



CENTER FOR
INTEGRATIVE NEUROSCIENCE

The Credentialing Cheat-Sheet

Payers, applications, credentialing, claims.

MICHIGAN PAYER EDITION • 2026

01 THE PAYER GRID 02 THE APPLICATION 03 CREDENTIALING 04 CLAIMS

PRIMARY SOURCES

Written from the primary sources and the Behavioral Health Workforce
Observatory's records. Public payer pages and CMS booklet
MLN909432, checked August 2026. Free, ungated, and yours either way.

What does payer enrollment require when a practice is setting up Collaborative Care?

Four payers do not implement integrated-care payment the same way, and the differences are not where people expect them to be. Most of the cost of finding that out is paid in staff hours nobody counted.

This Cheat-Sheet puts the public requirements side by side: which codes are recognized, who bills, what enrollment may be required, and where the practice has to verify its own arrangement. It shows what to check before a first claim goes out. It does not promise the claim will be clean.

WHO THIS IS FOR	YOU WILL LEAVE KNOWING
• A credentialer handling several payers at once. • A practice manager who inherited enrollment and no notes. • Billing staff seeing denials they cannot explain. • A practice adding integrated care to payers it already works with.	• What four Michigan payers publish, and where they differ. • Which two words in the grid carry the whole table. • That recognition, enrollment, and arrangement are three separate questions. • What to confirm before the first claim, and where to confirm it. • Why dating what you find matters as much as finding it.

HOW TO READ THIS DOCUMENT

Three kinds of line,
and the difference is
the whole method.

The key first, then what this particular document covers.

SOLID LINE

A cited public source
establishes this.

The source is named where the claim
is made, and dated. If you want to
check it, you can.

DASHED LINE

This describes what
happens today.

Current practice, or your own
situation. True as a description, and
not asserted as a rule.

DOTTED LINE, ENDING IN ?

The record does not tell us
this yet.

Nobody has measured it. A question
mark is printed rather than a
confident-sounding phrase standing
in for a number.

AND WHAT IT COVERS

THIS CHEAT-SHEET CAN ANSWER

What each payer’s public material says, and
which questions it leaves to you.

Public payer pages, CMS booklet MLN909432, and
Michigan Medicaid policy, each dated.

THIS CHEAT-SHEET CANNOT ANSWER

Whether your practice, with your contracts,
is enrolled correctly for this work.

No public document answers that for one practice. It is
verified with each payer, and dated when you do.

01 • THE PAYER GRID

Two words carry
the whole table.

Confirmed means a cited public source supports the answer. Verify
means the Center could not answer it for one practice from a
public document, and neither should you assume it.

FIGURE 01

Four payers, the same questions, side by side.

The last two rows matter most. This grid does not replace payer verification. It tells you where to go, and asks you to date what you find.

CHECK	MEDICARE	MI MEDICAID	BCBSM / BCN	PRIORITY HEALTH
INTEGRATION CODES RECOGNIZED	Yes, per MLN909432	Yes, per MSA 21-19	Yes, per payer pages	Verify with payer
WHO BILLS THE SERVICE	See code requirements	See code requirements	Verify role requirements	Verify with payer
ENROLLMENT TO CONFIRM	PECOS for the billing provider	CHAMPS enrollment	Practice and provider records	Practice and provider records
CARE-MANAGER ROLE	See code requirements	Verify with payer	Verify role requirements	Verify with payer
PROGRAM LAYER	Not applicable to this comparison	Not applicable to this comparison	PGIP, through the physician organization	Verify with payer
WHERE TO VERIFY	CMS booklet MLN909432	MSA 21-19 and the provider manual	Payer pages and your physician organization	Payer provider pages
LAST CHECKED	August 2026	August 2026	August 2026	August 2026

CENTER FOR INTEGRATIVE NEUROSCIENCE · PUBLIC PAYER PAGES, CMS MLN909432, AND MSA 21-19 · CHECKED AUGUST 2026 · [INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/CREDENTIALING](https://integrative-neuroscience.com/guides/credentialing)

Public sources only. Where a field says verify, the Center could not establish the answer from a public document. Where the public record stops, verification begins. Ask the payer directly, and record the answer with the date and the name of the person who gave it.

