BLUE CROSS BLUE SHIELD OF MICHIGAN
BOARD CERTIFIED BEHAVIOR ANALYST
PARTICIPATION AGREEMENT

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan a Michigan nonprofit healthcare corporation, ("BCBSM") and the undersigned Board Certified Behavior Analyst who is legally authorized to practice in Michigan ("Provider").

ARTICLE 1
DEFINITIONS

For purposes of this Agreement, the defined terms are:

1.1 "**Agreement**" means this written Agreement between BCBSM and Provider designating Provider as eligible to provide Covered Services and incorporates by reference the Provider Manual, and other BCBSM written or web based communications concerning the Provider network and any Addenda or Amendments thereto.

1.2 "**Certificate**" means benefit plan descriptions under the sponsorship of BCBSM, or certificates and riders issued by BCBSM, or under its sponsorship, or Member's coverage documents or benefits provided pursuant to contracts issued by other Blue Cross or Blue Shield (BCBS) Plans, administered through reciprocity of benefit agreements or other Inter-Plan Arrangements such as BlueCard. "Certificate" does not include benefits provided pursuant to automobile or workers' compensation insurance coverage.

For purposes of this definition, "sponsorship" includes:

a. Self-funded administrative accounts of BCBSM for which BCBSM provides any one or more of the following administrative services: utilization management, quality assessments, reviews, audits, claims processing systems or a cash flow methodology.

b. Self-funded administrative service accounts for which another Plan is Control Plan and BCBSM is a participating plan and for which BCBSM or the Control Plan assumes the risk of reimbursing Provider for Covered Services in the event the account becomes insolvent.

For purposes of this definition, "sponsorship" does not include Health Maintenance Organizations (HMOs) or benefit plans owned, controlled or operated in whole or part by BCBSM or its subsidiaries, or by other BCBS Plans or their subsidiaries.

1.3 "**Clean Claim**" means a claim that (i) identifies the Provider that provided the service sufficiently to verify the affiliation status and includes any identifying numbers; (ii) sufficiently identifies that patient is a BCBS member; (iii) lists the date and place of service; (iv) is a claim for Covered Services for an eligible individual; (v) if necessary, substantiates the Medical Necessity and appropriateness of the service provided; (vi) if prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained; (vii) identifies the service rendered using an accepted system of procedure or service coding adopted and published by

BCBSM; (viii) includes additional documentation based upon services rendered as reasonably required by BCBSM.

1.4 "**Copayment**" means the portion of BCBSM's approved amount that the Member must pay for Covered Services under the terms of a Certificate. This does not include a Deductible.

1.5 "**Covered Services" or "Covered**" means those health care services which are (i) identified as payable in Certificate(s), (ii) medically necessary as defined in such Certificates, and (iii) within Provider's scope of practice to perform.

1.6 "**Deductible**" means the portion of BCBSM's approved amount a Member must pay for Covered Services under a Certificate before benefits are payable. This does not include a Copayment.

1.7 "**HCPCS**" means the Healthcare Common Procedure Coding System.

1.8 "**Medically Necessary" or "Medical Necessity**" is set forth in Addendum A.

1.9 "**Member**" means the person eligible on the date the Covered Service was rendered to receive Covered Services.

1.10 "**Provider**" means a Provider who (a) is legally authorized to practice in the state of Michigan, b) meets the Qualification Standards stated in Addendum B, and (c) has signed a BCBSM Board Certified Behavior Analyst Participation Agreement.

1.11 "**Provider Manual**" means a working document, including but not limited to BCBSM published bulletins and provider notices, that provide specific guidelines and direction by which providers may meet their contractual responsibility as described in this Agreement. Provider Manuals are published on web-DENIS.

1.12 "**Qualification Standards**" means those standards set forth in Addendum B.

1.13 "**Reimbursement Methodology**" means the methodology by which BCBSM determines the amount of payment due Provider for Covered Services.

ARTICLE 2
BCBSM RESPONSIBILITIES

Under this Agreement, Provider and BCBSM agree as follows:

2.1 **Direct Payments.** BCBSM, or its representative, will make payment directly to Provider for Covered Services except for Copayments and Deductibles that are the responsibility of the Member.

2.2 **BCBSM Reimbursement.** BCBSM will pay Provider for Covered Services in accordance with the Reimbursement Methodology set forth in Addendum C.

2.3 **Claims Processing.** BCBSM will process Provider's Clean Claims submitted in accordance with this Agreement in a timely fashion.

2.4 **Provider Manual.** BCBSM will, without charge, supply Provider with BCBSM guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for Provider to deliver Covered Services to Members and be paid. As available, BCBSM may provide such information through electronic means via web-DENIS or internet.

