Limited-License Survival Guide

The BCBSM incident-to change, what it means, and three paths

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What this guide is and is not

This guide is for limited-license clinicians in Michigan, their employers, and their supervisors. It covers Blue Cross commercial professional claims. On March 1, 2027, Blue Cross Blue Shield of Michigan (BCBSM) will end office incident-to payment for the named limited-license group. Its other products follow their own rules.

It is written from BCBSM's own papers: its payment policy, FAQs, alerts, 2026 manuals, enrollment forms, and program rules. It also uses the PDCM pages of MICMT, BCBSM's training partner, and two CMS texts. And it quotes one email from BCBSM's PGIP team, with its date and author. It is not policy.

This guide is for education. It is not legal, billing, coding, clinical, or compliance advice. Where a point is not yet written, the guide says so and names the setup it limits.

Current through September 10, 2026. Corrections: send them through the Center's corrections page, integrative-neuroscience.com/updates-and-corrections. Release date: the day that page goes live with the Center's website.

Start with the product

> Blue Cross commercial, BCN commercial, Medicare Plus Blue, and BCN Advantage do not share one billing rule. Do not carry an instruction from one product to another.

Where each route stands today

STATUS	ROUTES
Supported with documented controls	Blue Cross commercial claims in the transition window. They go under the supervisor's NPI, with SA plus HO or AJ. Direct enrollment for the licenses the grid lists. [1, pp.2, 3; 2, p.7; 4, pp.9, 29]
Conditional, written confirmation required	A place in an OPC or other facility. A care manager role in CoCM or BHI. A role on a PDCM team. Get it in writing first. [2, pp.5, 7, 10; 14, pp.1 to 4; 19, PDCM FAQs pp.1 to 3]
Do not implement yet	99484 billed by a behavioral health provider with the modifiers that conflict. Medicare Plus Blue claims for the four limited licenses under the page 115 exception. [5, pp.10 to 12; 9, p.115]

Blue Cross Complete, Medicaid, BlueCard, FEP, and self-funded plans are outside this guide.

1. What is changing, in dates

Incident-to means one person gives the care and the supervisor's NPI goes on the claim. It is paid at the supervisor's rate. BCBSM's commercial policy changes this in two phases. [1, p.1; 2, p.2]

DATE	WHAT CHANGES	WHO	SOURCE
September 1, 2026, through February 28, 2027 (Phase I)	Incident-to claims need modifier SA. They are paid at the "submitting provider's applicable payment rate," with no value-based reimbursement. A limited licensed clinician in a professional setting "must use modifier SA on the claim in addition to any applicable modifier (HO or AJ)."	Blue Cross commercial incident-to claims.	[1, p.2; 2, pp.7, 12]
March 1, 2027 (Phase II)	Office-based incident-to payment ends for students, trainees, and the limited-license group. A participating, approved, and accredited facility may still bill eligible services under its product's rules.	The group in section 2.	[1, p.4; 2, p.9; 3, p.2]
March 1, 2027	Providers who can enroll directly must bill under their own NPI. Only two 90-day transition cases keep incident-to, at 80 percent and no VBR.	NPs, PAs, LLPs, LPCs, LMSWs (clinical, the clinical license), LMFTs, other eligible types.	[1, pp.2, 3, 5]

The September window: does your provider type qualify? The other claim rules still apply. Those are the supervisor's NPI, SA, HO or AJ, and a record that names you both. The August FAQ names the limited-license groups. It allows their services incident-to for Blue Cross commercial during the window. [2, p.7] The September FAQ describes the same window in a footnote. [10, p.3] Two 2026 manual chapters repeat the SA instruction. [4, pp.10, 29; 5, pp.3, 13] The detailed guidance supports eligibility.

One conflict, disclosed. The policy's grid has a row for students, trainees, and limited-license types. It says "No" under "Incident-to Allowed" for "All Dates." That column is about incident-to itself, so the conflict is real. Right below the grid, the policy says it "does not address all situations." It points to the manual, which supports the window. [1, pp.2, 5] Keep dated copies of the FAQ, the manual page, and the policy. File them with your September claims.

BCN is different. BCN providers "aren't permitted to bill incident-to in a professional setting and should continue to follow their current billing process." [2, p.7] The commercial transition is not new permission for BCN office incident-to billing.

