the right to appeal a complaint determination.

Our Policy

Our policy is to follow all regulations for Medicaid (STAR, STAR Kids) and CHIP member services.

What You Need to Do

Your responsibility is to:

- Refer to the specific procedures for filing a complaint as directed in the administrative unfavorable determination or medical necessity adverse determination letter. Refer to the complaint resolution letter for information about how to appeal the complaint resolution.
- Contact Magellan by telephone, email or U.S. Mail to file a complaint.

What Magellan Will Do

Magellan's responsibility to you is to:

- Provide a toll-free number to use to file a complaint.
- Provide assistance in the filing process, if needed.
- Acknowledge a complaint within five business days of receipt.
- Resolve complaints within 30 calendar days.

Complaint Appeals

Magellan follows all requirements in responding to complaint appeals. This includes the following:

1. The member must submit a complaint appeal within 30 days of the date of receipt of the complaint resolution letter. Instructions for the appeal process are included in this letter.
2. A complaint form will be included in the acknowledgment of a verbal complaint.

The member, someone acting on the member's behalf, and providers may file a written or verbal complaint about our utilization review process or procedures. Send your written complaint to: Magellan Healthcare, Inc., Attn: Complaints, P.O. Box 1718, Maryland Heights, MO 63043, or via fax to 1-888-656-5034.

Or call Magellan to submit a verbal complaint:

- 1-800-327-7390 STAR/CHIP
- 1-800-424-0324 STAR Kids

SECTION 5: PROVIDER REIMBURSEMENT

Texas Provider Reimbursement for Professional Services

Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.

Our Policy

Magellan reimburses mental health and substance abuse treatment providers using current procedural terminology (CPT) fee schedules for professional services. Magellan will deny claims not received within applicable state mandated or contractually required timely filing limits.

What You Need to Do

In addition to your responsibilities outlined in the National Provider Handbook, you need to:

- ***Not*** collect co-payments for CHIP members; co-payments are temporarily being waived. Medicaid (STAR and STAR Kids) members are not required to pay a copayment.
- Submit your claim for reimbursement promptly after the date of service or discharge (must be within 95 days).
- File telehealth claims with a modifier of 95.
- Include taxonomy codes for the billing and rendering providers on claims.
- Submit complete and accurate data elements on your claims. (See the *Elements of a Clean Claim* appendix of the *Magellan National Provider Handbook* located at www.MagellanProvider.com/handbook.)
    - Submit claims with the **license-level** modifier that represents the treating provider's license level if you are an organizational provider or an individual provider submitting professional service claims (CPT code related services) as part of an organization (using the organization's Taxpayer Identification Number).
    - Use the appropriate modifier associated with the degree level of the individual providing the service. (Magellan processes claims using the organization's record, and the license-level modifier provided on the claim communicates the correct rate for reimbursement.)

For your reference, we have included a table below defining the modifiers by degree/license level.

Degree/Licensure	HIPAA Modifier	HIPAA Modifier Description
Psychiatrist	AF	Specialty physician
Physician	AG	Primary physician
Psychologist	AH, HP	Clinical psychologist or doctoral level

Social Worker	AJ	Clinical social worker
Master's Level Counselor	HO	Master's degree level
Clinical Nurse Specialist	SA, TD	Nurse practitioner RN
Physician Assistant	U7*	
NCAC (National Certified Addictions Counselor) or state substance abuse counseling certification	HF	Substance abuse program
Bachelor's degree level counselors	HN	Bachelor's degree level
Less than bachelor's degree level counselors	HM	Less than bachelor's degree level

**Used only by Federally Qualified Health Centers and Rural Health Clinics*

For more information on reimbursement coding requirements, visit our provider website at www.MagellanProvider.com.

For autism claims, use the modifiers as provided by TMHP in the Medicaid Autism Services Policy.

Submit claims to:

P.O. Box 2154
Maryland Heights, MO 63043

For questions, contact Magellan at:

1-800-327-7390 STAR and CHIP
1- 800-424-0324 STAR Kids

What Magellan Will Do

In addition to the responsibilities outlined in the National Provider Handbook, Magellan's responsibility to you is to:

- Review our reimbursement schedules periodically in consideration of industry standard reimbursement rates and revise them when indicated.
- Provide a toll-free number for you to call for provider assistance. That number is 1-800-788-4005.
- Provide 90 days' notice prior to the implementation of changes to claims guidelines.
- Provide a paper or electronic copy of the fee schedule. To request this, please contact 1-800-788-4005.

SECTION 5: PROVIDER REIMBURSEMENT

Overpayments

Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.

Our Policy

Magellan has a mechanism in place through which network providers report overpayments.