2.5 **Confidentiality.** BCBSM and Provider will maintain the confidentiality of Member information and records in accordance with applicable federal and state laws, and as set forth in Addendum G.

2.6 **Contracts With Other Parties.** BCBSM and Provider acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

ARTICLE 3
PROVIDER RESPONSIBILITIES

3.1 **Maintain Qualification Standards.** Provider shall be legally authorized to practice in the state of Michigan and shall meet and maintain all requirements in the Qualifications Standards as set forth in Addendum B.

3.2 **Notice of Adverse Actions.** Provider shall promptly notify BCBSM of any action, determination, or circumstance involving Provider which affects or may affect the provision of Covered Services. Such circumstances shall include, without limitation, the following:

a. Plea of guilty or nolo contendere or conviction, or placement in a diversion program for any crime related to the payment or provision of health care;

b. Censure, reprimand, restriction, suspension, revocation or reduction to probationary status of Provider's license to practice (if applicable) or any hospital related privileges;

c. Disability or infirmity which prevents or reduces Provider's ability to meet accepted practice standards, as defined by BCBSM, or the failure to successfully complete a program related to substance abuse;

3.3 **Services to Member.** Provider certifies that all services billed or reported by Provider are: within the scope of Provider's practice, performed personally by Provider or as otherwise permitted by BCBSM published policy, and submitted in accordance with the terms and conditions of the Members' Certificates.

3.4 **Accept BCBSM Payment as Payment in Full.** Except for Copayments and Deductibles specified in Members' Certificates, Provider will accept BCBSM payment as full payment for Covered Services and agrees not to collect any further payment from any Member, except as set forth in Addendum D. Provider also agrees to accept, as payment in full for Covered Services, except for applicable Copayments and Deductibles, BCBSM's approved amount for Members covered under any of BCBSM's PPO programs or any BCBS program if Provider provides Covered Services to such Member. Provider will not collect deposits from Members. Deposit is defined as an amount in excess of a Copayment or Deductible which is collected on or prior to the date of service.

3.5 **Release of Records.** BCBSM represents that BCBSM Members, by contract, have authorized Provider to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. Provider will release patient information and records requested by BCBSM to enable it to process claims and for pre-payment or post-payment review of medical records and equipment, lawsuits, coordination of benefits, as related to claims filed.

3.6 **Claims Submission.** Provider will submit Clean Claims for all Covered Services to BCBSM within one hundred eighty (180) days of the date of service, and only for services performed personally by Provider or as otherwise permitted by BCBSM published policy.

3.7 **Provider Obligations.** Provider at all times during the term of this Agreement shall:

a. **Cost Sharing Waiver.** Not waive Copayments and/or Deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record or where reasonable collection efforts have failed.

b. **Adherence to BCBSM Quality and Utilization Management Policies.** Adhere to and cooperate with all quality management, utilization management and reimbursement policies and procedures of BCBSM regarding precertification, case management, disease management, retrospective profiling, radiology management program, credentialing or privileging specific to particular procedures, billing limitations or other programs which may be in effect at the time the Covered Service is provided;

c. **Provider Business Changes.** Notify BCBSM within thirty (30) days of changes in Provider's business including changes in ownership, name, tax identification number, National Provider Identifier, location, phone number, business structure, range of services offered and specialty. Prior notice of such changes does not guarantee continued participation under this Agreement;

d. **Coordination of Benefits.** Provide Covered Services to Members even though there might be coverage by another party under workers' compensation, occupational disease, or other statute. Provider shall bill the appropriate responsible party for Covered Services and shall provide information to BCBSM regarding the applicability of such statutory coverage;

Request information from Members regarding other payers that may be primarily responsible for Members' Covered Services, pursue payment from such other responsible payers, and shall bill BCBSM only for Covered Services not paid by the primary payers. All payments received from other primary payers for Covered Services shall be promptly credited against or deducted from amounts otherwise payable by BCBSM for such services. Except where BCBSM payment is secondary to Medicare, payments by BCBSM as a secondary payer shall not exceed the amount which would otherwise be payable by BCBSM as primary payer under this Agreement. Provider agrees to submit claims to the primary payers before submitting them to BCBSM;

e. **Medical Records.** Develop and utilize accurate medical, appointment, financial and billing records of all matters relating to obligations under this Agreement and provide them to BCBSM upon request;

f. **Member Eligibility.** Verify Member eligibility contemporaneous with the rendering of services. BCBS will provide systems and/or methods for verification of eligibility and benefit coverage for Members. This is furnished as a service and not as a guarantee of payment;

g. **Discrimination.** Not discriminate against Members based upon race, color, age, gender, marital status, religion, national origin, or sexual orientation nor may Provider refuse to render Covered Services to Members based upon BCBSM's payment level, benefit or reimbursement policies.

3.9 **Provider Directory.** Provider agrees to the publication of his/her name, location and specialty to Members.