Two March 1 rules. The policy's table says an eligible provider outside the two transition cases "Must bill directly" after March 1, 2027. The 80 percent rate belongs to those two cases only. They are a move to a Michigan license, or between practices, for 90 days at most. [1, pp.2, 3, 5] One FAQ sentence reads wider: eligible providers who keep billing incident-to "will receive 80% reimbursement." [2, p.4] Which applies is not written. Enroll and bill on your own NPI. Contracts and benefit papers may override the policy. There is no grandfathering. Medicaid, self-funded groups, and other payers are not covered. [1, p.6]

Medicare Plus Blue (MPB): hold. Do not implement: the reviewed Medicare Plus Blue materials do not establish that the page 115 exception includes LLPCs, LLMSWs, LLMFTs, or TLLPs. Do not bill their professional services under a physician's NPI on the strength of that sentence alone. Get written, license-specific Medicare Plus Blue authorization first. Here is why the question comes up. The commercial change "doesn't apply to Medicare Plus Blue and BCN Advantage." [2, pp.2, 13] It sets no rule there and no ban. The MPB manual says a network provider bills only services it personally provides. "The only exception is when a physician personally supervises a provider who cannot bill Blue Cross directly." [9, p.115] So the manual allows some supervised work by a provider who cannot bill directly. The 2024 grid shows no limited license in Medicare Advantage. The documents do not reconcile the exception with the eligibility grid; do not use it without written authorization. [11, pp.1, 2] Original Medicare's general supervision rule [21, (b)(5)] does not define "personally supervises." Read the MPB agreement and its billing terms against the setup you plan. If they leave supervision undefined, that narrow point stays open.

2. Who is affected, license by license

The policy names the excluded types and adds "equivalent provider types." [1, p.4] BCBSM's eligibility grid (July 2024) shows which licenses can enroll. Every limited license except the LLP is "N/A" in every network. [11, p.1]

LICENSE	WHAT THE SOURCES ESTABLISH
LLMSW, LLPC, LLMFT, TLLP	Named. Excluded from Blue Cross commercial office incident-to after March 1, 2027. Through February 28, 2027, the claim goes under the supervisor's NPI with SA plus the modifier for the person being supervised: AJ for an LLMSW; HO for an LLPC, LLMFT, or TLLP. The manual's table also names the supervisor. An LLMSW works under an LMSW (clinical). An LLPC works under an LPC. An LLMFT works under an LMFT. A TLLP works under a fully licensed psychologist. For the first three, the doctor or fully licensed psychologist who supervises that clinician may bill instead. [1, p.4; 4, p.29]
LLP	Not in the exclusion. The March 1 rule "doesn't apply to limited licensed psychologists who are eligible to participate with us and bill directly." The manual and the grid list the LLP as enrollable. Enroll by February 28, 2027, then bill under your own NPI. [2, pp.12, 13; 3, p.1; 4, pp.9, 29; 11, p.1]
Doctoral limited psychology license	Named in the grid as enrollable: Traditional on your own, BCN through a group. Enroll like any LLP. [11, p.1; 14, p.1]

LICENSE	WHAT THE SOURCES ESTABLISH
Doctoral temporary psychology license	Not named by degree. "Temporary Limited License Psychologists" are excluded with no qualifier. The grid's only temporary row is the master's TLLP, "N/A" everywhere. Plan as if the exclusion applies until an enrollment decision says otherwise. [1, p.4; 11, p.1]
LMFT	Eligible type. Direct enrollment: Traditional and Medicare Advantage on your own, BCN through a group. [10, pp. 1, 2; 11, p.1]
LLBSW	Never named by license. "Limited License Social Workers" are excluded with no qualifier. The supervisor tables, the grid, and the checklist have no bachelor's row. One program names a "Bachelor's-level social worker" as a care manager (section 5). No therapy or enrollment route is shown. [1, p.4; 4, p.29; 11, p.1; 12, p.7; 15, p.3]

Enrolling. "All eligible providers are required to be enrolled with Blue Cross by Feb. 28, 2027." [4, p.9] For an LPC, LMFT, LMSW (clinical), or LLP the checklist asks for eight items, a CAQH number among them. [12, p.7] Finish CAQH within 14 days or the request closes. Review "can take us up to 90 days." See no members until the confirmation letter arrives. For BCN, enroll on your own, then join a group. [13, p.1]

