

Behavioral Health

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Chapter contents

Important! Click a link below to go to that page in the chapter.

Behavioral health overview	1
About this chapter	1
Behavioral health benefits	1
Check member eligibility and benefits	1
Management of behavioral health benefits	2
Behavioral health screening tools	3
Behavioral health providers seeking BCN affiliation	3
Providers must be approved to use applied behavior analysis	4
CADC or CAADC credential is recommended but is not required	4
Behavioral health telehealth services	4
Accessing behavioral health services	5
Behavioral health contact information for providers	5
Behavioral health contact information on member ID card	5
Assistance for providers in arranging for behavioral health services	5
Member access to behavioral health services	6
Options for members in crisis	7
Access standards	8
Virtual option for treatment of anxiety and depression through AbleTo	8
Travel benefits	9
Expectations and incentives	10

Provider offices: general expectations	10
Clinical practice guidelines	10
Behavioral Health Incentive Program	10
Authorization for behavioral health services	10
Authorization required for certain services covered under behavioral health benefit	10
Clinical criteria used in authorization decisions	11
How the criteria are developed	12
BCN works collaboratively with behavioral health practitioners	12
Discussing a determination	12
Requesting prior authorization	13
Guidelines for requesting prior authorization for mental health and substance use disorder services.	14
Guidelines for ambulatory follow up after inpatient discharge	17
Covered services for autism spectrum disorder	18
Medical record documentation requirements	20
Overview	20
Documentation requirements for applied behavior analysis services	20
Documentation requirements for services other than applied behavior analysis	20
Behavioral health services under medical benefit.....	20
Acute detoxification	20
Emergency room services covered under medical benefit.....	21
Medical consultations for mental health or substance use disorder inpatients.....	21
Outpatient laboratory tests	21
Administering long-acting injectable medications at home.....	21
Psychiatric consultations for medical inpatients	22
Behavioral health assessment and intervention services.....	22
Behavioral health integration services under medical benefit.....	23
BCN reimburses behavioral health integration services under the medical benefit	23
Descriptions and procedure codes	23
Initiating office visit required	24
Correct procedure codes	24
More billing details.....	25
Additional information	26
Coordination of care.....	26

Coordination of care is a high priority	26
Guidelines related to obtaining the member's written consent	26
Discussing coordination of care with members	27
Expectations of providers	27
Standards for coordination of care	28
Monitoring compliance with coordination of care	28
Member complaints and grievances	29
Member complaints	29
Member grievances	29
Provider appeals	29
Appealing utilization management decisions	29
Appealing administrative denials	29
Claims for behavioral health services	29
Electronic claims submission	29
Paper claims submission	30
Making the transition to electronic claims submission	30
Billing telehealth services	30
Considerations for autism-related services	30
Billing instructions	30
Billing for comprehensive opioid treatment programs	31
Claims inquiries	31
Additional information about claims	32

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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 at MiBlueCrossComplete.com/providers.

Behavioral health benefits

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

- Mental health services: Use the appropriate ICD-10 diagnosis code. Providers can use the default ICD-10 code F43.20 until a more appropriate code is available.
- Substance use disorder services: Use the appropriate ICD-10 diagnosis code. Providers can use the default ICD-10 diagnosis code F19.10 until a more appropriate code is available.
- Applied behavior analysis for autism spectrum disorder services.

Note: Additional information about autism benefits is available at ereferrals.bcbsm.com > BCN > [Autism](#).

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 (availability.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?](#) Select *Real Time, Eligibility, Claim Status and Provider Authorizations/Referrals*.
- Provider Inquiry

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



The information about locating the guidelines for the HIPAA 270/271 electronic standard transaction is updated.

Management of behavioral health benefits

For BCN members, behavioral health benefits are managed by BCN's Behavioral Health department.

