# MANAGED BEHAVIORAL HEALTH PROVIDER AND FACILITY MANUAL

September 2021

NEW DIRECTIONS®

# Contents

# Key Changes Index for Provider and Facilities Manual

## September 2021

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| 5 | 43 – 148 | 3 Calendar days to 72 hours |
| 7 | 57-75 | All CPGs Updated except for “Eating Disorders” |

# Section 1: Introduction

## Preface

New Directions Behavioral Health takes pride in the collaborative relationships developed with network providers and facilities. Our members and your patients/clients gain when we work together to improve accessibility to the highest quality of care possible at the most affordable cost. New Directions encourages providers and facilities to give us feedback about programs, policies and processes.

Please consider this provider and facility manual a general guide to programs, policies and processes. When updates to the Provider Manual are made, New Directions makes every effort to communicate these changes to providers and facilities through email, fax, our website, and our quarterly Provider Newsletter. The current version of the manual is available on our website at www.ndbh.com.

Providers and facilities are encouraged to contact the Network Operations (Provider Relations) department at ProviderRelations@ndbh.com with questions and issues not covered here or to clarify content included here. To notify of updates to your practice locations, demographics and new areas of clinical specialization, please go to the Profile update form available on our website at www.ndbh.com. To discuss other matters, providers may also call 1-888-611-6285.

## About New Directions

Since its formation as a limited liability company in 1995, New Directions Behavioral Health® (New Directions) has become a leading managed behavioral health care organization (MBHO), with national accreditations and recognition. In addition to MBHO services, New Directions provides Employee Assistance Programs (EAP) and health coaching.

New Directions takes a population health, member-centric approach that meets members where they are and matches the level of intervention to the members' needs. Our approach is inclusive of mental health, substance use, chronic health conditions and social determinants of health. Our multifaceted care management program includes utilization management for members in higher levels of care; care transitions for members who are being discharged from inpatient and residential levels of care; care management for members who are high risk/high cost; and specialty programs focusing on high-risk acute need populations.

All services are designed to assure that members get the right care at the right time with the right provider and that they are connected with needed community supports. We partner with members, family members/support systems, providers and our customers in everything we do, taking into consideration the member's culture, geography, health status and other psychosocial factors. Our experience indicates

that this focus on quality results in lower health care costs and increased member safety, member satisfaction and provider satisfaction.

New Directions has built a national reputation for innovative services focused on patient safety. In addition to recognition and awards from URAC and NCQA (National Committee on Quality Assurance), New Directions has received honors for its Paradigm for the Telephonic Assessment of Suicide Program from URAC in the category, *Best Practices in Health Care Consumer Empowerment Protection.*

New Directions has URAC accreditation for Health Utilization Management and for Care Management, and full accreditation from NCQA as a MBHO. Our clinical operations follow the standards set by these nationally recognized organizations, as well as state and federal laws.

Providers and members give New Directions high marks. **The most recent surveys reflect satisfaction rates above 90%.** Our reputation for quality and service is grounded in a philosophy of collaboration with the behavioral and medical providers caring for our members.

## Expectations of Providers

We appreciate your hard work and dedication to empower members to live life to the fullest. Our goal in working with our provider community is to continuously improve the care delivery system within each of our networks from region to region. We strongly believe that we can only do so through continuing to strengthen our collaborative working relationships with providers who use evidence-based practices with fidelity to the model, and whose clinical outcomes for members support their recovery of health and life roles. The success of these efforts will be demonstrated by our ability, working with our network to achieve the Triple Aim of improved health, reduced cost and a better member experience.

This manual is a valuable resource that describes our commitment, expectations and services to support your success in delivering care to members. Please refer to our delivery of care expectations below and our supportive resources described in the Clinical Program section.

Delivery of Care Expectations and Supportive Resources

1. <u>Delivery of care in the least restrictive setting</u>

   Providing the least restrictive setting is especially important when members are being evaluated for higher levels of treatment. The level of intensity of services will need to match the member's clinical needs. We prefer that members be treated as close to their homes as possible to help ensure community-based resources are in place to support better outcomes over a longer period.

2. Setting clear and measurable goals

   We believe more treatment does not necessarily mean better treatment. It is the provider's responsibility to establish key treatment milestones with clear and measurable goals to understand progress and objectively determine when a member has successfully completed treatment. Treatment must answer the questions, "Why is this level of care needed now?" "What measurable outcomes will be used to define success?"

3. Improved member engagement

   Make use of New Directions Care Management team (see Section 6) to help members safely discharge to the community and have a comprehensive community-based treatment plan. We expect Providers will obtain a Release of Information (ROI) from the member before discharge as it enables New Directions to coordinate care and facilitate access to other types of clinical resources, including support groups, self-management resources, and assistance in addressing barriers to care. The ROI is important because it allows these resources to work directly with the patient, as well as family members.