The master's-level LLP and BCN Advantage. The 2024 grid gives the master's LLP no BCN Advantage or Medicare Advantage entry. The September FAQ says an LLP can enroll for BCN Advantage through a group. It gives no degree qualifier. [11, p.1; 10, pp.1, 2] The newer BCN chart settles the degree question. Its September 2026 table has its own row for the master's-level LLP and marks it "Yes" to treat BCN members directly in a solo or group practice and in a facility, with the HO modifier. The chart covers BCN commercial and BCN Advantage. [27, p.1] Current published answer: yes. A master's-level LLP may pursue BCN Advantage participation through the group enrollment and affiliation process. [10, pp.1, 2; 27, p. 1] The 2024 grid is the older paper, and it does not explain its degree line. [11, p.1] Do not treat participation as effective until the clinician and the group have written confirmation of the product, network, and effective date. File a truthful enrollment form that states your exact credential, or use a group's credentialing. One caution: Medicare's clinical psychologist category requires a doctoral degree and an independent-level license. [22, (d)] Do not present a master's LLP as meeting that category just because a BCN FAQ says "LLP."

Supervision. Two payer supervisor tables exist. One is the Blue Cross commercial office table above. [4, p.29] The other is the September FAQ's BCN column for accredited facilities (Path 1). [10, p.2] Therapy notes must carry the "Signature and credentials of the treating provider and supervisor, where applicable." [16, pp.2 to 4] Neither table says which supervision counts toward your license. "BCN does not provide guidance for clinical supervision." [8, p.33] Your profession's Michigan rule answers that. Ask your board at LARA (for counselors, the Board of Counseling).

3. What it means for your paycheck and your job

In the September window, "submitting provider" means the supervisor whose NPI is on the claim. An incident-to claim is "reimbursed at the supervising provider's rate." [2, pp.2, 11, 12] The Phase I text names no cut. One sentence on the policy's first page says professional incident-to services are "reimbursed at 80% of the applicable Physician Fee Schedule." The Phase I section does not repeat it. [1, pp.1, 2] Your first September payment notice, the remittance, will show how that one claim was paid. It does not set a rate for every code, contract, or claim system. Forecast nothing until then.

BCBSM's policy does not set your wage or promise a job or supervision. Ask your employer in writing which patients use the affected products. Ask what happens to your role and supervision after February. Ask how each patient continues care.

4. Three paths to examine

Path 1: Work through a qualifying facility

What it requires. The August FAQ describes facility-based continuation after February 2027 for students and the limited-license group. The policy excludes facility services, an OPC included, by a student, trainee, or provider with provisional license. Those providers "need to associate with a facility by Feb. 28." "Facilities are required to be accredited and supervision is standard practice." [2, pp.3, 5, 7] The June 16 alert names the settings: an OPC, a hospital, or a community mental health facility. [3, p.1]

Supervision in a BCN facility. The September FAQ's BCN commercial and BCN Advantage column lets the other limited-licensed providers bill under supervision "in an accredited facility and:" [10, p.2]

LICENSE	SUPERVISOR STATED IN THAT BCN COLUMN
LLMSW	LMSW
LLPC	LPC or LP
LLMFT	LP
TLLP	LP

These are payer statements for that column only. Do not copy them into the Blue Cross commercial table in section 2. They must also be squared with Michigan licensing rules. Those rules are outside this guide's sources. Look hardest at the LLMFT row. Its payer supervisor here is an LP. Its commercial office supervisor is an LMFT. [4, p.29; 10, p.2] Ask your board which counts.

The two "Requirements for providing behavioral health services" charts, one for BCN and one for Blue Cross commercial, are now public and on file. The BCN chart (updated September 2026) matches the table above. In a solo or group practice it marks the LLPC, LLMSW, LLMFT, and TLLP "No" for treating BCN members directly and "No" under a supervising provider. Only the facility column says yes. [27, p.1] The Blue Cross commercial chart is older (updated January 2024). It still shows the office setup the 2027 policy ends. It marks the LLPC "No" for direct participation and "Yes" to bill under an MD or DO, a fully licensed psychologist, or an LPC, with the HO modifier, in an office or in an OPC. [28, p.1] Read it as the before picture, and the policy as the after.