Exception: For BCN members with coverage through Healthy Blue ChoicesSM POS, behavioral health benefits are managed by Carelton Behavioral Health. For more information, contact Carelton Behavioral Health at 1-800-346-7651 or refer to BCN's [Healthy Blue Choices POS webpage](#). The information in this chapter pertains to BCN members with coverage through products other than Healthy Blue Choices POS.

BCN's Behavioral Health department 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



To this chapter, we added the Carelton Behavioral Health phone number (1-800-346-7651). Providers can contact Carelton Behavioral Health at that number with questions.



This chapter is updated to show that Carelon Behavioral Health (formerly known as Beacon Health Options) manages behavioral health services for members with coverage through Healthy Blue Choices POS.

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 at ereferrals.bcbsm.com > BCN > Behavioral Health > [Behavioral health screening tools](#). Click / *accept*.

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 [Join our Network](#). Review the information on that page and then click [Enroll Now](#). 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 30 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 BCN's Autism page at ereferrals.bcbsm.com > BCN > [Autism](#).
- Specialists who provide treatment for BCN members using applied behavior analysis must be approved by BCN, including those who are licensed behavior analysts.

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:

- [Medical policy – Telemedicine Services](#)
- [Determining a member's telehealth benefits](#)



The links in this chapter that open telehealth-related documents are updated to open the most current versions of the documents.

Accessing behavioral health services

Behavioral health contact information for providers

The contact information for accessing assistance with behavioral health services is:

Provider Inquiry (for authorization requests, claims questions, or assistance with other questions):

Providers should call the appropriate number as indicated on the *Provider Inquiry Contact Information* list, which is available at ereferrals.bcbsm.com > Quick Guides > [BCN Provider Inquiry Contact Information](#).

Address:

Blue Care Network
Behavioral Health
Mail Code C355
20500 Civic Center Drive
Southfield, MI 48076-4115

Note: Contact information for Blue Cross Complete Provider Inquiry and Customer Service is found in the *Blue Cross Complete Provider Manual*, available at MiBlueCrossComplete.com/providers.

Behavioral health contact information on member ID card

For both BCN commercial and BCN Advantage members, the behavioral health services telephone number provided on the [Provider Inquiry Contact Information](#) list 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 BCN's Behavioral Health department at the appropriate phone number as indicated on the *Provider Inquiry Contact Information* list for assistance in arranging behavioral health services for a BCN member. This list is available at ereerrals.bcbsm.com > Quick Guides > [BCN Provider Inquiry Contact Information](#).



In this chapter, we updated the information about services associated with prolonged psychotherapy codes.

Member access to behavioral health services

Members can access behavioral health services directly

BCN members can access behavioral health services directly by contacting an affiliated behavioral health provider or by calling the telephone number located on the back of their BCN identification card.

Members can access behavioral health providers through Quartet

Eligible members who are having difficulty obtaining timely care from a behavioral health provider in their area can use Quartet, an independent company that connects outpatient behavioral health providers with new patients through an online platform at no cost to the provider or patient.

Through Quartet's online platform, members are referred to behavioral health providers registered on Quartet's platform, based on the patient's needs and preferences and the provider's clinical specialty and their availability.

Behavioral health providers that join Quartet's online platform can receive referrals, accept new patients, track the patient's progress and access clinical assessments.

Quartet's services are available to the following adult members (18 years of age or older) who reside in Michigan:

- Fully insured Blue Care Network commercial members
- All BCN Advantage members

This is how Quartet works:

- Quartet works with the provider to create a provider profile and add the provider to the platform.
- Quartet matches members seeking outpatient behavioral health care to a provider based on their geographic location, treatment needs and preferences.
- Quartet can refer members to both in-person and virtual care.

- Quartet sends a referral to the selected provider through the platform for a specific member.
- The provider reviews and accepts or declines the referral.
- When the provider accepts the referral, the provider contacts the member to schedule an appointment.