4. Discharge planning

   Discharge planning is a critical component of quality member care that begins on the day of admission. Quality discharge planning includes coordination and linkage to any applicable behavioral health, medical, legal, and social determinant follow-up resources. New Directions expects comprehensive discharge planning that integrates elements of IDEAL Discharge Planning as published by the Agency for Healthcare Research and Quality. Guidelines summarizing best practice of IDEAL Discharge Planning should be reviewed at www.ahrq.gov. In a value-based system of care, improved health outcomes, such as reduced readmissions, will be critical to warrant increases in reimbursement. A facility's success will be measured by the patient's progress after discharge and other key indicators. Discharge planning is key to that progress. All facility-based care providers are required to submit quality discharge plans to New Directions for **all** levels of care within **forty-eight hours of** discharge or change in service level. Quality Discharge plans **must include** documentation of:

   - A scheduled discharge appointment within seven days of discharge. For mental health admissions, follow-up appointments should meet the defined criteria for HEDIS.
   - Member understanding of discharge plans, including knowledge of discharge appointments and aftercare goals
   - Member involvement in discharge decision making
   - A current crisis/safety/relapse prevention plan

5. A signed Authorized Designee / Authorization of Representation Form

   New Directions shall monitor and inform facility of de-identified scorecard information to evaluate their performance of quality discharge metrics. New Directions shall provide the performance data and analysis to provider and allow opportunity to discuss findings. Provider is expected to

review scorecard metrics and work cooperatively with New Directions to improve quality discharge performance. For more information on the specific form items, please visit Clinical Discharge Form Flyer and Clinical Discharge Review Form.

6. Scheduling 7-day follow-up appointment after mental health inpatient discharge
   After an inpatient discharge, members should follow up with a licensed clinician within seven days. When coordinating 7-day follow-up appointments, providers must verify the patient's availability for the appointment. New Directions can assist in identifying providers who can offer appointments within 7 days. To request assistance in identifying a provider who can see a member with 7 days, contact New Directions at the phone number on the insurance card.
7. Community-based resources
   Utilize community-based resources to address social determinants of health while providing longer-term stability and independence. New Directions can assist you with our sophisticated resource database to identify resources such as food pantries, domestic abuse shelters, energy assistance, job training and support groups, among many others.
8. Integration with physical health
   Coordinating care with the patient's primary care physician (PCPs) will create a holistic care plan to address comorbidity and offer the opportunity for the PCP to communicate and receive valuable information about the member's physical and behavioral.
9. Provider performance
   New Directions is committed to promoting a high-quality network of providers available to members. Consistent with the triple aim of healthcare, provider performance will be monitored and will include improved member health, reduced cost and a better member experience, measured by a variety of metrics that may include readmissions, timely access to treatment, etc.
   We recognize and may reward providers who consistently demonstrate excellent quality and outcomes as part of our ongoing commitment to outstanding care for members through partnership with our provider network.
10. Clinical record documentation
    Documentation must be clear and support the claims billed and/or services that meet medical necessity criteria for ongoing treatment.
    The medical record must include documentation of the active participation of the member in treatment and progress toward goals achieved.
11. Measure outcomes
    New Directions conducts provider profiling using claims-based analysis that enables us to understand network quality and cost performance at the individual provider and facility level. This allows us to guide members to top performing providers who meet member needs in terms of service, cultural attributes and accessibility factors.

12. Member Experience
    a. New Directions partners with providers to ensure members get the care they need at the right time with the right provider. We understand that members seeking services are often at their most vulnerable. Caring for them with dignity, respect and a spirit of collaboration contributes to a positive outcome.

New Directions expects providers to:

- Provide considerate, courteous care, treat members with respect, and recognize personal privacy, dignity and confidentiality.
- Have a candid discussion of medically necessary and appropriate treatment options or services for each member's condition regardless of cost or benefit.
- Deliver information in clear and understandable terms
- Engage members in treatment planning and treatment decisions and verify members understand treatment plan.
- Discuss medical records with members and keep health records confidential except when disclosure is required or permitted by law.
- Communicate effectively by returning messages within 24 hours and setting clear expectations with members regarding availability for appointments.
- Respond to questions concerning treatment sufficiently to address member's issues.
- Explain cost of treatment fully when members inquire. Provide New Directions with accurate information regarding demographics, discipline, specialty, and office hours to ensure members have accurate information.
- Assist members needing services and care that cannot be accommodated by clearly redirecting back to New Directions for assistance.

Together is the way forward. By collaborating, we can achieve more on the patient's behalf. When you need additional support, New Directions offers innovative resources to help support your success such as on-site care management, on-site care transitions, an enhanced network of outpatient providers who can see members within 7 days of discharge, in-home behavioral health services, coordination of medication delivery on the day of discharge, and coordination of medication compliance follow-up, among other services (services are not available in all locales). Email New Directions Provider Relations at ProviderRelations@ndbh.com to learn about the resources available in your area.

## Provider Communications

New Directions updates the manual annually and as needed. The updated version is available online at www.ndbh.com. Throughout the year, we convey policy changes and other pertinent information to Providers and Facilities through various channels:

- Newsletters
- Broadcast emails

- Office manager meetings
- Website at www.ndbh.com
- Educational workshops and symposiums

Please ensure your email address, office location and practice information is up-to-date by reviewing your provider directory information at Provider Update Form. Remember, as a participating provider in the New Directions network, **you are required to notify us within 72 hours if you have a change of address, phone number, fax number, or email.** New Directions will ask you to verify the accuracy of your provider directory information on a quarterly basis. You are required to attest to its accuracy, or update your profile to make it accurate.

## Contacting New Directions

To contact the New Directions Service Center for utilization management, care management, care consultation, or administrative questions regarding eligibility, benefits or claims, please refer to health and group plan-specific information in the appendix at the end of this manual.