3.10 **Audits and Recovery.** Provider agrees that BCBSM may review, photocopy and audit Provider as set forth in Addendum F, and BCBSM has the right of recovery of any overpayments as set forth in Addendum E.

3.11 **Third Party Administrator.** Provider understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

3.12 **Billing for Services to Family Members.** Provider shall not bill BCBSM for Covered Services rendered to themselves or immediate family Members (mother, father, sister, brother, spouse or child).

3.13 **Misuse of Billing Numbers.** Provider shall use a Provider Identification Number (PIN) for the billing of Covered Services which complies with BCBSM policy as well as all applicable federal or state statutes or regulations. Provider shall not permit any other individual or entity to use his/her PIN. If Provider becomes aware that his/her PIN has been used in any manner which is in violation of published BCBSM policy by any other individual or entity, he/she must notify BCBSM immediately. Such misuse of a PIN by Provider or Provider's failure to notify BCBSM when they have knowledge of such misuse of their PIN by others is grounds for termination of this Agreement in addition to any other remedies available to BCBSM or its Members.

ARTICLE 4
PROVIDER ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

4.1 BLUE CROSS®, BLUE SHIELD®, and the Cross and Shield symbols (Marks) are registered service marks of the Blue Cross and Blue Shield Association. Other than the placement of small signs on its premises indicating participation in BCBSM programs, Provider shall not use, display or publish the Marks without BCBSM's written approval.

4.2 Provider hereby expressly acknowledges his/her understanding that this Agreement constitutes a contract between Provider and BCBSM and that BCBSM is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the Association) permitting BCBSM to use the Blue Cross and Blue Shield Service Marks in the state of Michigan, and that BCBSM is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSM and that no person, entity, or organization other than BCBSM shall be held accountable or liable to Provider for any of BCBSM's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSM other than those obligations created under other provisions of this Agreement.

ARTICLE 5
CLAIM DISPUTES AND APPEALS

5.1 Provider may appeal claim and audit determinations through the BCBSM appeal process as set forth in the Provider Manual or other sources as published by BCBSM which may be amended from time to time. Provider agrees to abide by this appeal process.

ARTICLE 6
MISCELLANEOUS

6.1 **Term of this Agreement.** This Agreement will become effective on the later of October 15, 2012, or the date indicated on the Signature Document.

6.2 **Termination.** Either party may terminate this Agreement with or without cause. Without cause termination requires sixty (60) days written prior notice by either party. Provider may also terminate this Agreement as set forth in Section 6.6.

6.3 **Existing Obligations.** Termination of this Agreement shall not affect any obligations of the Parties under this Agreement prior to the date of termination including, but not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. BCBSM's obligation to reimburse Provider for any Covered Services will be limited to those provided through the date of termination. BCBSM's right of audit and recovery from Provider as set forth in Article 3, Section 3.10, shall survive the termination of this Agreement.

6.4 **Independent Contractor.** It is expressly understood that Provider is an independent

contractor. BCBSM shall not be responsible to withhold or cause to withhold any federal, state or local taxes, including FICA, from any amounts paid to Provider. The responsibility for the payment of such taxes shall be that of the Provider.

6.5 **Assignment.** This Agreement shall be binding upon, and shall inure to the benefit of the successors and assigns of BCBSM. BCBSM may assign any right, power, duty or obligation under this Agreement. Provider shall not assign any right, power, duty or obligation hereunder without the prior written consent of BCBSM.

6.6 **Amendment.** BCBSM may unilaterally amend this Agreement by providing ninety (90) days prior notice, written or electronic, of such amendment. Written form shall include publication in the *Record* or other appropriate BCBSM provider publication. Electronic notice shall include, but not be limited to, publication on web-DENIS. Provider's signature is not required to make the amendment effective. However, should Provider no longer wish to continue its participation in the network because of an amendment, then Provider may terminate this Agreement by providing forty-five (45) days written notice to BCBSM.

6.7 **Serviceability.** In the event any portion of this Agreement is declared null and void by statute or ruling of a court of competent jurisdiction or BCBSM's regulator, the remaining provisions of this Agreement will remain in full force and effect.

6.8 **Notice.** Unless otherwise stated in this Agreement, any notice required or permitted under this Agreement shall be sent by first class United States Mail addressed as follows:

If to Provider:	If to BCBSM:
Current site address on BCBSM Provider File	Provider Enrollment Department Blue Cross Blue Shield of Michigan PO Box 217 Southfield, Michigan 48034

6.9 **Waiver.** No waiver of any provision of this Agreement shall be valid unless in writing and signed by the parties. Failure to enforce any provision of this Agreement by either party shall not be construed as a waiver of any breach of this Agreement or of any provisions of this Agreement.

