Behavioral Health

This chapter is subject to change. To ensure that you review the most current version, we strongly discourage you from relying on printed versions.

Chapter contents

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Behavioral health overview

About this chapter

This chapter of the *BCN Provider Manual* provides information that is unique to behavioral health and may be different from information presented in the other chapters for:

- BCN commercial products
- BCN Advantage products

Note: In this chapter, "BCN Advantage" refers to both BCN Advantage HMO-POS and BCN Advantage HMO products unless otherwise noted.

The requirements and processes associated with BCN behavioral health are integrated within BCN as a whole and are, in general, described in the other chapters of this manual. These include but are not limited to affiliation, submitting claims and appealing utilization management and claims decisions. For a complete view of BCN processes and requirements, behavioral health providers should review all chapters of the *BCN Provider Manual*.

Note: Information about behavioral health services for Blue Cross Complete members is located in the *Blue Cross Complete Provider Manual*, available through the Blue Cross Complete Resources for Providers webpage.

Providers can access a variety of behavioral health-related resources to help them deliver effective, timely treatment to members. Links to these resources are available on the Behavioral Health webpage at **authorizations.bcbsm.com**.

Behavioral health benefits

For BCN members, behavioral health benefits consist of the following categories of benefits:

- Mental health services: Use the appropriate ICD-10 F code.
- Substance use disorder services: Use the appropriate ICD-10 F code.
- Autism spectrum disorder services: Use the appropriate ICD-10 F code.

For additional information, see the following webpages at **authorizations.bcbsm.com**:

- Behavioral Health
- Autism Services

This chapter is updated to show that for mental health, substance use disorder and autism spectrum disorder services, providers should use the appropriate ICD-10 F code.

Check member eligibility and benefits

Behavioral health providers must check that the patient is a BCN member and therefore eligible for services that may be provided. BCN will not pay for services provided to ineligible members or for services not covered in the member's benefit plan.

Because a member's eligibility and benefits can change over time, it is recommended that providers recheck the member's status frequently.

Behavioral health providers can use any of the following options to determine whether a patient is eligible for services and a service is a covered benefit:

- Our provider portal (availity.com**)
- HIPAA 270/271 electronic standard transaction. For information on this transaction, providers can visit **bcbsm.com/providers** > Help > (under "Provider online tools") How do I sign up for Electronic Data Interchange? Look under "Blue Cross Blue Shield and Blue Care Network Companion Documents", then refer to the HIPAA Transaction Standard Companion Guide - Real Time Transactions (270/271 Eligibility and Benefits, 276/277 Claim Status), which can be downloaded.
- Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections.

Additional information about checking member eligibility and benefits can be found in the Member Eligibility chapter of this manual.

Management of behavioral health benefits

For BCN members, behavioral health benefits are managed by Blue Cross Behavioral Health℠.

For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Blue Cross Behavioral Health assists BCN members in the following ways:

- Provides 24-hour telephone access for member emergencies
- Refers members for evaluation, and for treatment, as necessary, to appropriate behavioral health providers located in the member's geographic area or as close to it as possible
- Uses behavioral health providers contracted and credentialed with BCN who practice within the BCN service area
- Works with a member's primary care provider or with other providers to coordinate needed medical and behavioral health care

Behavioral health screening tools

BCN encourages the use of validated behavioral health screening instruments to identify members with undiagnosed disorders, monitor the severity of their ongoing symptoms and assess treatment outcomes. BCN

supports quality in clinical practice by providing access to some widely used screening instruments, as copyright provisions allow.

Providers can access these screening tools on the Behavioral Health: Screening Tools webpage at **authorizations.bcbsm.com**.

Behavioral health providers seeking BCN affiliation

BCN contracts with a limited but diverse network of behavioral health providers to ensure that BCN members have access to the range of behavioral health services required to address their needs in the geographic areas in which they are located.

Behavioral health providers seeking BCN provider status should visit **bcbsm.com/providers** and click Enrollment. Review the information on that page and then click *Enroll or Make Changes*. Make the appropriate selections and complete and submit the appropriate forms.

Behavioral health providers are contracted with BCN as follows:

- Group practices sign a provider group affiliation agreement.

  Note: Individual providers must be credentialed and affiliated with specific group practices.

- Substance use disorder treatment providers and OPC providers sign an ancillary provider affiliation (facility) agreement.

Note: Clinical nurse specialists (also referred to as clinical nurse specialists-certified) who are affiliated with BCN may provide only the following behavioral health services for BCN members: assessment, medical management, group therapy and family therapy.

It is also important for providers to update their information as changes occur so that members can see the most up-to-date information when using BCN's online provider search. For instructions on how to update information, refer to the Affiliation chapter of this manual. Look in the section titled "Updating provider information."

Note: For billing purposes, behavioral health providers can check their contract to remind themselves of the type of affiliation they have with BCN. For additional information, refer to the "Billing instructions" subsection on page 33 of this chapter.

Providers should refer to the Affiliation chapter of the *BCN Provider Manual* for additional information about affiliating with BCN.

Providers must be approved to use applied behavior analysis

Providers interested in evaluating or treating members with autism spectrum disorder using applied behavior analysis must be approved by BCN as follows:

- Facilities interested in applying as a BCN-approved autism evaluation center (AAEC) should submit a letter of intent. Providers whose letters of intent are accepted will be asked to complete a formal application. Additional information is available on Autism Services webpage at **authorizations.bcbsm.com**.

- Specialists who provide treatment for BCN members using applied behavior analysis must be approved by BCN, including those who are licensed behavior analysts.

Refer to these documents for more information about comprehensive diagnostic evaluations for autism:

- Obtaining a comprehensive diagnostic evaluation for autism and finding treatment
- Requirements for comprehensive diagnostic evaluations by approved autism evaluation centers and independent evaluation teams

CADC or CAADC credential is recommended but is not required

For members with a diagnosis involving a substance use disorder, it is recommended but not required that group counseling and didactic group sessions be provided by a professional who has a Certified Alcohol and Drug Counselor (CADC) or Certified Advanced Alcohol and Drug Counselor (CAADC) credential.

This applies to facilities that provide and bill for one or more of the following types of treatment for substance use disorders:

- Subacute detoxification
- Residential treatment
- Partial hospital program
- Intensive outpatient program
- Individual treatment

Note: Applications for these credentials are submitted to the Michigan Certification Board for Addiction Professionals.**

Behavioral health telehealth services

For information about behavioral health telehealth services, including what they consist of, what the requirements are and how to bill for them, refer to these documents:

- Telehealth for behavioral health providers
- Guidelines for ABA interventions via telemedicine (ABA and skills training)

For more general information on telehealth services, refer to these documents:

- The *Telemedicine Services* medical policy by using the Medical Policy Router Search tool at **bcbsm.com**
- Determining a member's telehealth benefits

Accessing training about behavioral health topics

From our dedicated provider training site**, you can access recorded webinars about a variety of behavioral health topics.