## Website

New Directions provides detailed and easy-to-use information about many programs and services at www.ndbh.com. Updates occur frequently to provide current information about behavioral health care and services. The website includes the following:

- Most recent version of the manual
- Documentation forms
- New Directions Medical Necessity Criteria for authorization of payment determinations
- Medical Policy for TMS
- New Directions Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy
- Clinical Practice Guidelines
- Provider WebPass (username and password are needed)
- Eligibility information for many New Directions' contracts
- Benefit information for many New Directions' contracts
- Notice of Privacy Practices for New Directions
- Member rights and responsibilities
- Information about our Quality and Care Management programs
- An Autism Resource Center for parents/caregivers of a child with an autism spectrum disorder
- A Substance Use Disorder Center to assist members and families struggling with alcohol misuse or dependency

The website also includes a provider search feature, allowing our members to locate Providers by name, location and specialization. Members can also filter their searches by gender, language, age group, ethnic origin, credential/discipline and whether providers are accepting new patients.

The Health Plan Member section includes a description of our Quality Improvement activities, results of Member Satisfaction Surveys, reports of access and appointment availability, and results and information about our Care Management Programs. These materials are also available in print upon request.

## NCQA Network Reports

**Please be aware that you or your patients may be selected to complete an NCQA survey about their New Directions experience.**

Geographical availability and access to appointments are measured at least annually, and the results shared with providers.

Member and Provider Satisfaction Surveys are conducted annually, and the results shared with providers.

# Section 2: Network Operations

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## Policies and Procedures

Pursuant to the terms of the Provider/Facility Agreement, providers and facilities must comply with New Directions policies and this manual. Certain policies may apply to only a designated line of business or type of benefit plan or government-sponsored health benefit program. You may find select policies and procedures at www.ndbh.com. To obtain a written copy of New Directions policies and procedures, email Provider Relations at ProviderRelations@ndbh.com.

## Change in Provider Demographics

Providers must notify New Directions of any changes to availability or demographics, including email address. Refer to the appendix below to determine the notification deadlines that apply to you. Providers should review and attest to the accuracy of their demographics at least quarterly to ensure they are accurate and up to date. To submit changes, please complete the electronic update form appropriate for your provider type, which are available on our website. Select the health plan you serve, then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

Facilities must notify New Directions of any changes to employee rosters. Contact your Provider Relations representative for the application link designed for your facility.

## Credentialing Criteria

New Directions credentials and re-credentials providers and facilities in compliance with NCQA accreditation standards, applicable health plan policies and applicable state and federal laws. Decisions regarding credentialing and re-credentialing are made by the New Directions Credentialing Committee.

Minimum criteria for consideration as a provider in the New Directions' network must include:

- Current unrestricted state professional license(s) or registration(s) that authorizes the applicant to practice independently in the state(s) where services are provided
- For facilities, PHP, IOP and CMHC programs, an active unrestricted license for the services seeking to be contracted
- Minimum practice of fifteen hours per week
- An acceptable level of professional liability insurance (preferred coverage is $1,000,000 occurrence/$3,000,000 aggregate but may vary according to state law or Plan requirements)
- Internet access
- Up-to-date mailing address and email address
- Have 24-hour phone coverage

## M.D. and D.O. eligibility requirements

Effective 12/01/18: M.D. and D.O. applicants must meet eligibility requirements in one of the following ways:

i. The M.D. or D.O. applicant has obtained board certification through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in Psychiatry by the ABMS/AOA certifying Member Board,
    1. Except, for those M.D. or D.O. applicants with recent completion of their psychiatry residency, those M.D. or D.O. applicants may apply to the network with the requirement they shall become board certified within one of the next two consecutive testing periods following the completion of their residency (e.g., residency completed June 2017, first testing period September 2017, second testing period September 2018, terminate November 2018 if not board certified). If board certification is not obtained during this time frame, the M.D. or D.O. credentials and, as a result, provider contract will terminate at the end of November of year following the second testing period; or

ii. The M.D. or D.O. applicant has obtained Board Certification through the ABMS or AOA in Addiction Medicine by ABMS/AOA certifying Member Boards or a non-expired certification from the American Board of Addiction Medicine (ABAM) and intends to treat individuals with substance use disorders. In addition, this category

of M.D. and D.O. applicants must be board certified by the ABMS or the AOA in the area they completed their residency. This type of physician will be referred to as an Addiction Medicine Specialist.

## Site Visits

New Directions may conduct a site visit of network provider facilities and/or offices. Site visits are conducted using the internal New Directions On-Site Evaluation Forms:
***Outpatient Site Visit Form***
***Inpatient Site Visit Form***

Site visits may include a review of any or all the following:

- Availability and access to services
- Physical plant safety & environment
- Adherence to HIPAA and confidentiality
- ADA Compliance
- Patient Rights and Responsibilities
- Treatment recordkeeping and maintenance practices
- Member record documentation
- Medication safety
- H.R. practices including credential verification of licensed staff, training and hiring practices of direct care staff
- Quality of services provided to members
- Quality & Risk Management processes and improvement programs
- Member treatment program philosophy
- Other

## Provider Rights and Responsibilities

### Providers have the right to:

1. Access information contained in personal credentials files

2. Rectify erroneous information in personal credentials files

3. Be informed of their status in the credentialing/re-credentialing process

4. Request a hearing in accordance with the Fair Hearing Plan policy, if an adverse recommendation by the Credentialing Committee regarding participation in the New Directions' network is made

5. Be credentialed in accordance with the Provider Credentialing and Re-credentialing policy, which describes the processes for credentialing and re-credentialing, including:

- Maintaining the confidentiality of the credentials files to the extent permitted under state or federal laws and New Directions' policies
- Credentialing and re-credentialing recommendations that are non-discriminatory
- Right to be notified if information received during the credentialing/re-credentialing process is substantially different from information received from a Provider
- Notification within 10 business days of adverse credentialing/re-credentialing decisions