For more information, or for details on how to register with Quartet as a behavioral health provider, refer to the [Quartet Care Navigation Platform: Frequently asked questions for behavioral health providers](#) document on ereferrals.bcbsm.com.



This chapter is updated to include information about Quartet, a company that connects behavioral health providers to patients through an online platform.

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. These options include:

- Psychiatric urgent care
- Mobile crisis services
- On-site crisis stabilization services
- Residential crisis treatment

Several facilities in Michigan currently offer these services. Refer to the [Help in times of crisis](#) flyer for the details on locations, phone numbers service areas and care options available at specific locations. The information in the flyer is updated from time to time.

Note: One provider (New Oakland Family Centers) offers mobile crisis services via telemedicine throughout the entire lower peninsula of Michigan, for members who prefer telemedicine services or who don't have a face-to-face option near them.

In a crisis, members and other individuals — including family members, friends, law enforcement personnel and emergency department staff — can call the number of a crisis location in their service area for guidance.

Information about mobile crisis services

Mobile crisis services include:

- Professional mental health teams in the community who can evaluate members wherever they are located — in their home, school, work or doctor's office

- Face-to-face evaluations, telemedicine or phone evaluations to develop a treatment plan, initiate treatment and, if needed, refer the member to an appropriate placement

The mobile crisis team may stay involved for two to four weeks after the initial encounter to ensure members are connected to the right level of care and to provide treatment as necessary.

Information about on-site crisis stabilization services

On-site crisis stabilization services include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)
- Physical site-based services that are necessary to support the mobile crisis team. These include:
 - Intake assessment, psychiatric evaluation, crisis intervention and initiation of treatment, such as psychotherapy, medication administration, therapeutic injection, observation and peer support, as needed
 - Initiation of coordinated linkages and “warm handoffs” to the appropriate level of care and community resources

Note: Facilities used for physical site-based services are open 24 hours a day, 7 days a week. They offer members access to services from a multidisciplinary staff, including physicians, registered nurses, licensed master social workers, psychologists, clinical supervisors and additional support staff. After evaluation and treatment at these facilities, some members may still need psychiatric hospitalization.



Information about behavioral health crisis services is added to this chapter. For BCN commercial members, these services are currently payable. For BCN Advantage members, these services are payable for dates of service on or after Jan. 1, 2024.

Access standards

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

Virtual option for treatment of anxiety and depression through AbleTo

Adult BCN commercial and BCN Advantage members can access a virtual option for the treatment of anxiety and depression through AbleTo, an independent company with a network of therapists serving adults 18 and older in all 50 states.

This service may be especially useful for members who are having trouble finding a therapist in their area or obtaining an appointment with their current provider.

AbleTo provides adult members with a structured and evidence-based eight-week cognitive behavioral treatment program for anxiety and depression. The program includes access to weekly sessions with a

licensed master's-level clinician and access to digital tools, resources and relaxation activities for practice between sessions.

To access services through AbleTo, members can:

- Call the number on the back of their member ID card.
- Visit ableto.com/bcbsm^{**}, click *Get Started* and follow the prompts.



This chapter is updated to include information about AbleTo, which offers adult BCN commercial and BCN Advantage members a virtual option for the treatment of anxiety and depression.

Travel benefits

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 (availability.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 Blue Cross Online VisitsSM (AmwellTM). 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 clinical practice guidelines related to behavioral health.

These guidelines are published by the Michigan Quality Improvement Consortium; they can be accessed at **improve.health** > [Michigan Quality Improvement Consortium](#)**.

Behavioral Health Incentive Program

The Behavioral Health Incentive Program was established to reward behavioral health providers for meeting specific quality standards. These incentives are available to both prescribers and non-prescribers.

The program rewards providers who meet select HEDIS measures and who close gaps to improve the quality of care and patient outcomes.



This chapter is updated to show that the MQIC guidelines have moved to the Improve Health website.