6.10 **Scope and Effect.** This Agreement constitutes the entire Agreement between the parties and supersedes any and all prior agreements or representations oral or written as to matters contained herein, and supersedes any agreements between Provider and BCBSM which conflict with the terms and conditions of this Agreement.

6.11 **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

6.12 **Provider Information.** BCBSM may disclose Provider specific information as follows:

a. pursuant to any federal, state or local statute or regulation;

b. to customers for purpose of audit and health plan administration so long as the customer agrees to restrict its use to these purposes; and

c. for purposes of public reporting of benchmarks in utilization management and quality assessment initiatives, including publication in databases for use with all consumer driven health care products, or other similar BCBS business purposes.

d. for civil and criminal investigation, prosecution or litigation to the appropriate law enforcement authorities or in response to appropriate legal processes.

6.13 **Member Discussions.** Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations in Member's Certificates, Provider's representatives shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSM or any other entity. Nothing in this Agreement shall prohibit Provider's representatives from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, provided the specific terms of the compensation arrangement are not mentioned to the Member. BCBSM shall not refuse to allow or to continue the participation of any otherwise eligible Provider, or refuse to compensate Provider in connection with services rendered solely because Provider has in good faith communicated with one or more of its current, former or prospective Members regarding the provisions, terms or requirements of a Certificate as they relate to the health needs of such Member.

6.14 **Compliance With Laws.** Both parties will comply with all federal, state and local laws ordinances, rules and regulations applicable to its activities and obligations under this Agreement.

6.15 **Governing Law.** This Agreement will be governed and construed according to the laws of the state of Michigan.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF

ADDENDA

A. Medical Necessity Criteria

B. Qualifications Standards

C. Reimbursement Methodology

D. Services for Which Provider May Bill Members

E. Service Reporting and Claims Overpayment Policy

F. Audit and Recovery Policy

G. Confidentiality Policy

ADDENDUM A
MEDICAL NECESSITY CRITERIA

"Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. Not primarily for the convenience of the Member, Provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

ADDENDUM B
QUALIFICATION STANDARDS

In order to participate with BCBSM, a Board Certified Behavior Analyst must practice in Michigan and have and maintain all of the following:

- Current certificate as a Board Certified Behavior Analyst from the Behavior Analyst Certification Board, Inc.
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review.
- Absence of fraud and illegal activities.

ADDENDUM C
REIMBURSEMENT METHODOLOGY

For Covered Services performed that are within Provider's scope of practice, BCBSM will pay the lesser of the billed charge or 60% of the published maximum payment, less any Deductible or Copayment for which the Member is responsible. The published maximum payment is set forth in BCBSM's Maximum Payment Schedule ("Payment Schedule").

BCBSM will make the Payment Schedule available to Providers via web-DENIS. Most of the maximum payment levels are based on the Resource Based Relative Value Scale (RBRVS) system developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them. The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM may give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

Nationally imposed changes to the nomenclature and national coding system (HCPCS) for procedural codes, and corrections of typographical errors may result in immediate modifications to the Payment Schedule without prior notice. No other modification to the Payment Schedule will become effective until after 90 days have elapsed from the date of BCBSM's notice to Providers in accordance with Section 6.6 of this Agreement. Notice may be provided either in written or electronic form. Written form shall include publication in the *Record* or other appropriate BCBSM provider publication. Electronic notice shall include, but not be limited to, publication on web-DENIS.

BCBSM will review Provider reimbursement levels periodically and may adjust them if BCBSM determines modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

ADDENDUM D
SERVICES FOR WHICH PROVIDER MAY BILL MEMBER

Provider may bill Member for:

1. Non-Covered Services *unless* the service has been deemed a non-Covered Service solely as a result of a determination by a BCBSM physician or professional provider that the service was:
    - Medically Unnecessary,
    - deemed experimental,
    - denied as an overpayment, or
    - denied because the Provider was not eligible for payment as determined by BCBSM based upon BCBSM's credentialing, privileging, payment, reimbursement or other applicable published policy for the particular service rendered,

    in which case Provider assumes full financial responsibility for the denied claims. BCBSM will endeavor to apply like medical specialties to the claims review process.

    Provider, however, may bill the Member for claims denied as Medically Unnecessary or experimental only as stated in paragraph 2, below;

2. Services determined by a BCBSM doctor or professional provider to be Medically Unnecessary or experimental, if the Member specifically agrees in writing in advance of receiving such services as follows:

    a. The Member acknowledges that BCBSM will not make payment for the specific service to be rendered because it is deemed experimental or Medically Unnecessary.

    b. The Member consents to the receipt of such services.

    c. The Member assumes financial responsibility for such services, and

    d. Provider provides an estimate cost to the Member for such services.