To request access to the provider training site:

1. Click here to register**.
2. Complete the registration. Use the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.
3. Follow the link to log in*.

If you need assistance creating your login ID or navigating the site, email ProviderTraining@bcbsm.com.

Additional behavioral health resources

Providers can access additional behavioral health resources, including flyers, brochures, tip sheets and frequently asked questions documents, by visiting the Behavioral Health webpage at **authorizations.bcbsm.com**.

Accessing behavioral health services

Behavioral health contact information for providers

The contact information for accessing assistance with behavioral health services is below.

- **For questions about prior authorization requests:** Call Blue Cross Behavioral Health at the appropriate number:
  - BCN commercial members: 1-800-482-5982
  - BCN Advantage members: 1-800-431-1059

  Note: For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.
- **For questions about claims or for assistance checking a member's eligibility and benefits:** Call Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections.

Note: Contact information for Blue Cross Complete Provider Inquiry and Customer Service is found in the *Blue Cross Complete Provider Manual*, available through the Blue Cross Complete Resources for Providers webpage.

Behavioral health contact information on member ID card

For both BCN commercial and BCN Advantage members, the behavioral health services telephone number they should call is displayed on the back of the member ID card.

Assistance for providers in arranging for behavioral health services

No referral is required in order for a BCN commercial or BCN Advantage member to access behavioral health services.

Exception: Services associated with prolonged psychotherapy codes require a global referral from the member's primary care provider, when the primary care provider is part of a medical care group based in the East or Southeast region. A global referral is not required when the primary care provider is part of a medical care group based in the Mid, West, or Upper Peninsula region.

While primary care providers are not typically responsible for arranging, referring or reviewing requests for behavioral health services for their BCN members, they:

- May directly refer a member to a BCN-affiliated behavioral health provider. It is not necessary for the primary care provider to provide a written referral to the behavioral health provider.
- Are encouraged to call Blue Cross Behavioral Health at one of the phone numbers below for assistance in arranging behavioral health services for a BCN member:
  - BCN commercial members: 1-800-482-5982
  - BCN Advantage members: 1-800-431-1059

Member access to autism comprehensive diagnostic evaluations

For information about how members can obtain a comprehensive diagnostic evaluation for autism, refer to the following documents:

- Obtaining a comprehensive diagnostic evaluation for autism and finding treatment
- Requirements for comprehensive diagnostic evaluations by approved autism evaluation centers and independent evaluation teams

Providers can access these documents and other resources on the Autism Services webpage at **authorizations.bcbsm.com**.

Options for members in crisis

BCN members have options for receiving help if they're having a behavioral health crisis. These options can be used in lieu of an emergency department to facilitate access to behavioral health-focused care.

For more information, refer to:

- The Behavioral Health Crisis Care page at **bcbsm.com**

- The Help in times of crisis flyer

Access standards

Information on access standards for behavioral health care is located in the Access to Care chapter of this manual.

Urgent and emergency care while traveling outside of Michigan

Members can receive urgent and emergency health care services wherever they live or travel, nationally or internationally, through providers who participate with Blue Cross Blue Shield plans.

BCN members can access urgent and emergency care and follow-up care for existing conditions while traveling outside of Michigan but within the U.S. and its territories. For additional information, providers should refer to the Member Benefits chapter of this manual.

Providers should keep the following guidelines in mind for members while traveling outside of Michigan:

- Services are not covered when members travel outside of Michigan for the sole purpose of obtaining treatment. This applies to all members.
- Psychotherapy services delivered via telephone or video chat/voice call services (such as Skype®) are not covered benefits.

Members with coverage through BCN Advantage HMO products do not have travel benefits, including follow-up care for existing conditions. The other BCN Advantage products do have travel benefits, including follow-up care for existing conditions.

Exception: Some plans cover behavioral health services provided by out-of-network and out-of-state providers. Members and providers can find details on that coverage by checking a member's benefit information provided online through our provider portal (availity.com**).

Note: Michigan members traveling outside of Michigan can use the number on the back of their ID card to find a participating provider where they are located. They can work with the provider to determine if the visit should be in person or via telehealth. Members can also access online care if their contract includes coverage for Virtual Care visits through Teladoc Health®. For information about billing behavioral health telehealth services, refer to the subsection titled "Behavioral health telehealth services", earlier in this chapter.

Expectations and incentives

Provider offices: general expectations

BCN behavioral health providers are expected to comply with the responsibilities described for other BCN providers, as applicable, in the BCN System of Managed Care chapter of this manual. These responsibilities include ensuring continuous coverage 24 hours per day, seven days per week, based upon the urgency of the care needed. If a

behavioral health provider is not available for any reason, the covering provider must also be one who is credentialed as a BCN behavioral health provider.

Clinical practice guidelines

Behavioral health providers affiliated with BCN are encouraged to review the standardized, nationally recognized and evidence-based clinical practice guidelines related to behavioral health.

These guidelines are available on the following webpages at **bcbsm.com**:

- Services That Need Prior Authorization (commercial)
- Medicare Advantage Prior Authorization

Requirements for providing behavioral health clinical programs and services

How to access the requirements

To access the documents that outline the requirements for providing various behavioral health clinical programs and services, refer to the Behavioral Health: Clinical Program Requirements webpage at **authorizations.bcbsm.com**. Look under the "Clinical program requirements" heading.

These documents include requirements for the following behavioral health programs and services:

- Adult intensive and child intensive services
- Urgent care and crisis services
- Opioid treatment programs
- Partial hospitalization and intensive outpatient programs
- Feeding and eating disorder partial hospitalization and intensive outpatient programs
- Residential psychiatric treatment services
- Residential treatment services for substance use disorders

Use this document to access links to all requirements documents: Various behavioral health programs and services.

Prior authorization for behavioral health services

Prior authorization required for certain services covered under behavioral health benefit

Certain services covered under a member's behavioral health benefit **must** be authorized by Blue Cross Behavioral Health for both BCN commercial and BCN Advantage members. These services include the following:

- Inpatient/residential admission
- Partial hospitalization
- Applied behavior analysis for autism spectrum disorder services (outpatient)
- Transcranial magnetic stimulation (outpatient)

Note: Prior authorization is not required for routine outpatient therapy for mental health and substance use disorders and for medication management services provided by an in-network provider.

Additional resources:

- For information about how to submit prior authorization requests for specific dates of service, refer to the document Michigan providers: BCN global referral, plan notification and prior authorization requirements document.
- For information about submitting prior authorization requests, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Clinical criteria used in authorization decisions

Blue Cross Behavioral Health uses nationally recognized criteria when making medical necessity determinations.