The information about the Behavioral Health Incentive Program is updated to show that the program rewards providers who meet select HEDIS measures and who close gaps to improve the quality of care and patient outcomes.

Authorization for behavioral health services

Authorization required for certain services covered under behavioral health benefit

Certain services covered under a member's behavioral health benefit **must** be authorized by BCN's Behavioral Health department. These services include the following:

- Inpatient/residential admission
- Partial hospitalization
- Intensive outpatient mental health and substance use disorder services
- Applied behavior analysis for autism spectrum disorder services (outpatient)

- Electroconvulsive therapy (outpatient):
 - For dates of service through Dec. 31, 2022, prior authorization is required.
 - For dates of service on or after Jan. 1, 2023, no authorization is required.
- Neurofeedback (outpatient)
- Transcranial magnetic stimulation (outpatient)

Note: 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.

See the Service Type / Action table found in this section for additional information about authorization requirements for various services.

Clinical criteria used in authorization decisions

The criteria BCN's Behavioral Health department uses to make utilization management decisions are outlined here.

Providers can find links to criteria documents and medical policies on the BCN [Behavioral Health](#) and [Autism](#) webpages at ereferrals.bcbsm.com.

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

Here are the types of criteria we use:

InterQual®. BCN's Behavioral Health department uses Change Healthcare's InterQual Behavioral Health Criteria as utilization management guidelines. The criteria require reviewers to consider the severity of illness as well as episode-specific variables that match the level of care to a patient's current condition.

The InterQual Behavioral Health criteria are developed with evidence-based rigor and are validated through the expertise of a multidisciplinary panel of psychiatrists, psychologists, psychiatric nurses and social workers. Change Healthcare comprehensively reviews medical literature and other respected sources to assure that the criteria are current with the latest advances in evidence-based medicine as well as with new terminology and diagnostic classifications.

Modifications of InterQual criteria. BCN uses modified InterQual criteria for the following services:

- Autism spectrum disorder / applied behavior analysis
- Residential mental health treatment (adult/geriatric and child/adolescent)

Local criteria. BCN Behavioral Health uses its own utilization management criteria (local rules or medical policies) for decisions about the following services:

- Neurofeedback for attention deficit disorder / attention deficit hyperactivity disorder
- Telemedicine
- Transcranial magnetic stimulation

How the criteria are developed

BCN's Behavioral Health department develops the criteria used for making medical necessity determinations in these areas. National experts, clinical advisory committees and contracted behavioral health clinicians contribute to the development of these criteria. 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 internal criteria include:

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

Providers who wish to obtain a copy of BCN's local criteria should visit these BCN webpages at **ereferrals.bcbsm.com**:

- [Behavioral Health](#)
- [Autism](#)

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.

BCN's behavioral health utilization management clinicians 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.

BCN 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. BCN's Behavioral Health department staff members don't have financial arrangements that encourage denial of coverage or service. BCN-employed clinical staff and physicians do not 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 BCN Behavioral Health department utilization management clinician consults with a BCN Behavioral Health

department physician reviewer, who may either deny the request or ask the care manager to contact the practitioner for additional information.

When a BCN 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 BCN 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 plan 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 inpatient admission, not to talk about the InterQual criteria or BCN's local rules.

For decisions on inpatient admissions, BCN allows onsite physician advisors at contracted facilities to discuss reviews of inpatient admissions with a BCN 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.

To discuss a behavioral health determination for a member, providers can call the following numbers:

- During business hours (8 a.m. to 5 p.m., Monday through Friday, except for holidays), providers should call 1-877-293-2788. If the call is not answered by a staff member, leave a message with the following information:
 - Physician advisor's or physician's name and phone number
 - Member's name, date of birth and contract number
 - Reason for requesting a peer-to-peer review. Calls will be returned within 48 business hours.
- After business hours (for emergency cases only), providers should call 1-800-482-5982.

