BlueCross BlueShield of Vermont
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Origination: July 2017
Last Review: January 01, 2018
Next Review: July 01, 2026
Effective Date: July 01, 2025

Description

Per Vermont law (18 V.S.A. § 8907), the commissioners of the Vermont Department of Mental Health and the Vermont Department of Disabilities, Aging, and Independent Living designate public or private nonprofit agencies to provide or arrange for the provision of services to persons with a mental health condition or psychiatric disability and persons with a developmental disability. Blue Cross and Blue Shield of Vermont (Blue Cross VT) recognizes that these designated agencies (or "DAs") provide some services using non-licensed individuals who do not satisfy our general credentialing requirements.

Policy & Guidelines

Blue Cross VT supports DAs in their mission to provide mental health and substance abuse services. We allow supervised billing for those Qualified Mental Health Providers that screen patients for involuntary psychiatric inpatient or outpatient admission.

Eligible

Services provided by specially trained Qualified Mental Health Providers (QHMP), employed by DAs, who screen emergency department patients for involuntary psychiatric admission. A QMHP must be certified by the State of Vermont and comply with scope of practice limitations.

Not Eligible

- A non-licensed, non-certified mental health practitioner fulfilling his/her training requirements for licensure.
- A practitioner who is not licensed, credentialed and enrolled in the Blue Cross VT network or working under the supervision of a licensed Blue Cross VT network provider.

- A non-licensed mental health/substance abuse practitioner who cannot practice independently and is not completing supervised practice hours for licensure.

- Providers employed by DAs that are licensed.

- Facility-based services provided by a DA are not within the scope of this policy.

- Services provided under the supervision of a non-licensed, non-certified mental health clinician.

Provider Billing Guidelines and Documentation

A QMHP may submit claims for their services if the following criteria are met:

- Has a clinical supervisor
    - Licensed Mental Health Master's level or higher clinician enrolled and participating in the Blue Cross VT network.
- Services provided by the QHMP must be billed under the supervising clinician's National Provider Identifier (NPI) using a modifier -HH.
- Only codes 90839 and 90840 are eligible for consideration
- Supervising practitioner must cosign all clinical notes made by the QMHP

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services

must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Medicare Primary Policies: Blue Cross VT Payment policies do not apply to any policies where Medicare is primary.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

18 V.S.A. § 8907

Related Policies

CPP_37 Supervised Practice of Mental Health and Substance Use Trainees

Facility Credentialing Policy

Practitioner Credentialing Policy

Document Precedence

Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on July 01, 2025 (Policy was changed from a Quality Improvement Policy to a Payment Policy).

Date of Change	Effective Date	Overview of Change
April 11, 2025	July 01, 2025	This policy is moving from a Quality Improvement Policy to a Payment Policy. Formatting changes and move to new template.

Approved by **Update Approved: 04/11/2025**

Tom Weigel, MD, Chief Medical Officer