OPC facts. BCBSM's OPC rules (March 2026) cover all four products. A nonparticipating OPC's services "are not reimbursed to either the facility or the member." The staff "at all approved sites" must include a board-certified or board-eligible psychiatrist, an LMSW, and a fully licensed psychologist. A master's or PhD LLP can fill that seat with a "supervisory or consulting licensed psychologist, or LP contractual relationship." Staff "may also include" LLPs, LPCs, LMFTs, and psychiatric nurse practitioners. Each site needs "Full accreditation, either three or four years, for each facility site, by address." Each needs 24-hour emergency coverage and a psychiatrist with "regularly scheduled hours." [14, pp.1, 2] Participation starts on the approval date. "It isn't retroactive," and no claims may be sent before it. Each location needs its own form and NPI. Agreement terms "aren't negotiable." Approval time is not stated. [14, pp.3, 4] A June 2026 BCBSM comparison paper adds three points. Incident-to billing is "Not permitted" in a professional group practice and "Permitted for specific provider types if requirements are met" in an OPC. An OPC does not credential each clinician, but "a roster is required." It lists an OPC's networks as Blue Cross PPO and BCN HMO only, while the March 2026 rules paper covers all four products. Ask which applies to Medicare Plus Blue and BCN Advantage. [26, pp.2 to 4]

Partner first. Adding a psychiatrist to an ordinary practice does not make it a facility. The fastest route is a partnership with a facility that already participates. It must be approved by BCBSM and accredited. Ask for its contract papers, approved staffing, and supervision procedures. Ask how its claims identify each clinician. The OPC rules and the manual's OPC lists name no LLPC, LLMSW, LLMFT, or TLLP. So ask which paper puts your license on the roster. [14, pp.1, 2, 4; 4, pp.4, 11, 12, 30, 31] One narrow question is left per placement. How does this facility lawfully employ, supervise, and report this clinician's work? The immediate answer must come from the facility's contract and billing protocol; BCBSM should still publish a general crosswalk.

Path 2: Complete the next license step and payer enrollment

What it requires. Reaching an eligible license and finishing payer enrollment are two steps. LLPs and LMFTs have the enrollment route in section 2. [1, p.2; 4, p.9; 12, p.7] Ask your supervisor to list the hours, supervision, exam, and form items still open. Read your profession's current rule, or ask your board at LARA.

Who decides, and how long. The licensing board decides your license. The payer decides enrollment. BCBSM gives eligible providers until February 28, 2027. Review can take up to 90 days, more for BCN. Neither is promised to finish in time. [4, p. 9; 2, p.5; 13, p.1]

Path 3: Take a care manager role

What the papers establish. The August FAQ preserves behavioral health integration (BHI) billing. BHI, "including the Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH)," is billed under the supervising physician's NPI through five codes. Its exclusion "applies to both provider types that are eligible for direct participation with Blue Cross and BCN" and to those that are not. [2, p.10] The Medical-Surgical chapter says CoCM codes (99492, 99493, 99494, G2214, G0512) are "billed by the treating medical provider." That can be primary care or a specialty. That provider "pays the consulting psychiatrist and behavioral healthcare manager as part of a separate agreement between them." Neither bills Blue Cross or BCN. Payment "is usually made with no member cost share." A new patient needs a first visit with the treating provider. Consent "can be obtained orally but must be documented in the medical record." BCN states the same rules. [5, pp. 9 to 12; 8, pp.25 to 28] It is enough to begin program design and due diligence, not to assign every license or submit claims without program confirmation. It does not settle each license's duties on its own.

Supporting correspondence. A written reply from the Blue Cross PGIP team dated August 4, 2026, agrees: "Restrictions on limited license providers don't apply to behavioral health integration for codes 99492, 99493, 99494, G2214 and 99484 as these must be billed by the treating provider MD, DO, NP or PA. A limited license provider can still serve as behavioral health care manager." This is one team member's email. It supports the papers above. It names no license or training. [18]

Medicare is its own authority. Medicare pays doctors and some other practitioners a monthly amount for BHI. Its booklet says the care manager "May or may not be a practitioner who meets all the requirements to independently deliver and report services to Medicare." So an inability to bill on your own is no bar to that role by itself. [23, pp.5, 11, 12]

Check each license, one sheet at a time. Before taking a role, run four checks. The actual tasks and the behavioral health training they need. Michigan scope and licensing supervision. The program's rules and the practice's setup. Whether the work counts toward license hours, checked on its own with your board. CIN's role sheets do this for each license.