Note: This does not apply to denials related to BCN Advantage outpatient services. Refer to the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

Requesting prior authorization

Providers will incur complete financial responsibility for all services provided without prior authorization from BCN's Behavioral Health department, when prior authorization is required.

Here are the general guidelines for authorization requirements:

- **For urgent services that require authorization, for members in an emergency room who need inpatient admission and for other member emergencies**, submit these requests through the e-referral

system or call these requests in to BCN's Behavioral Health department at 1-800-482-5982.

- **For all other services**, follow the guidelines in the Service Type / Action table found in this section.

For most services that require authorization, providers must submit the request via the e-referral system.

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 technological problems, such as a power or internet outage. Refer to the document [e-referral system maintenance times and what to do](#) for information about alternate methods that can be used when the e-referral system is not available or when providers are experiencing temporary technological problems.

The BCN Behavioral Health department responds to all requests for authorization via the e-referral system.

Note: To register for access to the e-referral system, follow the instructions at ereferrals.bcbsm.com > [Sign Up or Change a User](#).



This chapter is updated with information about Michigan's prior authorization law, Public Act 60 of 2022, which is effective June 1, 2023.

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.

For requests submitted through the e-referral system, providers should refer to the [Behavioral Health e-referral User Guide](#) for instructions on:

- How to submit each type of request, including how to complete a questionnaire that may be presented during the process of requesting prior authorization
- How to attach clinical documentation or a completed form to the request. Look in the subsection titled "Create New (communication)."

The user guide can be accessed at ereferrals.bcbsm.com > [Training Tools](#).

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)	<p>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:</p> <ul style="list-style-type: none"> • *90785 • *90836-*90840 • *90853 • *90882 • *90791-*90792 • *90846-*90847 • *90865 • S9484 • *90832-*90834 • *90849 • *90880
Medication management visits without therapy	<p>No referral or 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.</p> <p>This applies to procedure codes *99201 through *99205 or *99211 through *99215. The appropriate evaluation/management code must be used.</p>
Medication management visits with therapy	<p>When there is a therapy service or any other service provided in addition to medication management, that service does not require 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.</p> <p>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.</p>
Extension of outpatient treatment	<p>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:</p> <ul style="list-style-type: none"> • *90785 • *90836-*90840 • *90853 • *90882 • *90791-*90792 • *90846-*90847 • *90865 • S9484 • *90832-*90834 • *90849 • *90880

Service type	Action / additional information about requesting prior authorization
Outpatient ECT, neurofeedback and TMS services	<p>Providers must submit prior authorization requests for outpatient electroconvulsive therapy, neurofeedback and transcranial magnetic stimulation services through the e-referral system. Providers must complete the questionnaire that displays in the system during the process of requesting prior authorization.</p> <p>Note: For outpatient ECT, prior authorization is required for dates of service through Dec. 31, 2022. For dates of service on or after Jan. 1, 2023, no authorization is required.</p> <p>Note: For neurofeedback services, an independent evaluation confirming the diagnosis of ADHD/ADD must be submitted with the initial authorization request. This could be the Conners, the NICHQ Vanderbilt Assessment Scales, the Test of Variables of Attention (T.O.V.A.®) or another psychological or neuropsychological test. The questionnaire in the e-referral system must be completed for requests involving additional visits. If no questionnaire displays, attach the required clinical documentation to the case in the e-referral system. Instructions for attaching a document from the member's medical record are outlined in the Behavioral Health e-referral User Guide, in the subsection titled "Create New (communication)." BCN's Behavioral Health staff, not the medical Utilization Management staff, make the determination on neurofeedback authorization requests related to behavioral health. When these requests are authorized, neurofeedback is covered only for specific behavioral health diagnoses, not for medical diagnoses.</p> <p>Note: Biofeedback, when authorized, is covered only for specific medical diagnoses and not for behavioral health diagnoses. BCN's medical Utilization Management staff, not the Behavioral Health staff, make the determination on requests to authorize biofeedback.</p>
Initial inpatient/residential, partial hospital or intensive outpatient treatment	<p>Medical-surgical and behavioral health facilities that wish to arrange for an inpatient/residential, partial hospital or intensive outpatient admission for psychiatric or substance use disorder treatment should obtain authorization prior to the admission.</p> <p>Prior authorization requests can be submitted as follows:</p> <ul style="list-style-type: none"> 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 BCN's Behavioral Health department at 1-800-482-5982. <p>Note: That phone line is in service even when Blue Cross / BCN corporate offices are closed for a holiday. Refer to the document Holiday closures: How to submit authorization requests for inpatient admissions.</p> <ul style="list-style-type: none"> When the member has already been admitted, you must submit the initial prior authorization request through the e-referral system and complete the questionnaire presented within the system. <p>A BCN Behavioral Health department utilization management clinician 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, the BCN Behavioral Health utilization management clinician may suggest that other resources for treating the member's condition be explored. As necessary, the BCN Behavioral Health utilization management clinician will review the case with the BCN medical director for behavioral health.</p>