The criteria used to make utilization management decisions are available on these webpages at **bcbsm.com:**

- Services That Need Prior Authorization (commercial)
- Medicare Advantage Prior Authorization

Providers may request a copy of the specific criteria used to make a decision on a member's case by calling Blue Cross Behavioral Health at 1-877-293-2788.

How the criteria are developed

National experts, clinical advisory committees and contracted behavioral health clinicians contribute to the development of the criteria Blue Cross Behavioral Health uses to make determinations on prior authorization requests.

The criteria are reviewed and updated, if appropriate, at least annually and are presented at the Clinical Quality Committee for physician input and approval.

Scientific resources for the criteria include:

- *Diagnostic and Statistical Manual of Mental Disorders*
- Peer-reviewed scientific literature
- Available nationally recognized clinical guidelines

BCN works collaboratively with behavioral health practitioners

BCN is committed to a fair and thorough authorization process by working collaboratively with its participating behavioral health practitioners.

Blue Cross Behavioral Health may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

Blue Cross Behavioral Health bases utilization management decisions regarding care and service solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition. Blue Cross Behavioral Health staff members:

- Don't have financial arrangements that encourage denial of coverage or service
- Don't receive bonuses or incentives based on their review decisions

Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.

Discussing a determination

When there is a question about whether a request for authorization meets medical necessity criteria, the Blue Cross Behavioral Health utilization management clinician consults with a physician reviewer, who may either deny the request or ask the care manager to contact the practitioner for additional information.

When a physician reviewer denies a request, written notification is sent to the requesting practitioner and to the member. The notification includes the reason the request was denied as well as the phone number to call a Blue Cross Behavioral Health physician reviewer to discuss the decision, if desired. The notification also includes instructions on how to appeal the denial.

Providers have the right to discuss a decision related to medical necessity with a Blue Cross Behavioral Health medical director for behavioral health. The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the treatment services, not to talk about the criteria.

For decisions on inpatient admissions, Blue Cross Behavioral Health allows onsite physician advisors at contracted facilities to discuss reviews of inpatient admissions with a Blue Cross Behavioral Health medical director. In accordance with Blue Cross and Blue Care Network policy, facilities should initiate peer-to-peer conversations only through their

employed physician advisors and not through third-party advisors or organizations.

For information about how to contact Blue Cross Behavioral Health to discuss a behavioral health determination for a member, refer to the document How to request a peer-to-peer review with a Blue Cross or BCN medical director. Look under the "Behavioral health services" heading.

Requesting prior authorization

Providers will incur complete financial responsibility for all services provided without prior authorization from Blue Cross Behavioral Health, when prior authorization is required.

Here are the general guidelines for prior authorization requirements:

- **For urgent services that require prior authorization, for members in an emergency room who need inpatient admission and for other member emergencies**, submit these requests through the Blue Cross Behavioral Health provider portal or call these requests in to Blue Cross Behavioral Health:
  - For BCN commercial requests: Call 1-800-482-5982.
  - For BCN Advantage requests: Call 1-800-431-1059.
- **For all other services**, follow the guidelines in the Service Type / Action table found in this section.

For most services that require prior authorization, providers must submit the request via the Blue Cross Behavioral Health provider portal. For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Note: Michigan's prior authorization law** requires health care providers to submit prior authorization requests electronically for commercial members. Alternate submission methods are allowed in the case of temporary technical problems, such as a power or internet outage.

Blue Cross Behavioral Health responds to all requests for prior authorization via the Blue Cross Behavioral Health provider portal.

Guidelines for requesting prior authorization for mental health and substance use disorder services

Providers should use the guidelines in the table below when requesting prior authorization for behavioral health services related to mental health and substance use disorder diagnoses.

Providers should submit prior authorization requests through the Blue Cross Behavioral Health provider portal. For information about how to submit requests, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Note: For guidelines related to applied behavior analysis for autism spectrum disorders, refer to the Covered services for autism spectrum disorder subsection later in this chapter.

Service type	Action / additional information about requesting prior authorization
Routine outpatient treatment (in outpatient clinic or individual provider office settings)	Prior authorization is not required for contracted providers who are part of the designated network associated with the member's plan. This applies to the following procedure codes: • *90785 • *90836-*90840 • *90853 • *90882 • *90791-*90792 • *90846-*90847 • *90865 • S9484 • *90832-*90834 • *90849 • *90880
Medication management visits without therapy	No referral or prior authorization is needed for the initial evaluation and medication management service when the provider is an MD, DO, nurse practitioner, clinical nurse specialist or physician assistant who is contracted with BCN and who is part of the designated network associated with the member's plan and when these services are provided without therapy. This applies to procedure codes *99201 through *99205 or *99211 through *99215. The appropriate evaluation/management code must be used.
Medication management visits with therapy	When there is a therapy service or any other service provided in addition to medication management, that service does not require prior authorization for contracted providers who are part of the designated network associated with the member's plan. This applies to "add-on" procedure codes *90833, *90836 and *90838, which are performed by an MD/DO, nurse practitioner or physician assistant. In addition, any psychotherapy add-on procedure done when another therapist is also treating the member should be coordinated between both treating practitioners. The two components of each visit (the evaluation/management and the add-on psychotherapy service) should be adequately documented in the medical record in case of an audit. This includes documenting the rationale for having two practitioners treat the member concurrently.
Outpatient TMS services	For outpatient TMS services, prior authorization is required for all dates of service.
Initial inpatient/ residential or partial hospital	Medical-surgical and behavioral health facilities that wish to arrange for an inpatient/residential or partial hospital admission for psychiatric or substance use disorder treatment should obtain authorization prior to the admission. **Note:** For intensive outpatient treatment, authorization is required for dates of service before Jan. 1, 2024. For dates of service on or after Jan. 1, 2024, no prior authorization is required. **Exception**: BCN commercial and BCN Advantage members require prior authorization for IOP services rendered outside of Michigan. This doesn't apply to members who have coverage through Blue Elect Plus. Prior authorization requests can be submitted as follows: • When the member is in an emergency department and not yet admitted, and you need an immediate response to your request, call in your request to Blue Cross Behavioral Health: ○ For BCN commercial requests: Call 1-800-482-5982.