3. Covered Services denied by BCBSM as untimely billed, if both of the following requirements are met:

    a. Provider documents that a claim was not submitted to BCBSM within one hundred eighty (180) days of performance of such services because a Member failed to provide proper identifying information; and

    b. Provider submits a claim to BCBSM for payment consideration within three (3) months after obtaining the necessary information.

ADDENDUM E
SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Provider will furnish a claim or report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, and such other information as may be required by BCBSM to adjudicate claims.

Provider agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to worker's compensation, other group health insurance, third party liability and other coverages. Provider further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Provider is aware the patient has primary coverage with another third party payer or entity, Provider agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the arbitration determination, or the last unappealed determination, whichever occurs first. Audit refund recoveries and other overpayment obligations which cannot be fully repaid over the course of one month, will bear interest at the BCBSM prevailing rate, until fully repaid. Interest will run from the date of arbitration determination or last date an appeal could have been filed whichever is earlier. Provider agrees that filing an appeal tolls the applicable statute of limitations that may apply to BCBSM actions relating to the overpayment or recovery.

ADDENDUM F
AUDIT AND RECOVERY POLICY

I. Records

BCBSM or its designee shall have access to the Member's medical records or other pertinent records of Provider to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Provider for the reasonable copying expense incurred by Provider where Provider copies records requested by BCBSM in connection with BCBSM audit activities.

Provider shall prepare and maintain all appropriate records on all Members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to Providers by BCBSM, any such requirements subsequently developed which are communicated to Provider prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered. The Provider Retrospective Profiling System ("PRP") is one component of BCBSM audit policy. Audits may be conducted outside the Program based on review of information and data different from or not available under PRP.

III. Time

BCBSM may conduct on-site audits during Provider's regular business hours. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary as determined by BCBSM under Addendum A. BCBSM shall have the right to recover amounts for services not meeting the applicable benefit, reimbursement or Medical Necessity criteria established by BCBSM, overpayments, services not documented in Provider's records, any services not received by Member, non-Covered Services or for services furnished when Provider's certification was lapsed, restricted, revoked or suspended. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to eighteen (18) months from the date of payment or up to twenty-four (24) months from the date of payment as required by a (a) self-insured plan or (b) state or federal government plan. In instances of fraud, there will be no time limit on recoveries.

ADDENDUM G
CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for the protection of the privacy of Members, and the confidentiality of personal data and personal information.

BCBSM's Policy sets forth the guidelines conforming to MCLA 550. 1101 et seq. which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data."

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and with reasonable care to ensure confidentiality; to know that it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, which is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure, and will collect only the personal data necessary to review and pay claims and for health care operations, treatment and research. BCBSM will identify routine uses of Member personal data and notify Members regarding these uses.

Enrollment applications and claim forms will contain the Member's consent to release data and information that is necessary for review and payment of claims. These forms will also advise the Members of their rights under this policy.

Upon specific request, a Member will be notified regarding the actual release of personal data. BCBSM will disclose personal data as permitted by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the regulations promulgated under that Act and in accordance with PA 350 of 1980. Members may authorize the release of their personal information to a specific person.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal processes.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Applied Behavior Analysis Billing Guidelines and Procedure Codes

Revised and updated January 2015

Activity / Details	Code	Rate	Billing and Documentation
Initial assessment The initial assessment includes both direct face-to-face assessment time and time for developing the initial treatment plan.	H0031 (See note about DOS.)	Per hour	**NOTE: Use procedure code H0031 for initial assessments with dates of service on or after April 1, 2014. Use procedure code H0032 for initial assessments with dates of service prior to April 1, 2014.** • BCBA must bill the number of units that correspond to the number of hours spent during the initial assessment. This service can be billed only once per patient. EXAMPLE: If the initial assessment takes 4 hours, the BCBA needs to bill 4 units of H0031. • BCBA must bill by date of service. • Documentation: BCBA must document objective performance metrics in the patient record.
Reassessment Reassessments may occur anywhere from monthly to annually but are typically done on a semi-annual basis.	H0032 (See note about DOS.)	Per hour	**NOTE: Use procedure code H0032 for reassessments with dates of service on or after April 1, 2014. Use procedure code H0031 for reassessments with dates of service prior to April 1, 2014.** • BCBA must bill the number of units that correspond to the number of hours spent during the reassessment. EXAMPLE: If the reassessment takes 4 hours, the BCBA needs to bill 4 units of H0032. • BCBA must bill by date of service. • Documentation: BCBA must document progress on the performance metrics established during the initial assessment in the patient record.
Line therapy Services are provided by a BCBA or by a tutor who works under the direct supervision of the BCBA.	H2019	Per 15 min.	• Line therapy is billable by a BCBA only. A tutor's services are billed by the supervising BCBA. • Effective Jan. 1, 2015, there are no limits for billable applied behavior analysis services. The services billed must be based on the hours authorized. • BCBA needs to bill for the hours of direct interaction the BCBA or the tutors have with the patient. BCBA may not bill for caregivers (relatives or guardians) performing line therapy services. • Because the code is per 15 minutes, the BCBA must bill the correct number of units to correspond with the total time spent with the patient. EXAMPLE: If a patient receives 2.5 hours of tutoring, BCBA must bill 10 units of H2019. • BCBA must bill by date of service. NOTE: For guidance regarding BCBA supervision of line therapy, see "Supervision" for code S5108.