General BHI. General BHI (99484, G0511) is described two ways in one chapter. Pages 10 and 11 say it is billed by the treating medical provider "or by the behavioral health provider who bills with modifier AM, HA, HE or TD." Page 12 says "The treating medical provider must bill behavioral health integration services." The care manager and consultant do not. The modifier chapter gives none of those four a behavioral health meaning. [5, pp.10 to 12; 6, pp.4, 14, 42] The PGIP reply says 99484 "must be billed by the treating provider." [18] Build the treating-medical-provider setup, which the chapter and the FAQ state again and again. Hold any independent billing option until its authority is clear. Do not build a modifier recipe from conflicting pages. CoCM and 99484 are never billed in the same month. [19, CoCM FAQs p.1]

5. The policy's own exclusions: care management and team-based care

The policy lists eight exclusions. One, as printed, is "Provider Delivery Care Management (PDCM) /Team Based Care." Another is facility services by a trainee or student, OPCs included (Path 1). [1, pp.4, 5] These programs keep "their current billing methodology." The policy's own list does not name BHI; the FAQ adds it. [2, pp.3, 10]

PDCM: a serious candidate. PDCM "is billed under the supervising physician's NPI for services delivered by the appropriate care team members through 12 specific procedure codes." [2, p.10] Only PDCM-designated practices bill these codes. The manual lists "counselors" and "social workers" on PDCM teams with no license level. [7, p.23] MICMT trains PDCM teams for BCBSM. It is not the payer. Its public FAQ says "BCBSM distinguishes between licensed and non-licensed individuals." A licensed care-team member furnishes the service; the claim goes under the physician's NPI under the program rules. A limited license is a Michigan license. The open PDCM question is not whether the clinician is licensed; it is whether BCBSM's PDCM program accepts that exact license for each role and code. A licensed team member within scope "can bill all the PDCM codes" (examples: LPN, LBSW). A non-licensed member with a scope of service paper may bill only two sets of codes. Those are the phone codes (98966 to 98968) and care coordination (99487, 99489). Training, Introduction to Team-Based Care, "must be completed within 6 months of submitting codes." Claims go under the rendering physician's NPI. Visits may be in person, by secure video, or by phone. [19, PDCM FAQs pp.1 to 3] The G-codes and group education need a licensed member. G9007 needs a physician or APP. G9008 needs a physician. No MICMT page names a counselor, a social work license, a psychologist, or a limited license. [19, per-code pages p.1]

One paper would settle this: "BCBSM PDCM Commercial and MA Billing Guidelines (Updated April 2026)." MICMT's reference page lists it behind a login. [19, Reference Materials p.1] A PDCM physician organization (PO) or an MICMT account holder can obtain it. Have the PO map each credential to the program's rules. Do not assume a limited license settles the PDCM category on its own. Never call a licensed clinician unlicensed to fit a category.

Adult and child intensive services. One BCBSM rules paper (four products) lists the "Behavioral health care manager (limited-license Master's-level social worker, qualified behavioral health professional or Bachelor's-level social worker)." That person works "under the direction of the team lead," a "licensed Master's-level clinician." The ordering psychiatrist bills, with 99487 and 99489. The role names social work only. "Qualified behavioral health professional" is undefined. BCBSM expects an OPC or health system to run it, "less likely ... a group practice or a single provider." [15, pp.1 to 3] A counselor or family therapist should ask the program, in writing, whether it accepts their license.

Therapy billed under a doctor's NPI is incident-to, whatever the program's name.

6. Ways to keep working after March 1

The current manual describes an OPC claim this way. It goes on a CMS-1500 under the OPC's own identity. The rendering field is left blank. A level-of-care modifier is used. [4, pp.12, 31; 14, p.4] Confirm that this is still the process after March 1, 2027, for the member's product and your exact license. Each shape below starts with one question for the facility. Will BCBSM treat my service as the facility's, and how will the claim identify me? Its contract papers answer it.

Embedded in a hospital-owned or FQHC primary care program, or staffing a health system's clinic under a services agreement. "If the FQHC is considered a facility, the incident-to policy change won't apply." [2, p.13] Not written: whether a contractor's work counts as the facility's service. The facility answers that. How the agreement pays you raises anti-kickback and self-referral questions. A health care lawyer must read it first.

Part-time facility employment alongside your private practice. The policy applies "regardless of whether they are independent providers or employed by an organization." So each service is judged where it is rendered. [1, p.2] Not written: whether the facility supervisor counts toward your license hours. Also not written: whether the job limits outside practice. The facility's policy, your board, and a lawyer answer those.

A clinically integrated network. No BCBSM text mentions one. A network does not make a practice a facility. Ask the network in writing what it offers.