Service type	Action / additional information about requesting prior authorization
	○ For BCN Advantage requests: Call 1-800-431-1059. **Note**: The phone lines are in service even when Blue Cross Behavioral Health offices are closed for a holiday. Refer to the document Holiday closures: How to submit authorization requests for inpatient admissions. • When the member has already been admitted, you must submit the initial prior authorization request through the Blue Cross Behavioral Health provider portal. For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers. Blue Cross Behavioral Health will determine medical necessity and, if the member meets criteria, may authorize admission to a BCN network facility. If the member's condition does not meet medical necessity criteria for the level of care requested, Blue Cross Behavioral Health may suggest that other resources for treating the member's condition be explored. As necessary, Blue Cross Behavioral Health will review the case with the Blue Cross Behavioral Health medical director.
Requesting additional days of inpatient / residential or partial hospital treatment (mental health / substance use disorder)	All concurrent review requests require prior authorization. For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers. **Note**: For partial hospital treatment, to move forward the discharge date without adding days, call Blue Cross Behavioral Health: • For BCN commercial requests: Call 1-800-482-5982. • For BCN Advantage requests: Call 1-800-431-1059.
Subacute detoxification (managed under the mental health-substance use disorder benefit)	**Outpatient:** No prior authorization is required for providers contracted to provide this service. **Inpatient:** Providers must obtain prior authorization from Blue Cross Behavioral Health for subacute detoxification. Subacute detoxification is managed by Blue Cross Behavioral Health. Subacute detoxification is a service performed in a licensed freestanding or hospital-based residential treatment facility. It's typically used when the patient's medical problems, if any, are stable and do not require medical monitoring or may require medical management but that can be provided within the program. Prior authorization requests can be submitted as follows: • When the member is in an emergency department and not yet admitted to a bed, and you need an immediate response to your request, call in your request to Blue Cross Behavioral Health: ○ For BCN commercial requests: Call 1-800-482-5982. ○ For BCN Advantage requests: Call 1-800-431-1059. • When the member has already been admitted to a bed, you must submit the initial prior authorization request through the Blue Cross Behavioral Health provider portal.

Service type	Action / additional information about requesting prior authorization

Post-emergency services covered under behavioral health benefit	An inpatient admission for mental health or substance use disorder treatment that results from an emergency screening or assessment must be authorized. Prior authorization requests for inpatient admissions are accepted 24 hours per day, seven days per week.
	
	All other behavioral health services obtained as the result of an emergency screening or assessment must be authorized.
	
	Prior authorization requests can be submitted as follows:
	
	• When the member is in an emergency department and not yet admitted to a bed, and you need an immediate response to your request, call in your request to Blue Cross Behavioral Health:
	  ○ For BCN commercial requests: Call 1-800-482-5982.
	  ○ For BCN Advantage requests: Call 1-800-431-1059.
	• When the member has already been admitted to a bed, you must submit the initial prior authorization request through the Blue Cross Behavioral Health provider portal.
	
	For additional information, refer to the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Psychological or neuropsychological assessment	No referral or prior authorization is needed for providers who are contracted with BCN and who are part of the designated network associated with the member's plan. **Note**: This applies to procedure codes *96101 through *96105, *96118 through *96120, and *96130 through *96139 when billed by themselves.

Guidelines for ambulatory follow up after inpatient discharge

BCN believes that adequate management of a member's care immediately after discharge from an acute inpatient hospital stay is an effective intervention in preventing the member's early rehospitalization. In addition, member noncompliance with recommendations for ongoing follow up is a major predictor of rehospitalization.

To improve the likelihood that a member will initiate and continue outpatient care after a behavioral health admission, Blue Cross Behavioral Health requires that the member be seen for his or her initial outpatient visit within the first seven days after discharge. When clinically appropriate, more rapid outpatient follow up is desirable.

Blue Cross Behavioral Health encourages the outpatient provider to meet with the member for an extended period of time following the inpatient admission to do the following:

- Reinforce gains made by the member while hospitalized
- Reinforce the importance of continuing treatment following hospitalization
- Address any barriers to attending outpatient care (for example, dependent care, transportation)

- Identify the member's community supports
- Review the member's safety plan

Blue Cross Behavioral Health staff will complete a follow-up call to the identified outpatient provider to determine the member's compliance with the outpatient follow-up appointment.

Covered services for autism spectrum disorder

Autism spectrum disorder services are covered for all members, regardless of age, unless otherwise indicated by the member's benefit description.

Specialists within BCN's provider network are able to serve the various needs of individuals diagnosed with autism spectrum disorder.

The benefits outlined in the table that follows show the guidelines for coverage and for requesting prior authorization. In addition, other medical services used to diagnose and treat autism are included as covered services.

Service	Guidelines for coverage and for requesting prior authorization
Applied behavior analysis (ABA), a specialized treatment for autism spectrum disorder	• For applied behavior analysis, a diagnosis of autism spectrum disorder is required, which must be made through a **comprehensive diagnostic evaluation for autism.** For information about how members can obtain an autism comprehensive diagnostic evaluation, refer to the following documents: ○ Obtaining a comprehensive diagnostic evaluation for autism and finding treatment ○ Requirements for comprehensive diagnostic evaluations by approved autism evaluation centers and independent evaluation teams • For **treatment**, the request for applied behavior analysis services must be authorized by Blue Cross Behavioral Health. As part of that process, Blue Cross Behavioral Health must confirm that an approved autism evaluation center or the other autism evaluation providers involved in completing a comprehensive diagnostic evaluation for autism have made a diagnosis of an autism spectrum disorder and documented a recommendation for applied behavior analysis. **Note**: When questions arise about whether a request for ABA services can be approved, the questions and the associated clinical documentation must be reviewed by a Blue Cross Behavioral Health physician reviewer.
Other behavioral health services to diagnose and treat autism	For behavioral health evaluation and treatment not related to applied behavior analysis to be covered, the member needs to be seen by a BCN-contracted behavioral health provider. In these cases, follow the guidelines for requesting prior authorization for mental health services.

Service	Guidelines for coverage and for requesting prior authorization
Physical, occupational and speech therapy (by therapists) and physical medicine services (by athletic trainers and by chiropractors) as part of autism spectrum disorder treatment	The provider is responsible for verifying whether each member has autism benefits and, if so, how they are managed. When performed for an autism diagnosis, these services do not require prior authorization. Additional information is available on the PT, OT, ST and Physical Medicine webpage at **authorizations.bcbsm.com**.
Nutritional counseling as part of autism spectrum disorder treatment	Nutritional counseling related to autism spectrum disorder requires neither a referral from the primary care provider nor prior authorization from Blue Cross Behavioral Health.

Medical record documentation requirements

Overview

Providers contracted with BCN to provide behavioral health services are required to follow the guidelines set out in this section for medical record documentation.

Documentation requirements for autism treatment services including applied behavior analysis

For a summary of documentation requirements related to autism treatment services, including applied behavior analysis, providers should refer to the document titled Behavioral health medical record documentation requirements for autism treatment services at **authorizations.bcbsm.com**.

Documentation requirements for services other than applied behavior analysis

For a summary of documentation requirements related to services other than applied behavior analysis, providers should refer to the document titled Behavioral health medical record documentation requirements and privacy regulations — for services other than ABA at **authorizations.bcbsm.com**.