Applied Behavior Analysis Billing Guidelines and Procedure Codes

Revised and updated January 2015

Activity / Details	Code	Rate	Billing and Documentation
Skills training Delivered in a small-group format by a BCBA or a tutor. Patient practices socially based behavior goals. Services are provided by a BCBA or by a tutor who works under the direct supervision of the BCBA.	H2014	Per 15 min.	**NOTE: Procedure code H2014 is effective for dates of service on or after April 1, 2014.** • Skills training is billable by a BCBA only. A tutor's services are billed by the supervising BCBA. • Effective Jan. 1, 2015, there are no limits for billable applied behavior analysis services. The services billed must be based on the hours authorized. • BCBA must bill for the hours of direct interaction the BCBA or tutor has with the patient based on the number of patients the BCBA or tutor is working with during the session. • BCBA may not bill for relatives or guardians performing skills training. • Because the code is per 15 minutes, BCBA must bill the correct number of units to correspond with the total time spent in skills training. EXAMPLE: If 2.5 hours of skills training is provided, BCBA must bill 10 units of H2014. • BCBA or tutor working with more than one patient during the session must divide the time spent by the number of patients present for skills training and BCBA must bill accordingly. EXAMPLE: If there is one BCBA or tutor and four patients in a group that receives 1 hour of skills training, BCBA must bill only 15 minutes per patient, for a total of 1 billable hour. BCBA may not bill 4 hours total, or 1 hour for each of the four patients. • When a BCBA or tutor works with a skills training group in which there is a one-to-one ratio of BCBAs/tutors to patients, each BCBA may bill for the number of units provided for the group member in skills training. EXAMPLE: If there are four BCBAs or tutors and four patients in a group that receives 1 hour of skills training, each BCBA may bill for 1 hour per patient. • BCBA must bill by date of service. NOTE: For guidance regarding BCBA supervision of skills training, see "Supervision," code S5108.

Applied Behavior Analysis Billing Guidelines and Procedure Codes

Revised and updated January 2015

Activity / Details	Code	Rate	Billing and Documentation
Supervision Supervision is face to face during a line therapy (tutoring) or skills training session. Includes time afterward to process feedback and make adjustments to the treatment plan.	S5108	Per 15 min.	**NOTE: Procedure code S5108 must be used for supervision for dates of service on or after April 1, 2014.** • Effective Jan. 1, 2015, there are no limits for billable applied behavior analysis services. The services billed must be based on the hours authorized. • Because the code is per 15 minutes, providers must bill the correct number of units to correspond with the total time spent supervising. EXAMPLE: If 2.5 hours of supervision is provided, BCBA must bill 10 units of S5108. • BCBA may bill for the supervision of a tutor performing line therapy or skills training. o BCBA can supervise only one tutor at a time who is conducting a face-to-face ABA line therapy session. o BCBA may supervise a group of tutors conducting skills training. For the period of time the BCBA is supervising a group of tutors face to face while the tutors are conducting skills training, BCBA must split that billable time among all of the tutors who are in the room. EXAMPLE: If BCBA supervises a group of four tutors and four patients for 2 hours, BCBA may bill only 30 minutes per tutor and per patient, which adds up to the 2 billable hours. BCBA may not bill 2 hours for each of the four tutors and the four patients who were supervised. o BCBA may bill only for the time he or she spends face to face with the tutor and the member, and for the time spent after the session processing feedback and making adjustments to the treatment plan. • BCBA must bill by date of service. • BCBA may not bill for the training of a tutor to learn how to perform line therapy using this code. NOTE: For guidance regarding caregiver training, see "Caregiver training," code S5111.