What You Need to Do

If a network provider determines that an overpayment has been made, the provider must notify Magellan of the suspected overpayment and the amount of the overpayment within 60 days of identification that an overpayment has been made. "Identification" means that the network provider has or should have, through the exercise of reasonable diligence, determined that he/she has received an overpayment and has determined the amount of the overpayment. Documentation should be forwarded to:

P.O. Box 2154
Maryland Heights, MO 63043

For questions, contact Magellan at:

1-800-327-7390 STAR and CHIP

1-800-424-0324 STAR KIDS

What Magellan Will Do

Upon receipt of the notification of overpayment, Magellan will review the provided documentation and adjust claims, accordingly.

CHIP/STAR /STAR Kids Behavioral Health Services Comparison ***

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
Inpatient Mental Health Services	• Medically necessary services including, but not limited to, mental health services furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities. • Medically necessary inpatient mental health services are unlimited. • Includes inpatient psychiatric services, up to a 12-month period limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. • Does not require primary care physician (PCP) referral. • Neurological testing is covered under inpatient and outpatient services.	• Medically necessary services for treatment of mental, emotional or substance use disorders. • Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid (STAR) Program and are subject to utilization review requirements. • Includes inpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. • Admissions for chronic diagnoses such as mental retardation (MR), organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.	• Medically necessary services for the treatment of mental, emotional or substance use disorders. • Medically necessary inpatient admissions for children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid (STAR Kids) Program and are subject to utilization review requirements. • Includes inpatient psychiatric services, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. • Admissions for chronic diagnoses such as mental retardation (MR), organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.
Outpatient Mental Health Services	• Medically necessary services include, but are not limited to, mental health services provided on an outpatient basis. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.	• Medically necessary services for the treatment of mental, emotional or substance use disorders. • For members 20 and younger, medically necessary services include, but are not limited to, mental health services provided on an outpatient basis.	• Medically necessary services for the treatment of mental, emotional or substance use disorders. • Medically necessary services include, but are not limited to, mental health services provided on an outpatient basis.

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
	• Includes outpatient psychiatric services, up to a 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code. • Does not require PCP referral. • Outpatient visits are unlimited, including medication management visits. • Neurological testing is covered under inpatient and outpatient services. • A Qualified Mental Health Professional (QMHP) must be working under the authority of a Department of State Health Service (DSHS) entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers, if the services provided are within the scope of the services typically provided by QMHPs. These services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	• For members 21 and older, outpatient behavioral health services are limited to 30 visits per member, per calendar year. (Additional visits can be allowed if authorization is requested prior to the 25th visit). • Includes outpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code. • Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT). • Covered services are a benefit for members suffering from a mental psychoneurotic or personality disorder when provided in the office, home, skilled nursing facility, outpatient hospital, nursing home or other outpatient setting. • Does not require a PCP referral. • Medication management visits do not count against outpatient visit limit. • Psychological and neuropsychological testing is covered for specific diagnoses. Testing is	• Includes outpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code. • Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist (LMFT). • Covered services are a benefit for members suffering from a mental psychoneurotic or personality disorder when provided in the office, home, skilled nursing facility, outpatient hospital, nursing home or other outpatient setting. • Does not require a PCP referral. • Medication management visits do not count against outpatient visit limit. • Psychological and neuropsychological testing is covered for specific diagnoses. Testing is limited to four hours per day per member (any provider), 8 hours annual benefit limit. Applies to 30-visit maximum. • Psychological testing is limited to eight hours of testing per member, per calendar year (any