A MICHIGAN NOTE • BCBSM AND BCN

BCBSM and BCN recognize the Collaborative Care and general behavioral health integration codes. BCBSM separately supports Collaborative Care through its Physician Group Incentive Program, with practices working through their Physician Organization for participation and implementation guidance. BCBSM's publicly described Collaborative Care designation currently covers primary-care and OB/GYN practices.

Those are related facts, and not the same requirement. The designation is a program status a practice holds, not a credentialing step a credentialer files for, and it is separate again from code recognition. Seeing a payer name in a grid does not tell you what your own practice has to do.

02 • THE APPLICATION

Three different questions, and a yes to one answers neither other.

Credentialing problems become harder to untangle when these three questions are collapsed into one. They are asked of different people, answered by different documents, and fail in different ways.

01

Does the payer recognize the code?

That tells you whether the payment model exists with that payer at all. It tells you nothing about your practice.

02

Is the clinician or practice properly enrolled?

That determines whether the relevant people and the organization are recognized for the arrangement.

03

Does this arrangement meet the payer's requirements?

That depends on the actual roles, services, documentation, contracts, and payer rules. It is the question a grid cannot answer.

A yes to one does not automatically answer the other two.

What the application asks for, every time

Identifiers and licenses for each clinician, the practice's legal name and tax identification, service locations as the postal service writes them, ownership and control information, and a professional history that accounts for gaps. Applications are returned for mismatches between these records and the ones the payer already holds. How often that happens is not something the Center has measured, which is what the study at the end of this document is for.

03 • CREDENTIALING

Two clocks run at once, and only one of them is on your calendar.

A four-month enrollment does not mean four months of staff labor. Conflating the two is why practices cannot answer the simplest question about this work: what did it cost us?

STAFF TIME

The working hours your people spend: the application, the documents, the follow-up calls, the corrections, and the resubmissions.

ELAPSED TIME

The calendar between submitting and being able to bill. Mostly waiting, and mostly outside your control.

Track both, separately, from the first application. Nobody can reconstruct either one a year later.

Recredentialing is the part everyone forgets

Much of this work comes around again on the payer's clock rather than yours, and the person who did it the first time may not still be there. A single dated file per payer per clinician, holding the submission, the confirmations, every request and reply, the approval, and the effective date, is the difference between an afternoon and a fortnight.

Check these before the first one goes out.

A denial at this stage is rarely about the clinical work. It is about a date, an identifier, or an assumption about who may bill that nobody wrote down.

WORKSHEET

Before the first claim

Ten boxes, one payer at a time, all from what this document has already told you. Print it, or put it on the wall.

☐ The payer recognizes the code you are about to bill.

☐ The billing practitioner is the one the payer expects.

☐ Every relevant clinician is enrolled, and the record is active.

☐ The effective date is confirmed in writing, and you are billing after it.

☐ Identifiers match across the license, the enrollment, and the claim.

☐ Patient consent to the arrangement is recorded where the payer expects it.

☐ Documentation matches what the public guidance requires.

☐ Anything a payer told you by phone is written down and dated.

☐ A dated file exists per payer per clinician, ready for recredentialing.

☐ Both clocks are running: staff hours, and elapsed days.

If those boxes are checked, send the claim.

BEFORE THE FIRST CLAIM • CENTER FOR INTEGRATIVE NEUROSCIENCE • SOURCES CHECKED
AUGUST 2026

THE OPEN QUESTION

What does insurance participation actually cost a practice?

WHAT IS ESTABLISHED

Public data shows which clinicians are enrolled with which payers. The requirements above are published, and this Cheat-Sheet cites them.

WHAT IS NOT MEASURED

What the practice spent getting there: whose hours, how many, across how many weeks, and how much had to be done more than once.