Applied Behavior Analysis Billing Guidelines and Procedure Codes

Revised and updated January 2015

Activity / Details	Code	Rate	Billing and Documentation
Caregiver training Training of a parent or guardian to learn how to work with the child using the principles of ABA therapy and skills training	S5111	Per 15 min.	**NOTE: Procedure code S5111 is effective for dates of service on or after April 1, 2014.** • Effective Jan. 1, 2015, there are no limits for billable applied behavior analysis services. The services billed must be based on the hours authorized. • Because the code is per 15 minutes, BCBA must bill the correct number of units to correspond with the total time spent in caregiver training. EXAMPLE: If 2.5 hours of caregiver training is provided, BCBA must bill 10 units of S5111. • BCBA may not bill for the training of a tutor to learn how to perform line therapy or skills training. • BCBA must bill by date of service.
Supervision Supervision is face-to-face during a line therapy (tutoring) session and includes time afterward to process feedback and make adjustments to the treatment plan.	G9012	Per 15 min.	**NOTE: Procedure code G9012 is billable for supervision for dates of service on or before March 31, 2014. This code is not in effect and cannot be used for supervision for dates of service on or after April 1, 2014. Procedure code S5108 must be used for supervision for dates of service on or after April 1, 2014.** • Effective Jan. 1, 2015, there are no limits for billable applied behavior analysis services. The services billed must be based on the hours authorized. • Because the code is per 15 minutes, BCBA must bill the correct number of units to correspond with the total time spent supervising. EXAMPLE: If 2.5 hours of supervision is provided, BCBA must bill 10 units of G9012. • BCBA may bill for the supervision of a tutor, parent or guardian performing line therapy. BCBA may not bill for the training of a tutor, parent or guardian to learn how to perform line therapy (that is, skills training). • BCBA must bill by date of service.

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Applied Behavior Analysis Billing Guidelines and Procedure Codes

Revised and updated January 2015

FOR BCBSM CLAIMS ONLY

General information for submitting claims to BCBSM is located in the *BCBSM Provider Manuals.* Here's how to find the *BCBSM Provider Manuals*:

1. Go to **bcbsm.com/provider**, click *Login* and log in to Provider Secured Services as a provider.
2. Click *web-DENIS* to access the "Welcome to web-DENIS" page.
3. On the left navigation bar, click *BCBSM Provider Publications and Resources*, then click *Provider Manual.*
4. Click *Provider Type.* In the Provider Type Criteria field, select your provider type (Board Certified Behavior Analyst (BCBA) or MD-DO–all specialties) from the Search for Provider Type drop-down menu.
5. Click *Search.* In the results that appear, scroll down and click *Claims.*

Electronic claims: For electronic billing information, refer to the Blues' **electronic connectivity (EDI) user guide.**

Paper claims: The following are additional instructions for submitting paper claims for applied behavior analysis services to BCBSM:

Field # on CMS-1500	Field name on CMS-1500	Instructions	Additional information
Field 21	Diagnosis or nature of illness or injury	Enter the autism diagnosis code specified in the authorization as the primary diagnosis.	Do not enter any other diagnosis codes.
Field 23	Prior authorization number	Enter the prior authorization number for the service that was preapproved by Magellan Behavioral of Michigan.	• The prior authorization number is a 10-digit number. • Prior authorization for autism services is not required for all groups. Be sure to confirm the member's autism coverage and check authorization requirements.
Field 24A	Dates of service	Bill for each date of service on a separate line.	• You cannot bill a range of dates of service on a single line. • You may bill multiple days of service on separate lines in a single claim submission. • The dates of service being billed must fall within the dates specified on the authorization letter. Please be aware that there may be multiple letters for a single authorization. You must match the dates of service billed to the letters you receive. • If you're using web-DENIS to view the authorization record, the authorized dates of service are specified as the Actual Admission Date and the Discharge Date.
Field 24D	Procedures, services or supplies	Enter the appropriate HCPCS code for the procedure performed.	The procedure code in Field 24D must match the procedure code on the authorization record.
Field 24G	Days or units	Based on the service you're billing, enter an applicable quantity here.	• Enter units in whole increments. • Make sure the number of units submitted does not exceed the number specified on the authorization letter for a specific procedure code.

Blue Cross Blue Shield Blue Care Network of Michigan

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Autism Mandate Coverage

Fact Sheet

February 19, 2016

For Providers

Topic	Fact
General information	• The state of Michigan autism mandate was effective on October 15, 2012. • The law requires that underwritten group and individual plans provide coverage for the diagnosis and treatment of autism spectrum disorders, or ASD. • The autism mandate does not apply to members in federal programs (such as FEP, TriCare, VA, Medicare, Medicaid, Medicare Advantage, or Medicare Part D). • Effective January 1, 2015 there are no hour or dollar limits on applied behavior analysis, or ABA, treatment.
To qualify for ABA treatment and the approved autism valuation center	To qualify for ABA treatment, members are diagnosed by an approved autism evaluation center, or AAEC, to ensure they receive appropriate, high-quality care. • Approved AAECs were conceived to ensure that members receive appropriate, high-quality care. Facilities are located around the state of Michigan and can be found using the Find a Doctor link. • The AAEC must be part of an academic medical center or hospital-based facility in network. • The AAEC must use a multi-disciplinary approach by specialists with significant experience diagnosing and treating autism. • Providers who conduct the evaluation must include these specialists: o Board-certified pediatrician o Developmental pediatrician or pediatric neurologist o Fully licensed pediatric neuropsychologist o Board-certified child psychiatrist or fully licensed child psychologist o Speech and language therapist • Evaluation must include a team conference to solidify appropriate diagnosis and treatment plan. • Typically, the wait is two to three months, but can be as long as seven months, depending on the facility. Members can choose from multiple sites to get an appointment at the earliest date. • For members who are concerned about obtaining an AAEC evaluation, providers can contact one of the following based on the member's coverage: o Blue Care Network - contact Behavioral Health at 800-482-5982 o Blue Cross Blue Shield of Michigan - contact New Directions at 877-563-9347