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
		limited to four hours per day per member (any provider). • Psychological testing is limited to eight hours of testing per member, per calendar year (any provider). • Neuropsychological test battery is limited to eight hours per member, per calendar year (any provider). • Testing does count toward the 30-visit limit. • Additional services such as mental health screenings are covered under the Texas Health Steps Consumer Choice program. • For members 21 years of age or older: counseling by LPCs, LCSWs, LMFTs and Psychologists. Limit of 30 visits per calendar year. If additional visits are required, they must be prior authorized.	provider), 8 hours annual benefit limit. Applies to 30-visit maximum. • Neuropsychological test battery is limited to eight hours per member, per calendar year (any provider), 8 hours annual benefit limit. Applies to 30-visit maximum. • Testing does count toward the 30-visit limit. • Injectables including psychotropic medication. • Telehealth services.
Inpatient Substance Abuse Treatment Services	• Medically Necessary services include, but are not limited to, inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. • Thirty days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost. • Does not require PCP referral.	• Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. • Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.	• Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. • Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
	• Medically necessary detoxification/ stabilization services, limited • 24-hour residential rehabilitation programs, or the equivalent, are unlimited per 12-month period.	• Detoxification (inpatient and residential) is limited to 21 days a year and prior authorization is required. • Residential Treatment: Rehabilitation is limited to 35 days per episode and prior authorization is required. (Includes two episodes of care per rolling six-month period and four episodes per rolling year.) Specialized female (including pregnant women and women with children) up to 90 days per episode. Members aged 20 and younger are eligible for additional days with prior authorization.	• Detoxification (inpatient and residential) is limited to 21 days a year and prior authorization is required. • Residential Treatment: Rehabilitation is limited to 35 days per episode and prior authorization is required. (Includes two episodes of care per rolling six-month period and four episodes per rolling year.) Specialized female (including pregnant women and women with children) up to 90 days per episode.
Outpatient Substance Abuse Treatment Services	• Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by a physician and non-physician providers, such as screening, assessment and referral for substance use disorders. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services and life skills training, which consist of at least 10 hours per week for 4 to 12 weeks, but fewer than 24 hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.	• Substance use disorder treatment services are age appropriate medical and psychotherapeutic services designed to treat a client's substance disorder and restore function. • Group counseling is limited to 135 hours per member, per calendar year and requires prior authorization. • Individual counseling is limited to 26 hours per member per calendar year. • Additional counseling services may be considered for aged 20 and younger based upon medical necessity. • Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening is for clients 10 and older. Client may receive a maximum of two screenings per rolling year and up to four	• Substance use disorder treatment services are age appropriate medical and psychotherapeutic services designed to treat a client's substance disorder and restore function. • Group counseling is limited to 135 hours per member, per calendar year and requires prior authorization. • Individual counseling is limited to 26 hours per member per calendar year. • Additional counseling services may be considered for aged 20 and younger based upon medical necessity. • Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening is for clients 10 and older. Client may receive a maximum of two screenings per rolling year and up to four

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
	• Does not require PCP referral. • Outpatient treatment services are unlimited.	combined screening and brief intervention sessions per rolling year. • Medication Assisted Therapy (MAT) In Person is limited to once per day and prior authorization is required. • Medication Assisted Therapy (MAT) Take Home is limited to once per day up to 30 doses and prior authorization is required. • Ambulatory (Outpatient) Detoxification Services may be covered for a medically appropriate duration of care based on treatment needs for up to 21 days. (Clients aged 20 and younger may receive additional days of treatment with prior authorization.) • Members who are in an inpatient status, such as residing in a DSHS facility, are not eligible to receive outpatient group and individual counseling in an outpatient setting. • Does not require a PCP referral.	combined screening and brief intervention sessions per rolling year. • Medication Assisted Therapy (MAT) In Person is limited to once per day and prior authorization is required. • Medication Assisted Therapy (MAT) Take Home is limited to once per day up to 30 doses and prior authorization is required. • Ambulatory (Outpatient) Detoxification Services may be covered for a medically appropriate duration of care based on treatment needs for up to 21 days. • Members who are in an inpatient status, such as residing in a DSHS facility, are not eligible to receive outpatient group and individual counseling in an outpatient setting. • Does not require a PCP referral.
Program Services	Not applicable	These services may only be provided by the Local Mental Health Authority (LMHA) who is eligible to provide these services. May be provided to individuals with a severe and persistent mental illness (SPMI) or severe emotional disturbance (SED) as defined in the DSM V (or DSM-IV-TR) and who require these services as determined by the Adults Needs and Strengths Assessment (ANSA) or Child and	These services may only be provided by the Local Mental Health Authority (LMHA) who is eligible to provide these services. May be provided to individuals with a severe and persistent mental illness (SPMI) or severe emotional disturbance (SED) as defined in the DSM V (or DSM-IV-TR) and who require these services as determined by the Adults Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS) assessment.

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit	STAR Kids Description of Benefit
		Adolescent Needs and Strengths (CANS) assessment. Mental Health Rehabilitative services: • Adult Day Program • Medication Training and Support • Crisis Intervention • Skills Training and Development • Psychosocial Rehabilitative Services • Targeted Case Management Services	Mental Health Rehabilitative services: • Adult Day Program • Medication Training and Support • Crisis Intervention • Skills Training and Development • Psychosocial Rehabilitative Services • Targeted Case Management Services
Emergency Services			• Mobile crisis intervention child and adolescent • Emergency screening services • Short term crisis stabilization • Training for Members and Individuals • Behavioral Health Previous Education Service to impact knowledge where delivery is focused with a target population.
Autism Services	Not covered	Covered if the member meets the criteria for services.	• Covered if the member meets the criteria for services.

*** **Benefits are subject to change. Please contact the telephone numbers listed on page 3 to confirm the most current benefits.**