7. For supervisors and practice owners: before March 1, 2027

Assign an owner and a date.

- List each clinician's exact license and enrollment status by product (grid). Check license records for those near full license.
- Review September claims for SA plus HO or AJ. File the first payment notice beside the FAQ page and the policy grid.
- Start direct enrollment for every eligible clinician, including LLPs. CAQH within 14 days; allow 90 days.
- Ask participating, approved facilities about openings and for their contract papers. If seeking OPC status, be ready for an on-site visit.
- Open talks with medical practices that run, or want to run, CoCM or general BHI. For PDCM, ask a PO for the April 2026 guidelines and book MICMT's training.
- Give each clinician a written job and supervision plan. Give each patient a continuity plan with a named contact. Set a decision date and a fallback.

Three structural options, each needing counsel

Supervision offered as a service. A fully licensed clinician may be able to provide the required supervision for limited-license staff at a facility, subject to the facility's rules and Michigan licensing rules. This helps where the facility lacks the right supervisor class. Two payer tables govern (sections 2 and 4). Your board at LARA decides what counts toward your license. Whether a facility may use an outside supervisor of record is its own policy call. BCBSM does not pay for supervision meetings. [4, p.14]

Moving a training program into a nonprofit. A nonprofit that bills BCBSM commercial is bound by the same policy. [1, p. 2] Setup and funding need a lawyer and an accountant.

Employing a psychiatrist in a counselor-owned practice. Who may own, employ, or contract with whom across professions is Michigan law. Ask a lawyer. On the payer side, the exclusion turns on the rendering clinician's license and the setting. Changing the supervisor's specialty does not turn an office into a facility or lift the rendering-clinician restriction. A psychiatrist in your office does not make it a facility. It does not restore office payment after March 1, 2027. [1, p.4; 4, p.9; 3, p. 2] A psychiatrist as a remote consultant to a medical practice's care team is a different thing (Path 3).

8. Timeline: from now to March 1, 2027

- **Now: count your BCBSM limited-license caseload** by product, and **file the policy pages.** Two are still not public. They are the PDCM billing guidelines (April 2026) and the Medicare Advantage provider-type requirements. (The Medicare Plus Blue practitioner attachment, 2016, is public but does not list provider types.)

- **September 1, 2026 through February 28, 2027: the enrollment window.** Start direct enrollment for every LLP and LMFT now. Read the first payment notice.

- **A suggested internal deadline.** Aim to submit enrollment by November 30, 2026, so a review of up to 90 days can finish before February 28, 2027. [13, p.1]

- **This fall: talk to medical practices and participating, approved facilities.** Ask for written answers and a date. An OPC form takes effect only on approval.

- **Tell clients early.** BCBSM tells members to transition care "by March 1, 2027." Tell each affected patient their options in writing first. [20]

- **February 28, 2027.** BCBSM's date to join a facility and to enroll. The last Phase I date of service. **March 1, 2027.** Office-based incident-to payment ends for the named group. Eligible providers must bill directly.

9. Claims you will see online: what the sources support, do not support, or leave open

> Three Medicare claims, answered from the CMS texts. Medicare's rules and BCBSM's are not the same.
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> **"CMS bans incident-to for LPCs and MFTs."** Not supported as a blanket statement. The CMS booklet speaks to marriage and family therapists and mental health counselors. Its March 2026 edition says Medicare "may cover ancillary MHC services when you provide them as auxiliary personnel incident to the personal professional services of a physician, CP, CNS, NP, PA, or CNM." The same line appears for MFTs. State scope law is one limit; every Medicare incident-to requirement also applies. [24, pp.22, 24; 21, (a)(1), (b)(7)]
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> **"The physician must be on site."** Out of date for behavioral health. The booklet exempts "behavioral health services provided by auxiliary personnel from the direct supervision requirement." They "can be provided under the general supervision of a physician or an NPP." CMS does not define them by code. So a service for a physical illness may not fit. Ask your Medicare contractor in writing. [24, p.26; 21, (a)(2), (b)(5)]
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> **"Health behavior codes can be billed under the physician at 100 percent."** Unproven. The booklet's code table marks the health behavior codes "CPs, CSWs, MFTs, and MHCs can bill these codes." No CMS text here lets a doctor bill them for a counselor's work. One Medicare contractor article says a physician, clinical nurse specialist, or nurse practitioner who performs these services reports evaluation and management codes instead. [24, p.35; 25]
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> **On BCBSM.** The policy exempts no code family by its place in the CPT book. The Medical-Surgical chapter covers the assessment codes (96156 to 96171). That is when the main diagnosis is physical. It has "an appropriately credentialed behavioral health provider" report them. It does not mention incident-to. Routine outpatient therapy needs no prior approval. [1, pp.4, 5; 5, pp.3, 8, 13; 8, p.25; 17, p.2] Benefit routing of those codes is a plan question.