### Providers have the responsibility to:

1. Use and disclose protected health information in accordance with federal and applicable state laws

2. Comply with New Directions and the applicable plan's credentialing, quality management, member grievance, care transitions, performance evaluation, disciplinary process, utilization review, care management and disease management programs

3. Comply with New Directions and the applicable plan's claims submission and processing requirements

4. Maintain health information (treatment records); submit to reasonably requested audits; implement action plans as required; and participate in follow-up reviews of deficiencies

5. Obtain Release of Information (ROIs) and other consents required to enable coordination of care, care management, and claims resolution activities by New Directions and the member's plan

6. Communicate with primary care physicians and other providers about mutual members

7. Comply with billing rules and guidelines

8. Coordinate care with other in-network health care providers whenever possible and appropriate

## Checking Member Eligibility and Plan Benefits

### Provider WebPass

WebPass is available for the convenience of providers and facilities. You will find membership eligibility and plan benefits at www.ndbh.com in the provider WebPass section.

**Web-based online support via the Internet**: New Directions' online WebPass system is a password-protected website that offers providers the ability to request and verify member authorizations 24/7/365, communicate discharge information, and submit care

management referrals. The WebPass system provides users with a safe and secure way to send protected health information to New Directions.

**Utilization management review for eating disorder cases:**
**Effective January 1, 2019, all New Directions contracted providers will complete utilization management reviews for Eating Disorder cases by phone rather than WebPass. For more information, please read Introduction to New Directions Utilization Management Telephonic Review Process* ***here.***

**Utilization management review changes for Florida providers effective 02/01/19:**
*******Effective February 1, 2019, Florida contracted providers will complete utilization management reviews by phone rather than WebPass for the following cases in addition to Eating Disorder cases:*

- *Children and Adolescents under the age of 18 for all diagnoses and levels of care*
- *Residential cases for members and primary substance use disorder diagnosis*
- *Medicare members for all levels of care*

*For more information about the Florida Provider Telephonic Review Process, please click and read guidelines* **here**.

***Important Timeline Information Regarding UM Reviews for Florida Providers, effective Feb. 1, 2019:***

*After we receive all necessary clinical information for the types of cases listed on the previous page, New Directions must process reviews within specific time frames. The time frame guidelines are listed below:*

***Urgent cases timeline requirement***

- *Inpatient Services (substance use disorder inpatient detox, psychiatric acute inpatient, substance use disorder inpatient rehabilitation) – *1 calendar day*
- *Post-admit Residential Treatment Center (member has been admitted to unit level of care) – 1 calendar day**

- **Extensions of up to 3 calendar days to process cases are available when additional clinical information is needed to determine if Medical Necessity Criteria are met*

***Non-urgent cases timeline requirement***

- *Pre-admit to Residential Treatment Center (member is waiting to be admitted) – 3 calendar days*
- *Partial Hospitalization Program (PHP)/Intensive Outpatient Program (IOP)/Outpatient services (OP): includes Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) – 15 calendar days*
- *Retroactive Reviews – 30 calendar days*

- *When a second "peer-to-peer" review is to be conducted because the first "peer-to-peer" review did not result in a live conversation – 1 calendar day regardless of the level of care*

## Getting Started with WebPass

To initiate WebPass as a facility, facilities will need to identify an administrator user and sign up using the following instructions:

1. Send an email to New Directions (PRWebpass@ndbh.com) with the request to be an administrator for your organization.
    a. The administrator will be responsible for managing facility users. This responsibility includes adding users, resetting passwords and deleting users who are no longer authorized to access the facility WebPass account.
2. Include the facility Tax ID.
3. Indicate the requested WebPass user's fist name, last name and email address.

Training resources for WebPass are located on the WebPass Login Page at: https://webpass.ndbh.com/.

Training guides for the Authorization Forms are located at: https://www.ndbh.com/Providers/Resources.

## Let Us Know How the System Works

If you experience problems with obtaining timely eligibility and benefits information, please contact us toll-free at 1-888-611-6285 or by email at PRWebPass@ndbh.com

## WebPass Reminders

- New Directions will require that providers include a fax number for their UR department/treating practitioner when submitting requests for authorization. Having a correct fax number allows New Directions to provide timely communication of adverse determinations for requests considered urgent. **When using WebPass, you will need to add the fax number to the online request form before the authorization request can be submitted.**
- Urgent care coverage review schedule - New Directions will be completing continued stay reviews and step-down reviews for urgent care on the last covered day. **Please submit continued stay review requests and step-down review requests for inpatient and residential on the last authorized day.**
*[Ex., New Directions authorizes urgent care coverage for 11/27-11/29. We will review continued or step-down requests on 11/28. Provider should therefore submit review request on 11/28 because it is the last covered day. Remember that the day of discharge is not covered. In this example, 11/29 is the day of discharge.]*

- Timely submissions – For members in inpatient or residential care, **please submit continued stay review requests and step-down review requests prior to 5:30 p.m. EST**. Again, reviews should be submitted on the last covered day. Doing so enables New Directions to provide a timely and complete medical necessity determination, allowing for peer reviews if needed.
- Diagnosis – **Please provide the most accurate diagnosis and update in each WebPass submission** as reflected in the medical record.
- Continued stay requests – **Updated clinical information is required** to reflect member's current status and progress on measurable goals, as listed on the member's individualized treatment plan.
- Progress – **Please provide CIWA scores, vitals and labs, as indicated**. Include the most recent results.
- Medications – **Medications must be updated** in each submission.
- Discharge plan – Please ensure that a discharge plan is populated on the initial authorization request and updated with each concurrent authorization review request, including specific providers and appointments. All facility-based care providers are required to submit a WebPass Discharge Form to New Directions for all levels of care within 48 hours of discharge or change in service level. Members require follow-up appointments within 7 days of discharge. For mental health admissions, follow-up appointments should meet the defined criteria for HEDIS.