These requirements apply to all levels of care.

Documentation requirements related to AAECs and CDEs

For a summary of documentation requirements related to approved autism evaluation centers and independent interdisciplinary comprehensive diagnostic evaluations, refer to the document titled Behavioral health medical record documentation requirements for AAECs and independent interdisciplinary comprehensive diagnostic evaluations at **authorizations.bcbsm.com**.

HIPAA privacy regulations and documentation

The Health Insurance Portability and Accountability Act affects the documentation of mental health and substance use disorder treatment. To protect the patient's privacy, HIPAA restricts the way psychotherapy notes may be used and disclosed.

For information about HIPAA privacy regulations and documentation guidelines, refer to the last page of the document titled Behavioral health medical record documentation requirements and privacy regulations — for services other than ABA at **authorizations.bcbsm.com**.

Medical record documentation requirements for mental health and substance use disorder services – general guidelines

A patient's medical record for mental health and substance use disorder services must include legible documentation of at least the following:

- Patient identification
- Individuals present at the session
- Date of session
- Session start and stop times
- Location of service and if telemedicine delivery technology was utilized (for example, audiovisual, telephone-only, asynchronous)
- Signature and credentials of the treating provider

Outpatient psychiatric care – general guidelines

The base guidelines come from AMA and CMS and are used to determine our documentation guidelines.

Evaluation documentation requirements

In addition to the medical record documentation requirements for mental health and substance use disorder services, the evaluation of a specific problem or group or problems must include legible documentation of the following:

- Integrated biopsychosocial assessment to include past psychiatric and substance use disorder history, including inpatient or outpatient treatment
- Complete mental status examination
- Results of relevant diagnostic testing (when available)
- Objectively stated treatment plan and rationale
- Assignment of appropriate DSM codes
- Treatment interventions provided during the session
- Instructions, recommendations and precautions given to the patient or other significant parties
- Risk assessment

Note: If the initial evaluation is provided by a psychiatrist, a medical history (including all prescriptions, over-the-counter medications, and holistic and "natural" supplements) must be documented.

Inpatient psychiatric initial evaluation

In addition to the medical record documentation requirements for mental health and substance use disorder services, the evaluation for a specific problem or group or problems must conform to CMS guidelines and include legible documentation of the following:

- Integrated biopsychosocial assessment to include past psychiatric and substance use disorder history, including inpatient or outpatient treatment
- Complete mental status examination
- Physical examination
- Results of relevant diagnostic testing (when available)
- Objectively stated treatment plan and rationale including medication and any changes
- Assignment of appropriate DSM codes
- Treatment interventions provided during the session
- Instructions, recommendations and precautions given to the patient or other significant parties
- Risk assessment

Note: If the initial evaluation is provided by a psychiatrist, a medical history (including all prescriptions, over-the-counter medications, and holistic and "natural" supplements) must be documented.

Inpatient psychiatric subsequent day visit

For evaluation and management and medication management, documentation must conform to CMS guidelines and include legible documentation of at least the following:

- Date of visit
- Session start and stop times
- Evidence that face-to-face contact occurred between the provider and the patient, any collateral contacts or discussion with outside providers coordinating care
- Notation of all current psychotropic medications and any other drugs that may interact with those medications.
- Patient's response to the medications, including any current side effects.
- Laboratory findings related to these medications, as applicable.
- Response to the medication regimen and its effects on progress or lack of progress toward the treatment goals
- Include any additional CMS requirements to justify medical decision making for the services that day
- Diagnosis
- Follow-up visit schedule
- Homework/practice/community resources or outside providers
- Signature and credentials of the treating provider

Outpatient psychophar-macotherapy

For evaluation and management, documentation must conform to CMS guidelines and include legible documentation of at least the following:

- Date of the visit
- Session start and stop times
- Evidence that face-to-face contact occurred between the provider and the patient, any collateral contacts regarding coordination of care
- Notation of all current psychotropic medications and any other drugs that may interact with those medications
- Patient's response to the medications, including any current side effects
- Laboratory findings related to these medications, as applicable
- Response to the medication regimen and its effects on progress or lack of progress toward the treatment goals

- Include any additional CMS requirements to justify medical decision making for the services that day
- Diagnosis
- Follow-up visit schedule
- Homework/practice/community resources or outside providers
- Signature and credentials of the treating provider

Inpatient and outpatient individual psychotherapy

Requirements

These services must be provided, at minimum, by a master's level behavioral health clinician.

Progress notes

Blue Cross requires progress notes documenting each psychotherapy session. In addition to the medical record documentation requirements for mental health and substance use disorder services, psychotherapy progress notes must include legible documentation of the following:

- Presenting problem
  - Detailed diagnosis
  - Change in diagnosis and supporting details
  - Patient's current clinical status including patient's signs and symptoms at the time of each session
- Progress toward treatment goals
  - Results of interval homework or practice of prior intervention
  - Statement summarizing the relationship between signs and symptoms and the primary focus of the therapy session
  - Assessment of current and long-term risk including Interventions to minimize risk and contingency management (advanced directive or crisis plan)
- Interventions used and patient's response
  - Statement summarizing the therapeutic interventions used in the therapy session
  - Effectiveness of intervention
  - Adjustments to interventions/plan of care
- Summary
  - Statement summarizing the patient's degree of progress toward treatment goals
  - Diagnosis

- Follow up appointments, homework/practice
- Signature and credentials of the treating provider

Inpatient and outpatient group or family therapy

Requirements

Services must be provided at a minimum by a master's level behavioral health clinician.

Group psychotherapy sessions should last 90 minutes. For patients unable to tolerate group sessions of 90 minutes due to significant limitations in attention span or frustration tolerance, the minimum time limit may be reduced to one hour. Documentation must explain the reason for limiting the length of the group session or the patient's participation.

Some patients on an inpatient floor can participate only minimally; some patients cannot tolerate any psychotherapy at all. If there is no therapy session, or if the patient participated minimally, documentation must explain the reason.

Progress notes

Blue Cross requires progress notes for each group or family therapy session. In addition to the medical record documentation requirements for mental health and substance use disorder services, group or family therapy progress notes must include legible documentation of the following:

- Number of participants in group therapy (minimum of four, maximum of 12)
- Relationship of additional participants to the patient in family therapy (for example, spouse, parent, child)
- Primary focus of the group session
- Statement summarizing the clinical intervention used in the therapy session
- Nature and degree of the patient's participation and response in the session if the patient was present at family therapy
- For group therapy, a statement summarizing the current clinical status and progress of the group as a whole
- Risk assessment of the member at the end of the session
- Whether the member participated in the group, or how the member participated in the group
- Signature and credentials of the treating provider

Note: Other than the group member in whose chart the note is written, there should be no mention of other patients in the group by name.