Eight implementation questions remain, including several inconsistencies across published documents

As of September 10, 2026. Each question limits one setup. None stops the guide or the work the papers already support.

1. **The September window.** The policy grid's "All Dates" row conflicts with the FAQ, the alert, and the manual. The Phase I rate is not defined. This limits office incident-to claims for the four limited licenses through February 28, 2027. It also limits how you forecast them. It does not touch facility work, care management, or direct enrollment. A corrected grid or a written BCBSM clarification would close the conflict. Paid claims are strong evidence for your own practice and may narrow the question; they do not settle the policy.

2. **Direct billing after March 1, 2027.** Whether an eligible provider who keeps billing incident-to pays 80 percent or denies. This limits any clinician who could enroll on their own but is not yet enrolled, or in a group, by March 1, 2027. Enrolling in time removes it.

3. **Who counts in each category.** The doctoral temporary license, the LLBSW, the reach of "limited license provider" in the PGIP reply, and "qualified behavioral health professional." Each limits one clinician's fit for one role, checked on that clinician's role sheet. None limits the care-management model itself.

4. **A specific facility's setup.** How a given facility employs, supervises, and reports a limited-license clinician. How long OPC approval takes. How the BCN supervision pairs fit Michigan licensing, above all for the LLMFT. This limits each placement, one at a time. The facility route itself stands.

5. **General BHI billed by a behavioral health provider.** The chapter's two descriptions and the four undefined modifiers. One clue: in the September 2026 BCN chart, AM and HA are the psychiatrist's modifiers (adult and child), TD is the nurse practitioner's and clinical nurse specialist's, and HE is the physician assistant's. [27, p.1] So the chapter's line may describe medical providers, not counselors. That is a reading, not a rule. This limits only the independent billing option, which is on hold. The treating-medical-provider setup proceeds.

6. **PDCM credential and code fit.** Which PDCM roles and codes accept each exact limited license. What training and supervision apply. What the April 2026 guidelines require. This limits which PDCM services a credential may furnish until the PO maps it. It does not stop a clinician from exploring a PDCM team role.

7. **The master's-level LLP's enrollment, and the Medicare Plus Blue supervision exception.** The master's-level LLP's BCN Advantage status is answered by the September 2026 FAQ and BCN chart together (section 2); what remains is a replacement for the 2024 grid and each clinician's own enrollment letter. What "personally supervises" means under MPB stays open. It limits MPB claims under the p.115 exception until the agreement is read.

8. **Telehealth and remote facility work.** Say you work for an OPC but see the patient from home or another off-site place. Is that service given in the facility? Which place counts, yours or the facility's? Must your address be named in the facility approval? Which place-of-service code goes on the claim? How does the roster record the site? Who supervises you at a distance, and who covers an emergency? Does the answer change by product? None of that is written. [14, pp.1 to 4; 2, pp.3, 5; 26, pp.2 to 4] Ask the facility and BCBSM in writing before you plan remote work. Facility employment by itself does not establish that a remotely rendered service qualifies as facility-based.

Two Medicare questions in section 9 wait on the Medicare contractor. License supervision is for your board at LARA. Contracts and ownership are for a lawyer.

Words and short forms

- **NPI.** The number that identifies a provider on a claim.

- **CAQH.** The online provider profile named in the enrollment checklist.
- **PGIP.** The Blue Cross provider program team quoted in source 18.
- **PDCM.** Provider-Delivered Care Management, the BCBSM program in section 5. The reimbursement policy prints it as "Provider Delivery Care Management."
- **BHI.** Behavioral health integration.
- **CoCM.** The Collaborative Care Model, one form of BHI.
- **PCBH.** Primary Care Behavioral Health, another form of BHI.
- **APP.** Advanced practice provider, such as a nurse practitioner or physician assistant.
- **SA.** The modifier BCBSM requires on incident-to claims in the transition window.
- **AJ, HO.** Modifiers that show the license level of the person who gave the care. AJ is a clinical social worker. HO is a master's level clinician.
- **OPC.** Outpatient psychiatric care facility.
- **FQHC.** Federally qualified health center.
- **PO.** Physician organization.
- **VBR.** Value-based reimbursement.
- **LP.** Licensed psychologist, the full psychology license.
- **LLP.** Limited licensed psychologist.
- **CMS-1500.** The claim form named in the manual for professional claims.
- **Remittance.** The payment notice that shows how a claim was paid.