- Forms – **Please submit all needed forms**, including releases of information, member consent for referral to Behavioral Health Homes (BHH), consent for referral to other providers to coordinate care, and the Medicare Important Message Form.

# Section 3: Provider Accessibility

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## Overview

New Directions is committed to assisting members obtain timely access to services with appropriate network providers. When members contact New Directions and request assistance in finding a provider for a routine referral, New Directions provides the name and contact information for 3-5 providers. For members contacting New Directions with urgent needs, New Directions links the member with the provider and sets up the appointment.

## Availability Standards

New Directions requests that providers make every effort to be available for emergent appointments. If a member contacts your office with an emergent situation, and your office cannot provide an appointment within appropriate timeframes based on the member's clinical situation, your office should refer the member to an emergency room.

### Emergent Care, Life-Threatening

In an emergency, the member must be offered the opportunity to be seen in person immediately.

### Emergent Care, Non-Life-Threatening

Based on triage, when there is a significant risk of serious deterioration, the member must be seen within six (6) hours of the request.

### Urgent

In an urgent situation, the member must be offered the opportunity to be seen within twenty-four (24) hours of the request.

### Routine Office Visit - Initial

For a routine office visit that is considered the initial visit, the member must be offered the opportunity to be seen within seven (7) days of the request.

### Routine Office Visit - Follow-Up

For a routine office visit that is considered a follow-up visit, the member must be offered the opportunity to be seen within thirty (30) days of the request.

## Coordination of Care with Primary Care Physicians and other Providers

New Directions encourages all providers to coordinate and share information with your patients' primary care physicians (PCP) and other behavioral and medical specialists (e.g., neurologists, pain management, etc.), whenever appropriate. New Directions actively participates in these collaborative efforts. You may be contacted by a New Directions staff member to assist you in scheduling an appointment, verifying attendance, treatment planning, medication reconciliation, and completing an authorization form, as well as other efforts to coordinate care. To facilitate coordination of care, New Directions provides several authorization forms on our website for your use.

Members benefit when all health care providers share health information. New Directions recommends network providers educate and explain to members the important reasons for sharing health information with their PCP and other health care providers.

Authorization from a member may be required when sharing health information with other treating health care providers or with New Directions. Such activity may fall under the treatment, payment, and health care operations exceptions under HIPAA, which allows information to be shared without a release in many situations. Heightened requirements exist for substance use disorder information under 42 CFR Part 2, and some state laws specific to mental health or substance use clinical information are more restrictive than HIPAA. Psychotherapy notes, identifying information related to HIV/AIDS, and genetic information are also subject to more stringent requirements. Providers are expected to comply with relevant federal and state laws regarding contact with other health care providers.

To promote better outcomes and whole person treatment, providers are encouraged to educate their patients on the benefits of coordinated care and request an authorization for release of information, when applicable and appropriate. We encourage all providers to participate in these collaborative efforts to ensure the best possible outcomes for members. For more information, email Provider Relations at ProviderRelations@ndbh.com.

# Section 4: Member Safety and Quality of Care

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## Member and Client Rights and Responsibilities

### Members/Clients have the right to:

1. Receive information about New Directions, its services, its network providers and affiliates, and their rights and responsibilities
2. Be treated with respect and receive recognition of their dignity and right to privacy
3. Participate with network providers and affiliates in decisions about their health care
4. Have a candid discussion of appropriate or medically necessary treatment options for their health conditions, regardless of cost or benefit coverage
5. Voice complaints or appeals about New Directions or the care it provides, either verbally or in writing, and obtain prompt resolution
6. Make recommendations regarding this Statement of Rights and Responsibilities for members and clients

7. Expect confidentiality of their personal health information

8. Inspect and copy their personal health information

9. Be ensured reasonable access to care without discrimination of any kind

10. Inclusion of family/significant others in health care decision-making and treatment planning

11. Treatment that is individualized and offers interventions and options that are customized, flexible and adapted to meet member's unique needs

### Members/Clients accept the responsibility to:

1. Provide information (to the extent possible) that New Directions and its providers and affiliates need to provide health care

2. Follow the plans and the instructions for care and treatment agreed upon by plans, providers and affiliates

3. Understand their health conditions and participate in developing mutually agreed-upon treatment goals, to the extent possible

## Quality Improvement

New Directions establishes and maintains the Quality Improvement (QI) Program, which is designed to continuously improve the quality of behavioral health care and service provided to our members. QI initiatives strive to achieve significant improvement in identified clinical and non-clinical service areas and are expected to have a positive impact on health outcomes, services received, and member and provider satisfaction over time.

Data collected for QI projects and activities are related to key indicators of clinical care and service that focus on high-volume and high-risk diagnoses, services or populations. Goals are established, measured and analyzed; many of which are based on those established by national accrediting organizations and best practices. The QI Program is intended to ensure that the structure and processes in place lead to desired outcomes for both members and providers.

The scope of the New Directions QI Program includes:

- Member safety
- Treatment services
- Treatment outcome
- Access and availability of care
- Continuity and coordination of care

- Cultural and linguistic needs
- Care Management services
- Complaints
- Member and provider satisfaction
- Confidentiality and privacy

New Directions evaluates its QI Program annually. Based on the results, a new work plan is created for the following year. Further information about the Quality Improvement Program is available on request by emailing QualityImprovement@ndbh.com.