Service type	Action / additional information about requesting prior authorization
Requesting additional days of inpatient/residential, partial hospital or intensive outpatient treatment (mental health / substance use disorder)	<p>Submit all concurrent review requests through the e-referral system. For assistance in accessing the system, visit ereferrals.bcbsm.com > Get help accessing e-referral.</p> <p>Providers must complete the questionnaire presented within the system.</p> <p>Note: For partial hospital or intensive outpatient treatment, to move forward the discharge date without adding days, call BCN's Behavioral Health department at 1-800-482-5982.</p>
Subacute detoxification (managed under the mental health-substance use disorder benefit)	<p>Providers must obtain authorization from BCN's Behavioral Health department for subacute detoxification. Subacute detoxification is managed by BCN's Behavioral Health department. 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.</p> <p>Prior authorization requests can be submitted as follows:</p> <ul style="list-style-type: none"> • 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 BCN's Behavioral Health department at 1-800-482-5982. • When the member has already been admitted to a bed, you must submit the initial prior authorization request through the e-referral system.
Post-emergency services covered under behavioral health benefit	<p>An inpatient admission for mental health or substance use disorder treatment that results from an emergency screening or assessment must be authorized. Authorization requests for inpatient admissions are accepted 24 hours per day, seven days per week.</p> <p>All other behavioral health services obtained as the result of an emergency screening or assessment must be authorized.</p> <p>Prior authorization requests can be submitted as follows:</p> <ul style="list-style-type: none"> • 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 BCN's Behavioral Health department at 1-800-482-5982. • When the member has already been admitted to a bed, you must submit the initial prior authorization request through the e-referral system.
Psychological or neuropsychological assessment	<p>No referral or authorization is needed for providers who are contracted with BCN and who are part of the designated network associated with the member's plan. Providers do not need to complete a form.</p> <p>Note: This applies to procedure codes *96101 through *96105, *96118 through *96120, and *96130 through *96139 when billed by themselves.</p>

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, BCN's Behavioral Health department 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.

BCN's Behavioral Health department 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

BCN's Behavioral Health department 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

Covered benefits for members are available as follows:

- **For dates of service on or after Jan. 1, 2022:** Autism spectrum disorder services are covered for all members, regardless of age, unless otherwise indicated by the member's benefit description.
- **For dates of service before Jan. 1, 2022:** Autism spectrum disorder services are covered through the age of 18 (until the member's 19th birthday) 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	<ul style="list-style-type: none"> • For applied behavior analysis, a diagnosis of autism spectrum disorder is required, which must be made through an evaluation at a facility contracted with BCN and approved by BCN as an approved autism evaluation center (AAEC). <ul style="list-style-type: none"> ○ If you or the member has a concern about obtaining an AAEC evaluation, or if you have questions about past autism testing, screening and clinical information, call BCN's Behavioral Health department at 1-800-482-5982