Didactic sessions in substance use disorder treatment

Requirements

Didactics must be provided by a professional with a Certified Advance Alcohol and Drug Counselor (CAADC), Registered Nurse (RN), or higher credentials.

Documentation must reflect that didactic presentations last at least 90 minutes and have no more than 15 patient participants.

Progress notes

In addition to the medical record documentation requirements for mental health and substance use disorder services, the progress notes for didactic sessions in substance use disorder treatment must include legible documentation of the following:

- Content of the session
- Length of the session and number of participants
- Educator's intervention with respect to the patient
- Patient's active participation and degree of understanding of the information
- Signature and credentials of the treating provider

Note: Other than the group member in whose chart the note is written, there should be no mention of other patients in the group by name.

Psychological testing services

Requirements

The documentation for psychological testing services must show that:

- The patient has (or may have) an emotional or mental disorder, or a medical or surgical illness with a significant emotional or mental component, which justifies the use of psychological tests.
- The tests are ordered by a physician (or a fully licensed psychologist if the patient's contract includes direct reimbursement to a psychologist), or any other practitioner that the scope of practice allows for ordering and providing psychological testing and interpretation in the state in which they practice and approved by the insurance carrier (such as Medicare provider list).
- The rationale for the referral (the clinical question) is explicitly stated and clinically appropriate. The clinical question might address the level of depression, suicidal or homicidal potential, cognitive disabilities, neuropsychologic disorders, personality disorders, and so on. The chart must contain either a letter from the referring physician or psychologist or a notation documenting a conversation between the referring physician and the provider of testing services. If the psychologist or other qualified health professional, or QHP, is referring the testing themselves, the chart must contain a note that explicitly

describes the referral question as well as how the treatment will be altered as a result of the testing.

Note: Psychological testing that is self-referred by the patient is not covered.

- Based on the referral questions, the psychologist has selected appropriate tests.

  Note: Test batteries must be individualized (not routine and not pre-selected). For each patient, tests included in a battery must be selected to answer clinical questions relevant for that particular patient.

Written report and interpretation

A fully licensed psychologist, psychiatrist or QHP must submit a formal, written report that includes an interpretation of the psychological test results.

The psychiatrist, psychologist or QHP billing for the service must co-sign the report when the testing is administered by another fully licensed psychologist or limited licensed psychologist.

The results of the tests must be used actively in the process of diagnosis and formulation of a treatment plan for the patient.

In addition to the medical record documentation requirements for mental health and substance use disorder treatment, the psychological testing report must include legible documentation of the following:

- Diagnosis
- Follow-up visit schedule if indicated
- Patients understand the results if this was a session devoted to the discussion of results
- Risk assessment of the patient before discharge if this was devoted to discussion of results
- Signature and credentials of the treating provider

Medical services that may require behavioral health follow up

Acute detoxification

Acute detoxification is a service performed in an acute-care medical facility that additionally provides specialty consultation and intensive care services.

Acute detoxification services require clinical review through BCN's medical Utilization Management department. Providers should request

	prior authorization for an inpatient medical admission using the e-referral system. If criteria are met, services are covered under the member's medical benefit.
Emergency room services	All emergency services related to a mental health or substance use disorder condition provided by the emergency department of an acute-care hospital are covered under the member's medical benefit, not under the mental health or substance use disorder benefit.
Medical consultations for mental health or substance use disorder inpatients	Medical consultations that occur when a BCN member is admitted as an inpatient to a psychiatric or substance use disorder treatment unit are covered under the member's medical benefit. These services do not require referral or prior authorization.
Outpatient laboratory tests	Toxicology and drug-of-abuse tests and other outpatient laboratory tests are covered under the member's medical benefit. All providers contracted with BCN are expected to use only laboratories that are part of the Joint Venture Hospital Laboratories network to perform outpatient laboratory testing for BCN commercial and BCN Advantage members. This includes behavioral health treatment providers who order toxicology, drug-of-abuse and other laboratory tests for these members. To locate a local JVHL laboratory, call the JVHL Customer Service center at 1-800-445-4979. JVHL also works with providers to address any unique testing needs they may have.
Administering long-acting medications for behavioral health	For Blue Cross Blue Shield of Michigan and BCN members, long-acting medications can be administered by facilities, outpatient providers and home health care agencies contracted with Blue Cross and BCN. These providers can work together to initiate and continue members on these medications. For detailed information, refer to the document titled Obtaining, initiating and continuing long-acting medications for behavioral health. **Note**: For information about prior authorization requirements for home health care, refer to the Utilization Management chapter of this manual. Look in the section titled "Guidelines for transitional care."
Psychiatric consultations for medical inpatients	Psychiatric consultations that occur when a BCN member is hospitalized on a medical-surgical inpatient unit are covered under the member's medical benefit. These services do not require prior authorization.

Behavioral health assessment and intervention services

Behavioral health assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive and interpersonal factors that are important to assessing, treating or managing a patient's physical health problems.

For behavioral health assessment and intervention services:

- The patient's primary diagnosis must be physical in nature.
- The focus of the assessment and intervention must be on the factors that complicate the patient's medical conditions and treatments.
- The goal is to improve the patient's health and well-being by using psychological or psychosocial procedures or both that are designed to ameliorate specific disease-related problems.

When an appropriately credentialed behavioral health provider delivers services to a member whose primary diagnosis is medical (and not behavioral health), the provider should report the assessment and treatment using the following procedure codes:

- Base codes: *96156, *96158, *96164, *96167 and *96170
- Add-on codes: *96159, *96165, *96168 and *96171

These codes indicate that the focus of the assessment and treatment are the biopsychosocial factors that affect the member's medical care.

Note: These services do not require prior authorization.

Behavioral health integration services

Reimbursement for behavioral health integration services

BCN reimburses medical practices that perform behavioral health integration services. These services are reimbursed under members' medical benefits.

There are various behavioral health integration models in a primary care setting; these include the specialty referral model, the Primary Care Behavioral Health model and other models. The two models highlighted by CMS are:

- Collaborative care model of behavioral health integration
- General behavioral health integration model

No medical or behavioral health prior authorization is required for these services.

These services can be billed for both BCN commercial and BCN Advantage members. Providers should use our provider portal (availity.com**) to check each member's benefits and eligibility and to understand specific policy limitations.