## Utilization Management (UM) Services

The UM program promotes positive health outcomes by providing the structure and processes needed to provide care management for Managed Behavioral Health (MBH) members. New Directions' care and utilization management approach aims to align attention and resources to address:

- The care needs of members with clinical complexities, requiring high levels of health care services
- Needs of members in populations requiring specialty care
- The need for evidence-based care for all members, including newly diagnosed or first presenting
- Transitions in care, so that members experience continuity of care as they move through the behavioral health/substance use disorder continuum of services.
- The UM Program is a framework for making benefit determinations affecting the health care of members in a fair, impartial and consistent manner. All UM services are provided by phone or through New Directions' website (www.ndbh.com).

The UM staff is available 24/7 to provide information about UM processes and to address requests for benefit coverage. Members have direct access to all behavioral health providers and can self-refer to providers for assessment. Members who contact New Directions for assistance to find a provider and obtain an appointment are asked a series of questions. These questions enable UM staff to determine the type of services needed, the acuity of the member's condition, and the appropriate time frame for the appointment. In urgent and emergent situations, the member is assisted with access to services. The safety of the member is the primary concern. The staff facilitates peer clinical reviews, appeals and coordinates services with other departments.

## Focus Areas

**Member Safety -** New Directions promotes the exchange of information between medical and behavioral health providers. Communication with providers about key elements associated with member care improves member safety, continuity of care and coordination of care.

**Medication Safety** - Identifying opportunities for medication reconciliation is one of the key elements of coordination of care activities. When members participate in our Care Management (CM) program, New Directions provides a list of the medications reported by the member or from facility discharge orders to their prescribing physicians. This enables the prescribing physicians to review the medication list and identify and reconcile any discrepancies. New Directions' care managers utilize our Coordination of Care fax form (COC Form) to communicate with medical and behavioral health providers to facilitate medication reconciliation. By informing ordering providers of the need for medication reconciliation, actions can be taken to reduce inconsistencies, decrease the potential for harm and provide a channel to communicate a list of members' prescribed medications to medical and behavioral health providers.

**Medication Overdose –** Studies show that suicide attempt by overdose is associated with high personal and social costs along with a high rate of repeated admissions. New Directions designed a Medication Overdose Prevention Program to decrease the potential for recurrent prescribed medication overdose among members hospitalized for psychiatric and/or substance use treatment. When New Directions' care managers learn that a member is hospitalized for a suicide attempt by overdosing with prescribed medications, they notify the prescribing physician prior to member discharge. Physicians can then determine if a change in prescription is needed.

**Quality of Care –** New Directions strives to develop, maintain and promote best practices in behavioral health care. Our focus is on defining and measuring quality.

**HEDIS Performance Measure Monitoring -** HEDIS (Health Care Effectiveness Data and Information Set) measures are tools used to gauge performance on important dimensions of care and service. The following measures, monitored by New Directions, involve providers' implementation of best practices in managing their patients' behavioral health care.

**Antidepressant Medication Management –** Studies indicate that nearly half of all patients who begin antidepressant treatment discontinue medications within the first 90 days of being prescribed medications, while half the remaining patients discontinue medications during the continuation phase, which includes the initial 180 days. New Directions monitors members 18 years and older with a diagnosis of major depression who have been treated with antidepressant medication, for their continued use of the medication at 84 days (acute phase) and 180 days (continuation phase).

**Follow-Up Care for Children Prescribed ADHD Medication –** The AACAP 2007 ADHD Practice Parameter recommends an office visit after the first month of treatment to review progress and determine whether the stimulant trial was successful and should continue as maintenance therapy. Children who are newly prescribed ADHD medication are monitored for completion of at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed and continuation on the medication prescribed.

- **Follow-Up after Hospitalization for Mental Illness –** Timely follow-up after hospitalization promotes continuity of care and reduces the likelihood of rehospitalization. New Directions assists members in receiving timely outpatient behavioral health services following a discharge from an in-patient behavioral health admission. Members, 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses, are monitored for completion of an outpatient visit, intensive outpatient encounter or partial hospitalization encounter within 7 days and 30 days of discharge.
- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications –** People with schizophrenia and bipolar disorder are at a greater risk of metabolic syndrome due to their serious mental illness. Diabetes screening for individuals with schizophrenia or bipolar disorder and who are prescribed an antipsychotic medication may lead to earlier identification and subsequent treatment of diabetes. Members 18-64 years of age with schizophrenia, or bipolar disorder, and who were dispensed an antipsychotic medication are monitored to determine if they have had a diabetes screening test during the year.
- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment –** Studies have identified the need to quickly engage members in follow-up treatment after they have been diagnosed with a substance use disorder. New Directions monitors members, ages 13 years and older, with newly diagnosed alcohol and drug dependence, to assure that treatment was initiated within 14 days of the diagnosis. The measure also reflects the percentage of members who meet these criteria and who are engaged in two or more additional services within 30 days of the initiation visit to evaluate ongoing treatment engagement.
- **Readmissions –** Discharge from an inpatient setting is a critical transition point in a member's care. New Directions, in conjunction with health plans, monitors the number of adult acute inpatient stays that were followed by an acute readmission within 30 days. The measure is used, in part to identify additional discharge planning needs for the member who readmits, to identify facility trends and identify potential gaps in discharge resources. Both behavioral health and medical admissions are considered in this annual HEDIS measure.
- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia–** For members with schizophrenia, lack of adherence to treatment with antipsychotics is common, and can be a significant cause of relapse. New Directions monitors the percentage of adult members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
    - Monitoring antipsychotic medication adherence may lead to a reduced rate of relapse and fewer hospitalizations.