Staff hours per enrollment, per payer	?
Elapsed days from submission to billable	?
Applications returned for correction	?
Recredentialing hours per year	?
Claim denial work after participation begins	?

You may know one of the numbers nobody has.

The enrollment record shows the outcome. It does not show the hours, the corrections, or the weeks of waiting behind it, and no public dataset holds them. The people who do this work can fill in the ledger.

Put your experience in the record.

About five minutes. What your practice spent becomes part of what the field can finally measure.

TELL THE OBSERVATORY WHAT HAPPENED →

integrative-neuroscience.com/research/credentialing

Findings return to respondents before broader publication.
Participation is optional. The Cheat-Sheet is yours whether you answer or not.

NEXT MOVE

You have the grid. What comes next depends on why you are here.

→ **I am enrolling clinicians now**

Work the claims checklist one payer at a time, and start both clocks today. Neither can be reconstructed later.

→ **We are starting with Medicare**

The Medicare Enrollment Cheat-Sheet covers PECOS, the three participation positions, specialty selection, and payment lookup.

→ **We are building the arrangement itself**

The CoCM Startup Brief covers the model, the team, the codes, and what a practice works out before it begins.

→ **I want help getting this done**

JOIN KEDGE EARLY ACCESS →

Knowing what to verify is not the same as tracking it across four payers and a dozen clinicians. Kedge is building guided enrollment for practices and clinicians, with step-by-step help based on your role, state, payer, and practice structure.

Kedge is a separate software platform, and it is not open yet. The Cheat-Sheet is free and complete whether or not you ever use it.

PRIMARY SOURCES

Everything above comes from these, and each carries a date.

Public sources only. No payer or agency correspondence appears in this document. Where a source is a landing page rather than a specific section, that is stated rather than hidden.

SOURCE	USED FOR	CHECKED
CMS booklet MLN909432	The Collaborative Care model requirements and the billing practitioner	August 2026
Michigan Medicaid policy MSA 21-19 and the provider manual	Michigan Medicaid recognition of the integration codes, and CHAMPS enrollment	August 2026
BCBSM and BCN published payer pages	Michigan commercial recognition of the Collaborative Care and integration codes	August 2026
BCN Provider Manual, behavioral health integration section	That BCN lists the Collaborative Care codes and identifies the treating medical provider as the billing practitioner	August 2026
Michigan Institute for Care Management and Transformation, Collaborative Care Model page micmt-cares.org/collaborative-care-model-cocm-1	That Physician Organizations implement Collaborative Care as part of BCBSM's Physician Group Incentive Program	August 2026
MICMT Collaborative Care Services payer table micmt-cares.org/collaborative-care-cocm	Collaborative Care coverage broken out by commercial payer, Medicare, Medicare Advantage, and Medicaid	August 2026
BCBSM Collaborative Care article, 30 September 2025	That BCBSM operates a Collaborative Care designation, and that the designated practices are primary-care and OB/GYN	August 2026
Priority Health provider pages	Where the practice verifies recognition and enrollment. The Center could not establish these answers from a public document	August 2026

Requirements differ by payer and change over time, which is part of why this work is expensive. Confirm what applies to your practice with each payer, your Physician Organization, and your compliance advisor before acting on anything here.

COLOPHON

*Independent educational research
and practice guidance, grounded in
primary sources.*

Educational information, not medical, legal, billing, or licensure advice.

Payer and regulatory requirements change; confirm what applies to your practice with the relevant payer, agency, and compliance advisor. Each publication carries the date its sources were last checked. Do not send protected health information.

AUTHORSHIP

Co-authored by the co-founders of the Center for Integrative Neuroscience, from the primary sources and the Behavioral Health Workforce Observatory's records.

CORRECTIONS

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integrative-neuroscience.com/sources

FOUR NAMES, FOUR JOBS

Center for Integrative Neuroscience · what the public rules say

Kedge · guided enrollment, in build. A separate company

Behavioral Health Workforce Observatory · what the record cannot show. The Center's research arm

Integral Neuroscience Initiative · evidence carried into public-interest work. A separate nonprofit

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