Descriptions and procedure codes

Here's additional information about the two models of behavioral health integration highlighted by CMS:

- **The collaborative care model of behavioral health integration, also known as CoCM,** enhances the usual primary care services through two added caregiver roles. These added caregivers work with the treating provider, who is either a primary care or specialty care provider and who manages the overall patient care. The two caregivers who are required along with the treating physician are:
  - A behavioral health care manager, who assesses patients and works with them on developing care plans and who regularly meets with the consulting psychiatrist
  - A consulting psychiatrist, who provides recommendations through a systematic case review with the behavioral health care manager

  Services delivered under the CoCM model are billed monthly using procedure codes *99492, *99493 and *99494 and HCPCS codes G2214 and G0512. These services are performed in a primary care or specialty setting and are billed by the treating medical provider:
  - The treating medical provider pays the consulting psychiatrist as part of a separate agreement between them.
  - The consulting psychiatrist does not bill Blue Cross or BCN for services. The consulting psychiatrist is reimbursed through a contractual relationship with the treating medical provider.

  Note: The Physician Group Incentive Program, through the Blue Cross Value Partnerships area, launched a Collaborative Care Designation Program that builds on the Patient-Centered Medical Home foundation.
- **The general behavioral health integration model of behavioral health integration** may include service elements such as:
  - Systematic assessment and monitoring
  - Care plan revision for patients whose condition isn't improving adequately
  - A continuous relationship with an appointed care team member

  Services delivered as part of this model are billed monthly using procedure code *99484 and HCPCS code G0511. These services are billed either by the treating medical provider or by the behavioral health provider who bills with modifier AM, HA, HE or TD.

Note: These codes are also used to bill chronic care management services. The applicable procedure code for general behavioral health integration is *99484.

Initiating office visit required

For both models, an initiating office visit with the treating primary care provider is required prior to billing behavioral health integration services for patients who:

- Are new to the practice
- Have not been seen within the year prior to beginning behavioral health integration services

During this office visit, the treating provider does the following:

- Establishes a relationship with the patient
- Assesses whether the patient would be a good candidate for either collaborative care or general behavioral health integration services
- Obtains consent from the member to discuss his or her treatment with all members of the care team

  Note: The member's consent can be obtained orally but must be documented in the medical record.

No medical or behavioral health prior authorization is required for this service.

The initiating office visit and the associated cost share are payable according to the member's benefit plan. Providers should use our provider portal (availity.com**) to check each member's benefits and eligibility and to understand specific policy limitations.

Correct procedure codes

Providers should use the procedure codes in the table below when billing behavioral health integration services. Each code represents accrued time spent during a specific month.

Behavioral health integration model	Code	Description	Guidelines
Collaborative care, or CoCM, model (billed by treating medical provider)	*99492	Initial month of collaborative care services at 70 minutes per month	Cannot bill in the same month as *99484 is billed.
	*99493	Subsequent month of collaborative care services at 60 minutes per month	Cannot bill in the same month as *99484 is billed
	*99494	Add-on code for either *99492 or *99493. Provides an extra 30 minutes of collaborative care per month.	Can bill *99494 more than once per month if needed. Cannot bill in the same month as *99484 is billed.

Behavioral health integration model	Code	Description	Guidelines
	G0512	60 minutes or more of care in rural health clinic or federally qualified health center.	G0512 is the only code allowable for Medicare or Medicaid beneficiaries in these settings. No other behavioral health integration codes can be billed when using G0512.
	G2214	30 minutes of care for initial or subsequent psychiatric collaborative care management.	Cannot bill in the same month as *99484, *99492, *99493 or *99494 is billed.
General behavioral health integration model (billed either by the treating medical provider or by the behavioral health provider who bills with modifier AM, HA, HE or TD)	*99484	Initial or subsequent month of general behavioral health services at 20 minutes per month	Cannot bill in the same month as *99492, *99493, *99494 or G2214 is billed.
	G0511	20 minutes or more of chronic care management services or behavioral health integration services in a rural health clinic or federally qualified health center.	G0511 is the only allowable code for Medicare or Medicaid beneficiaries in these settings. No other behavioral health integration codes can be billed when using G0511.

More billing details

Here is additional information that's important when billing behavioral health integration services:

- These services should be billed once per month. The monthly claim should include all the time spent on a patient that month by both the behavioral health case manager and the consulting psychiatrist who are coordinating care with the treatment team for that patient.
- The care coordination should be billed using the appropriate units of time according to the code descriptions.

Example: Three hours of "subsequent month" time billed by the primary care provider in February would be billed on April 30 as 1 unit of *99493 and 4 units of *99494.

Additional information

Providers may access additional information about behavioral health integration in MLN909432, titled Behavioral Health Integration Services.** This is published by the U.S. Department of Health & Human Services.

Coordination of care

Coordination of care is a high priority

The coordination of care between primary care providers and other providers, including behavioral health providers, is a high priority. Processes are in place to ensure appropriate communication between a member's behavioral health provider and primary care provider.

Guidelines related to obtaining the member's written consent

The following guidelines apply to whether written consent for the release of information for coordination of care is required:

- The member's written consent is not required for behavioral health providers to disclose pertinent mental health treatment information to medical care providers in the interest of coordinating care. This includes information such as the following:
  - Diagnosis
  - Encounter data
  - Prescriptions
- The member's signed, written consent is required for the following:
  - Disclosure of substance use disorder treatment information
  - Disclosure of HIV treatment information
  - Release of therapy notes

The Michigan Department of Health and Human Services has made available a standard consent form for sharing behavioral health and substance use disorder treatment information. Providers should visit michigan.gov/bhconsent** to access the MDHHS-5515 *Consent to Share Behavioral Health Information* form and to read more about it. Below is some additional information about this form:

- The form complies with Public Act 129 of 2014.
- Although providers are not required to use this form, they are required to accept it.

Discussing coordination of care with members

When BCN members call for a referral to a behavioral health provider, the Blue Cross Behavioral Health clinician advises them of the importance of the coordination of care between medical and behavioral health providers and, if the treatment in question is for a substance use disorder, discusses the benefits of signing a release to allow communication.

All behavioral health providers must discuss the importance of coordination of care with all the BCN members they treat. If a member is admitted to an inpatient facility for mental health treatment, the primary care provider should be informed of the admission and should assist in the coordination of all medical consultations. If a member is admitted to an inpatient facility for substance use disorder treatment, they should be

encouraged to sign a written consent form to allow communication between the behavioral health provider and primary care provider. If the member signs the consent, the primary care provider must be informed of the admission and must assist in the coordination of all medical consultations.

Expectations of providers

Behavioral health providers are expected to communicate the following information to the member's primary care provider, to promote the appropriate coordination of care between the member's behavioral health providers and other providers involved in the member's care:

- The fact that the member is receiving behavioral health treatment
- The date of the clinical evaluation
- The member's psychiatric diagnosis
- The names of all psychotropic medications prescribed by the behavioral health provider
- The types of specialized mental health or substance use disorder treatment the member is involved in
- The dates of any mental health or substance use disorder hospitalizations
- The member's medical conditions that require attention and their relationship to the member's psychiatric or substance use disorder condition
- The name, location and telephone number of the behavioral health provider
- An invitation to the primary care provider to contact the behavioral health provider as needed

Note: All information that does not require a member's consent should be communicated as described above. Behavioral health providers are responsible for obtaining the member's consent before releasing substance use disorder treatment information and any other member consents that they deem appropriate or necessary.