New Directions Behavioral Health Screening programs are designed to provide early identification of potential disorders and assist providers as they direct members to appropriate assessments and levels of care to avoid complications of untreated conditions.

- **The Behavioral Health Screening for Coexisting Depression and Substance Use** program aims to detect depression in members admitted to a higher

level of care for substance use disorder. New Directions utilizes WebPass and telephonic utilization management contacts to collect information as to whether a depression screen was performed, and if the result was positive during all admissions for a substance use disorder. If left unidentified and untreated, the coexistence of substance use and depression can complicate treatment of the member and can hinder providers' efforts to address the member's substance use disorder. This comorbidity places individuals at high risk for suicide and social and personal impairment.

- **The Behavioral Health Screening for Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications** is a program based on scientific evidence that, in patients diagnosed with schizophrenia or bipolar disorder, a strong correlation exists between the prescription of antipsychotic medications and the occurrence of diabetes. Members with bipolar disorder or schizophrenia who are actively engaged in New Directions' Care Management programs and who are being treated with antipsychotics will be asked if they have had a fasting glucose or HbA1c test in the past calendar year. If not, they will be encouraged to speak with their prescriber to obtain this screening.

## Adverse Event Reporting

An editable version of Sentinel Event Reporting Form can be found on the Behavioral Health Plan Providers page of New Directions website here.
Please follow instructions regarding Adverse Event Reporting below.

## Sentinel Event Reporting

Sentinel events must be reported by the facility or provider within one (1) business day from learning of the occurrence. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury may include loss of limb or function. The following are considered sentinel events:

a. **Unexpected Death/Completed Suicide** – Any unexpected death that occurs during treatment by the facility or provider; or a death that occurs within three (3) calendar days of the member receiving care from the facility or provider.
b. **Homicide or Serious Homicide Attempt** – Any act of a member, who has received care from the facility or provider within three (3) calendar days prior to the incident, which results in the death of another individual, or which was a serious attempt to kill another individual.
c. **Serious Suicide Attempt** – Any act of self-harm by a member that results in stabilization in an intensive care unit. Consideration will be given to lethality of the attempt, intent of member, and potential pattern of behavior.
d. **Sexual Assault** – Nonconsensual sexual contact involving a member, including oral, vaginal, or anal penetration or fondling of the member or another patient's sex organ(s).

## Incident Reporting

For incidents not meeting the definition of a sentinel event, but that could present a quality of care concern, the facility or provider must notify New Directions within two (2) business days from learning of the occurrence. Examples include but are not limited to:

a. **Altercation with injury or without injury**
b. **Self-harming behavior or suicide attempt with or without injury**
c. **Elopement/unauthorized absence**
d. **Falls with or without injury**
e. **Medication error**
f. **Alleged or suspected abuse: verbal, physical, sexual, neglect**

If you need to report a sentinel event or other adverse incident, please fill out and submit the Adverse Event Reporting Form. **Fax completed forms to 816-237-2374**.

Please report the incident as soon as possible even if all information is not yet available. Final submission of all information is required within five business days of the event. Though New Directions recommends using our reporting form, we will accept the information in any form or format. Should you wish to submit the information without using our recommended form, please ensure to include all the information requested in the form.

Note: when there is secondary coverage or denied care, reporting is still required.

If you have questions, please contact: QM_Florida@ndbh.com for the Florida network, QM_AL@ndbh.com for the Alabama network, and KCRSC_QM_Facility@ndbh.com for the Kansas City and Arkansas FEP network.

NEW DIRECTIONS®

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# Adverse Event Reporting Form

Facility Name

Patient Name

Reporter Name

Patient DOB

Reporter Title

Patient Policy Number

Reporter Phone Number

Patient Phone Number

Reporter Email:

Coverage (if also secondary coverage):

Incident Date

Date of Report

Persons Involved:

- ☐ Patient
- ☐ Staff
- ☐ Persons not associated with facility
- ☐ Other _____

Location:

- ☐ In facility
- ☐ On grounds
- ☐ Off grounds
- ☐ Home
- ☐ Other _____

Incident Type:

- ☐ Unexpected death:
  - ☐ Suicide
  - ☐ Homicide
  - ☐ Accidental
  - ☐ Cause unknown
- ☐ Expected death:
  - ☐ Non-suicide
  - ☐ Natural causes
- ☐ Altercation (if checked, please complete injury section):
  - ☐ With injury
  - ☐ Without injury
- ☐ Self-harming behavior or suicide attempt (if checked, please complete injury section):
  - ☐ With injury
  - ☐ Without injury
- ☐ Fall
  - ☐ With injury
  - ☐ Without injury
- ☐ Alleged or suspected abuse (If any checked, please complete Abuse/Assault section):
  - ☐ Verbal
  - ☐ Physical
  - ☐ Sexual
  - ☐ Neglect
- ☐ Elopement/unauthorized absence
- ☐ Medication error (if checked, please complete Medication Error section)
- ☐ Other_____

1. ABUSE/ASSAULT SECTION

Alleged or suspected sexual abuse/assault:

- ☐ Nonconsensual contact (peer to peer)
- ☐ Nonconsensual contact w/staff
- ☐ Nonconsensual contact w/other perpetrator
- ☐ Consensual contact (peer to peer)
- ☐ Consensual contact w/staff
- ☐ Consensual contact w/other perpetrator