Service	Guidelines for coverage and for requesting prior authorization
	<ul style="list-style-type: none"> ○ Authorization is not required for the behavioral health components of the evaluation. If the member was diagnosed with autism spectrum disorder by an approved autism evaluation center within three years of the date of the request, BCN will accept the diagnosis without a new evaluation. This is true even if the evaluation center had not yet been deemed approved at the time of the diagnosis. ○ The autism evaluation center will need to identify the medical specialists who will be evaluating the member so that the member's primary care provider can submit a referral for each specialist. A referral from the primary care provider is required for each medical specialist who will see the member during the evaluation process. ○ The results of the multidisciplinary evaluation must be reported on the AAEC Evaluation Results Form. Follow the instructions on the form for faxing it to BCN. <p>Note: AAECs should submit a claim for the evaluation of each member using procedure codes *99367 and T1023.</p> <ul style="list-style-type: none"> ● For treatment, the request for the behavioral health components of the applied behavior analysis services must be authorized by BCN's Behavioral Health department. As part of that process, BCN must confirm that an approved autism evaluation center has made a diagnosis of an autism spectrum disorder and documented a recommendation for applied behavior analysis. <p>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 BCN physician reviewer.</p>
Other behavioral health services to diagnose and treat autism	<p>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 but not necessarily by an approved autism evaluation center.</p> <p>In these cases, follow the guidelines for requesting prior authorization for mental health services.</p>
Physical, occupational and speech therapy (by therapists) and physical medicine services (by chiropractors and by athletic trainers) as part of autism spectrum disorder treatment	<p>The provider is responsible for verifying whether each member has autism benefits and, if so, how they are managed.</p> <p>When performed for an autism diagnosis, these services require authorization by eviCore® healthcare for members 19 years of age and older. For members under age 19, no authorization is needed.</p> <p>Additional information is available in the "Managing PT, OT and ST / Managing physical medicine services" section of the Utilization Management chapter of this manual.</p>

Service	Guidelines for coverage and for requesting prior authorization
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 authorization from BCN's Behavioral Health department.

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 applied behavior analysis services	<p>Providers should refer to the Behavioral health medical record documentation requirements for applied behavior analysis services document for a summary of requirements related to applied behavior analysis services.</p> <p>This document is found on the BCN Behavioral Health page at ereferrals.bcbsm.com > BCN > Behavioral Health.</p>
Documentation requirements for services other than applied behavior analysis	<p>Providers should refer to the Behavioral health medical record documentation requirements and privacy regulations — for services other than ABA document for a summary of requirements related to services other than applied behavior analysis.</p> <p>These guidelines apply to all levels of care.</p> <p>This document is found on the BCN Behavioral Health page at ereferrals.bcbsm.com > BCN > Behavioral Health.</p>

Behavioral health services under medical benefit

Acute detoxification	<p>Acute detoxification is a service performed in an acute-care medical facility that additionally provides specialty consultation and intensive care services.</p> <p>One or more of the following characterizes the patient's status:</p> <ul style="list-style-type: none"> • Severe medical complications of addiction requiring medical management and skilled nursing • Significant concurrent medical illness or pregnancy • Medical problems that require inpatient diagnosis and treatment
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- Other medical problems that require 24-hour observation and evaluation

Acute detoxification services require clinical review through BCN's medical Utilization Management department. Providers should request authorization for an inpatient medical admission using the e-referral system. If criteria are met, services are covered under the member's medical benefit.

Following successful detoxification, the member should be referred to BCN's Behavioral Health department for discharge planning and continued treatment.

Emergency room services covered under medical benefit

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.

If a member considers his or her condition to be serious enough that a delay in receiving treatment might cause serious impairment of a bodily function, permanent disability or death, the member should call 911 or seek help from the nearest medical facility as soon as possible.