Topic	Fact
Qualifications for ABA payable benefits in Michigan	• Before treatment begins, the AAEC is used to make or confirm the ASD diagnosis and provide a plan containing comprehensive treatment recommendations that include ABA. • The member must receive care from a board-certified behavior analyst, or BCBA. • The BCBA must obtain preauthorization from Blue Cross or BCN prior to rendering ABA services. • For Blue Cross, the BCBA may be nonparticipating, but must be registered with Blue Cross. For BCN, members should always confirm in advance that the provider and facility are in BCN's network.
Qualifications for ABA payable benefits outside of Michigan	• The member must obtain a multi-disciplinary evaluation that makes or confirms the ASD diagnosis. • The evaluation must include a plan containing comprehensive treatment recommendations that include ABA.
Preauthorization requirements	• Preauthorization is necessary for ABA. • Services other than ABA to treat ASD do not require preauthorization. • The BCBA is responsible for obtaining preauthorization for ABA treatment. • Blue Cross members and providers will receive a statement about the approval in the mail. Only BCN members will receive a statement about the approval in the mail. • If Blue Cross denies preauthorization for ABA treatment, the member can follow the standard member grievance appeal process. • Participating providers in Michigan who do not get preauthorization before they administer the ABA treatment will be liable for the cost. • If a nonparticipating provider in Michigan or other states does not obtain necessary preauthorization, the member is liable for the cost.
Impact on physical, occupational and speech therapy limits	• Physical, occupational and speech therapy services related to autism treatment do not accumulate toward visit limitations that are specified by the member's plan.
Prescription drug coverage	• Coverage for prescription drugs used to treat autism-related symptoms are subject to member's benefit plan. (There are no drugs specific to the treatment of autism.)
Out-of-state claims	• Out-of-state claims will be handled as they normally are through BlueCard. • The following services are covered at applicable cost share: – ABA (for service on or after February 2, 2014) – Physical, speech and occupational therapy given to treat ASD – Nutritional counseling provided to treat ASD – Other mental health benefits to diagnose and treat autism – Other medical services used to diagnose and treat autism

Topic	Fact
When a member qualifies for ABA treatment, but can't find a participating BCBA provider	• For Blue Cross, the member who qualifies but is unable to find a provider can go to a nonparticipating provider. However, the BCBA must be registered with Blue Cross. For BCN, members should always confirm in advance that the provider and facility are in BCN's network. • For Blue Cross, the member may be balance billed for the difference between the provider's actual charges and the amount Blue Cross pays for the services.
Autism coverage both in and out of their networks?	• Network requirements remain the same and cost variations will continue for in-network versus out-of-network services where applicable.
BCBA supervision of tutors	• ABA line therapy is conducted one-on-one between the member and a BCBA or a tutor who works under the direct supervision of the BCBA. • According to the billing guidelines, supervision is conducted face-to-face during a line therapy (tutoring) session. • A BCBA can only supervise one tutor conducting a face-to-face ABA line therapy session at a time. • The BCBA may only bill for the time he or she spends face-to-face with the tutor and the member, and for the time after the session to process feedback and make adjustments to the treatment plan. • A BCBA may supervise a group of tutors who are conducting skills training. • For the period of time the BCBA is supervising a group of tutors face-to-face while the tutors are conducting skills training, the BCBA must split that billable time up among all of the tutors that are in the room. For example, if the BCBA supervises a group of four tutors and four patients for two hours, they may only bill thirty minutes per tutor and per patient to add up to the two billable hours. • The BCBA may not bill two hours for each for the four tutors and the four patients they supervised.

Questions? Contact your managing agent or Blues representative.

Provider Information

Provider Name:	CENTRIA HEALTHCARE LLC	Portico ID:	G1000000[redacted]
Provider Type:	Group	Type 2 NPI:	1063641[redacted]

Practitioner Information

Practitioner Name:	Marissa Magil	Portico ID:	112[redacted]
Provider Type:	Board Certified Behavior Analyst	Type 1 NPI:	1720[redacted]