Standards for coordination of care

The following standards are related to the coordination of care for BCN members involved in behavioral health treatment:

Outpatient behavioral health providers will do the following:

- Notify the member's primary care provider within 30 days of prescribing psychotropic medication
- Consult with the clinicians who treated the member in the preceding inpatient level of care, when applicable

- Refer member to follow-up psychosocial support services, when appropriate

Behavioral health providers will do the following for members in inpatient/ residential, partial hospital and intensive outpatient levels of care:

- Communicate with the member about follow-up appointments, prior to discharge
- Communicate discharge summaries to follow-up clinicians

In addition, behavioral health providers will do the following for members in inpatient/residential care:

- Arrange follow up prior to, and within seven days of, discharge
- Notify the member's primary care provider regarding hospitalization within 30 days of discharge
- Consult with the clinicians who treated the member in the preceding level of care, when applicable, within 24 hours of admission

All behavioral health providers will notify the member's primary care provider about the physical conditions the member has that require attention.

Monitoring compliance with coordination of care

BCN monitors the compliance of behavioral health providers with the BCN standards for continuity and coordination of care by reviewing the records of behavioral health providers.

Member complaints and grievances

Member complaints

Member complaints or concerns related to behavioral health care or treatment are addressed in the same way member complaints about other types of care are addressed.

A description of the manner in which member complaints are handled is provided in the Member Rights and Responsibilities chapter of this manual.

Member grievances

If a member's concern has not been resolved by BCN to his or her satisfaction, the member may (as a next step) file a formal grievance.

Member grievances related to behavioral health care or treatment are addressed in the same manner in which grievances related to other types of care are addressed.

A description of the member grievance process is provided in the Member Rights and Responsibilities chapter of this manual.

Provider appeals

Appealing utilization management decisions

All providers have the right to appeal an adverse decision made by Blue Cross Behavioral Health.

To submit an appeal of a prior authorization or concurrent review request that wasn't approved, follow the instructions in the determination letter.

Appealing administrative denials

Administrative denials are determinations made by BCN in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness.

Additional information about administrative denials and the process for requesting a reconsideration is provided in the Utilization Management chapter of this manual. Look in the section titled "Administrative denials."

Claims for behavioral health services

Electronic claims submission

Electronic billing is faster, easier and more accurate than filing paper claims. Providers who wish to learn more about filing claims electronically can visit **bcbsm.com/providers** > Help > Provider online tools > How do I sign up for Electronic Data Interchange?

For additional information on submitting claims electronically, providers should refer to the Claims chapter of this manual.

Paper claims submission

Paper claims for mental health and substance use disorder services, including emergency room claims, must be submitted to:

For **BCN commercial** claims:

Blue Cross and BCN Claims
P.O. Box 312500
Detroit, MI 48226

For **BCN Advantage** claims:

Blue Cross and BCN Claims
P.O. Box 32593
Detroit, MI 48232

No handwritten claims are accepted.

Information related to Blue Cross Complete claims is found in the *Blue Cross Complete Provider Manual*, which is available through the Blue Cross Complete Resources for Providers webpage.

This chapter is updated to show that the address for submitting BCN commercial claims is Blue Cross and BCN Claims, P.O. Box 312500, Detroit, MI 48226 and for BCN Advantage claims is Blue Cross and BCN Claims, P.O. Box 32593, Detroit, MI 48232.

Making the transition to electronic claims submission

For smaller provider offices currently submitting paper claims who would like to submit claims electronically but without the expense of purchasing software, our provider portal (availity.com**), has a Direct Data Entry claims submission tool that is available to registered Availity Essentials™ users.

Billing instructions

To access additional information on how to bill some types of behavioral health claims:

1. Log in to our provider portal (availity.com**).
2. Click *Payer Spaces* on the Availity menu bar and then click the BCBSM and BCN logo.
3. Click *Secure Provider Resources (Blue Cross and BCN)* on the Resources menu.
4. Click *Billing and Claims* > *BCN and BCN Advantage*. Look in the "BCN commercial and BCN Advantage" column.

Providers can also refer to the following documents available on the Behavioral Health webpage at authorizations**.bcbsm.com**:

- Requirements for providing behavioral health services to BCN members
- LLPs and LMFTs — Frequently asked questions.

For billing purposes, behavioral health providers can check their contract to remind themselves of the type of affiliation they have with BCN.

Note: For supervision of clinical work with patients, behavioral health providers should follow the requirements associated with their state-issued license or registration. This includes, for example, requirements for the minimum number of supervision hours, the proximity of the supervisor to the treating practitioner and the keeping of notes and records. BCN does not provide guidance for clinical supervision.

Billing telehealth services

For information about billing behavioral health telehealth services, refer to the subsection titled “Behavioral health telehealth services”, earlier in this chapter.

Billing split or shared visits

Split or shared visits occur when more than one therapy provider has provided services to the same Blue Cross or BCN member during the same time interval – for example, from 1 to 2 p.m. on a specific day for a member involved in physical therapy, occupational therapy, speech therapy and applied behavior analysis.

For guidelines on billing split or shared visits, including those related to behavioral health services, refer to the Claims chapter of this manual. Look in the subsection titled “Guidelines for billing split or shared visits.”

Considerations for autism-related services

Providers should refer to the Autism services: Billing guidelines and procedure codes document for more information. This document is on the Autism Services webpage at **authorizations.bcbsm.com**.

Billing for comprehensive opioid treatment programs

For information on billing for comprehensive opioid treatment programs, refer to the Claims chapter of this manual. Look in the section titled “Reimbursement guidelines for providers who offer comprehensive opioid treatment.”

Claims inquiries

To obtain assistance with behavioral health services claims inquiries, providers can call Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections.

Providers can use our provider portal (availity.com**) to check the status of both pending and finalized claims.

Providers authorized to submit claims electronically may also electronically validate the adjudication status (pending, paid or denied) of claims accepted for processing. This can be done in the following instances:

- When the provider is authorized to use the HIPAA-mandated Health Care Claim Status Request and Response (276/277) transaction standard
- Through the provider’s vendor/clearinghouse, when they are set up to use this transaction

Additional information on how to submit claims or claim status inquiries electronically is available at **bcbsm.com/providers** > Help > Provider online tools > How do I sign up for Electronic Data Interchange?. Click the pertinent link and follow the prompts.

Additional information about claims	For additional information about claims, including about appealing claims denials, providers should refer to the Claims chapter of this manual.

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