Medical consultations for mental health or substance use disorder inpatients

When medical consultations are needed for BCN members admitted as inpatients to a psychiatric or substance use disorder treatment unit, a representative from the behavioral health facility or another individual, as appropriate, contacts the primary care provider to arrange for a medical consultation and discuss the member's care.

The primary care provider is not required to submit a referral to BCN for the requested services.

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 injectable medications at home

For BCN commercial and BCN Advantage members, long-acting injectable medications can be administered in the home. BCN-contracted provider facilities, outpatient providers and select home health care agencies can work together to initiate and continue members on these medications.

For detailed information, refer to the document [Administering long-acting injectable medications at home \(behavioral health\)](#).

Note: For information about 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 authorization by BCN’s Behavioral Health department.

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 authorization.



The information about behavioral health assessment and intervention services is clarified.

Behavioral health integration services under medical benefit

BCN reimburses behavioral health integration services under the medical benefit

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 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 (availability.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 provider:

- The treating provider pays the consulting psychiatrist as part of a separate agreement between them.
- The consulting psychiatrist does not bill for services.

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.

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 physician 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 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 (availability.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	*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.
	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	*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 physician in February would be billed on Feb. 28 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.



The information about behavioral health integration services is relocated from the Claims chapter to the Behavioral Health chapter of this manual and is updated to reflect current practices.

Coordination of care

Coordination of care is a high priority

The coordination of care between behavioral health providers and primary care providers is a high priority. Processes are in place to closely track communication between a member's behavioral health provider and primary care provider.

Guidelines related to obtaining the member's written consent

In BCN's interpretation of federal and state privacy laws, the following guidelines apply related to the need to get the member's written consent for the release of information:

- 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, with limited exceptions, 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. Here 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.

Providers should visit michigan.gov/bhconsent^{**} to access the MDHHS-5515 *Consent to Share Behavioral Health Information* form and to read more about it.

Discussing coordination of care with members

When BCN members call for a referral to a behavioral health provider, the BCN Behavioral Health department utilization management 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, encourages them to sign 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, he or she 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: Before any information related to a member's substance use disorder treatment may be communicated to the primary care provider, a written consent must be obtained from the member. Behavioral health providers are responsible for obtaining the member's consent to the

release of 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 continuity and 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:

- Complete an Adobe® PDF version of the [Behavioral Health Discharge Summary](#) form and attach it to the case in the e-referral system.

Note: The PDF form is available at ereferrals.bcbsm.com > BCN > [Behavioral Health](#). For instructions on how to attach the completed form to the case in e-referral providers should refer to the [Behavioral Health e-referral User Guide](#). Look for instructions titled "Create New (communication)."

- 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 the BCN's Behavioral Health department staff.

A description of the process for appealing adverse decisions is provided in the [Utilization Management chapter](#) of this manual. Look in the section titled "Appealing utilization management decisions."

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 > (under "Provider online tools") Help > [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 Care Network
P.O. Box 68710
Grand Rapids, MI 49516-8710

For BCN Advantage claims

BCN Advantage
P.O. Box 68753
Grand Rapids, MI 49516-8753

No handwritten claims are accepted.

Information related to Blue Cross Complete claims is found in the *Blue Cross Complete Provider Manual*, available at MiBlueCrossComplete.com/providers.

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 users.

Billing telehealth services

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

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 BCN Autism page at ereferrals.bcbsm.com > BCN > [Autism](#).

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 at **ereferrals.bcbsm.com** > BCN > [Behavioral Health](#):

- [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 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 the appropriate phone number as indicated on the *Provider Inquiry Contact Information list* and follow the prompts.

To access the list, providers should go to **e-referrals.bcbsm.com** > Quick Guides > [BCN Provider Inquiry Contact Information](#).

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 > (under 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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Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Quartet is an independent company contracted by Blue Cross Blue Shield of Michigan to connect Blue Cross and BCN members seeking outpatient behavioral health services with the appropriate behavioral health providers.