Companion tools in preparation. A denial workflow. A patient script. A facility form. A form for reporting issues.

Where this guide gets its facts

Numbers in brackets point to these sources, with pages. Quotes are copied as printed. Sources 1 to 17, 20, and 26 to 28 are BCBSM's own. Source 18 is an email. Source 19 is BCBSM's training partner. Sources 21 to 25 are federal texts. Where a BCBSM paper differs from this guide, that paper controls.

1. BCBSM and BCN Reimbursement Policy, "Incident-to Services and Billing - Professional." Effective September 1, 2026 and March 1, 2027.

2. BCBSM and BCN, "Incident-to services and billing - professional: Frequently asked questions for providers." Revised August 17, 2026.

3. BCBSM provider alert, June 16, 2026, clarification for students and limited licensed clinicians.

4. Blue Cross Commercial Provider Manual 2026, Psychiatric Care Services chapter, revised September 2026. Pp.4, 9 to 14, 29 to 31.

5. Same manual, Medical-Surgical Services chapter, revised September 2026. Pp.3, 8 to 13.

6. Same manual, Valid Modifiers chapter, revised January 2026. Pp.4, 14, 42.

7. Same manual, Quality of Care chapter, revised January 2026. P.23.

8. BCN Provider Manual 2026, Behavioral Health chapter, revised August 2026. Pp.25 to 28, 33.

9. Medicare Plus Blue PPO Provider Manual, July through September 2026 edition. P.115.

10. BCBSM, "Frequently asked questions: LLPs and LMFTs." Revised September 2026.

11. BCBSM, Behavioral health provider eligibility and contract type grid. Updated July 2024.

12. BCBSM, Provider Enrollment and Change Process Required Document Checklist. May 2023. P.7.

13. BCBSM, New behavioral health providers only: Enrollment documents helpful hints. August 2023.

14. BCBSM, Clinical program requirements for behavioral health outpatient psychiatric care facilities. March 2026. Pp.1 to 4.

15. BCBSM, Clinical program requirements for behavioral health adult intensive and child intensive services, revised November 2025. Pp.1 to 3.

16. BCBSM, Behavioral health medical record documentation requirements and privacy regulations, non-ABA. September 2025. Pp.2 to 4.

17. BCBSM, Summary of utilization management programs. May 2026. P.2.

18. Email reply from Kathleen Kobernik, Blue Cross PGIP team, August 4, 2026, answering Elizabeth Teklinski's July 30, 2026 request sent through MICMT. Correspondence, not policy.

19. MICMT (Michigan Institute for Care Management and Transformation, micmt.org): PDCM FAQs; the per-code PDCM pages; CoCM Billing FAQs; Reference Materials.

20. MI Blue Daily (BCBSM), May 31, 2026.

21. 42 CFR 410.26, eCFR; paragraphs (a)(1), (a)(2), (b)(5), (b)(7).

22. 42 CFR 410.71, eCFR; paragraph (d).

23. CMS, MLN909432, "Behavioral Health Integration Services." January 2026. Pp.4, 5, 11, 12.

24. CMS, MLN1986542, "Medicare & Mental Health Coverage." March 2026 edition. Pp.22, 24, 25, 26, 35.

25. Wellpoint Federal (a Medicare Administrative Contractor), Medicare Coverage Database Article A52434, "Health and Behavior Assessment/Intervention - Medical Policy Article." Revision effective April 1, 2026. Coding guidance section. Retrieved September 8, 2026 from cms.gov/medicare-coverage-database.

26. BCBSM, "Professional group practice, outpatient psychiatric care facility: Provider type comparison." June 2026. Pp.2 to 4. Public at bcbsm.com.

27. BCBSM, "Requirements for providing behavioral health services to BCN members." Effective January 1, 2015, updated September 2026. P.1. Public at authorizations.bcbsm.com.

28. BCBSM, "Requirements for providing behavioral health services to Blue Cross commercial members." Published January 10, 2019, updated January 2024. P.1. Public at authorizations.bcbsm.com.