If nonconsensual:

- ☐ Staff witnessed
- ☐ Admission by the perpetrator
- ☐ Sufficient evidence obtained to support allegations

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2. MEDICATION ERROR SECTION

Medication error severity:

- ☐ None (no harm)
- ☐ Mild (monitoring)
- ☐ Moderate (treatment and monitoring)
- ☐ Serious (life threatening &/or permanent adverse consequences)

Medication error category:

- ☐ Failure to administer
- ☐ Wrong med
- ☐ Wrong dose
- ☐ Wrong route
- ☐ Wrong time
- ☐ No MD order
- ☐ Administered w/o parental consent
- ☐ Adverse reaction
- ☐ Other_____

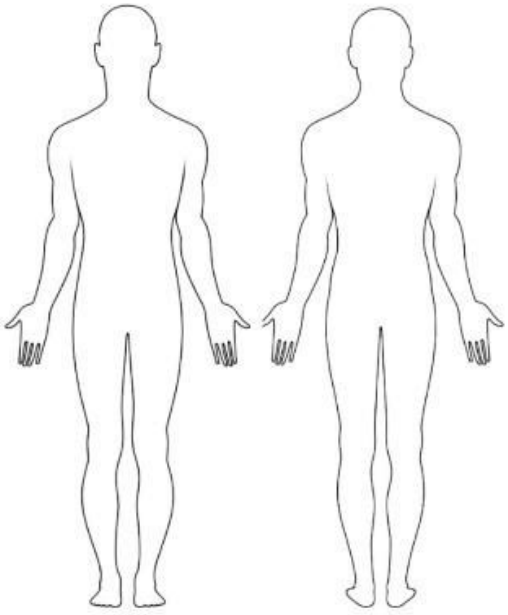
3. INJURY SECTION

Injury description:

- ☐ Abrasion
- ☐ Bite
- ☐ Burn
- ☐ Complaint of pain
- ☐ Contusion/bruise
- ☐ Dislocation
- ☐ Fracture/break
- ☐ Laceration/cut
- ☐ Puncture
- ☐ Scratches
- ☐ Strain/sprain
- ☐ Swelling
- ☐ Other: _____

Injured body parts:

- ☐ Head
- ☐ Face
- ☐ Eye – left/right
- ☐ Ear – left/right
- ☐ Nose
- ☐ Mouth
- ☐ Teeth
- ☐ Neck
- ☐ Back
- ☐ Chest
- ☐ Shoulder-left/right
- ☐ Arm –left/right
- ☐ Elbow – left/right
- ☐ Wrist – left/right
- ☐ Hand –left/right
- ☐ Waist
- ☐ Belly
- ☐ Hip
- ☐ Genitals
- ☐ Buttock-left/right
- ☐ Thigh-left/right
- ☐ Calf –left/right
- ☐ Knee – left/right
- ☐ Shin – left/right
- ☐ Ankle – left/right
- ☐ Foot – left/right
- ☐ Other: _____



FRONT BACK

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| | |
|---|---|
| Family/Guardian Name | Date/Time Contacted |
| Physician Name | Date/Time Contacted |
| Law Enforcement | Date/Time Contacted |
| Department of Child Services | Date/Time Contacted |
| 911 | Date/Time Contacted |
| Other | Date/Time Contacted |
| Other | Date/Time Contacted |

Summary of Incident

Immediate Action Taken

Exam Information

| | | |
|---|---|---|
| Date | Time | Provider Type |

| | |
|---|---|
| Medication | Date/Time Contacted |

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## Complaint Reporting

Reporting Dissatisfaction or Complaints to New Directions:
New Directions Behavioral Health defines “Complaints” as an expression of dissatisfaction. There are several ways you may file a complaint with New Directions. Should you desire to file a complaint regarding any aspect of your experience with New Directions, please see the ways you can do this below.

Complaints may be sent by Email:
QMComplaints@ndbh.com (no PHI, please)

Mailed to:
New Directions
Complaints
P.O. Box 6729
Leawood, KS 66206

Or sent by fax to:
816-237-2374

## Section 5: Managing Utilization

### Key Changes Index

| SECTION | PAGE | CONTENT CHANGE |
|---|---|---|
| 5 | 44 | • Change from 3 calendar days to 72 hours |
| 5 | 102 | • Change from 3 calendar days to 72 hours |
| 5 | 109 | • Change from 3 calendar days to 72 hours |
| 5 | 111 | • Change from 3 calendar days to 72 hours |
| 5 | 131<br>133<br>136 | • Change from 3 calendar days to 72 hours<br>• Change from 3 calendar days to 72 hours<br>• Change from 3 calendar days to 72 hours |

## Medical Necessity Criteria

Medical necessity criteria (MNC) can be located and downloaded in the provider section of the New Directions website. Our MNC helps to guide our utilization management philosophy and overall approach to delivery of behavioral health services.

New Directions bases medical necessity decisions on appropriateness of care and service as well as available and applicable benefits. New Directions does not reward or offer financial incentives to employees or personnel contracted to perform clinical review functions to make judgments that would deliberately result in under-utilization of services or utilization of inappropriate care/services. The Utilization Management

Program serves as a framework for making benefit and medical necessity determinations in a fair, impartial and consistent manner. A physical copy of the Medical Necessity Criteria can be requested by emailing Network Operations at ProviderRelations@ndbh.com.

## Utilization Management

Behavioral health benefits requiring Utilization Management (UM) are managed by New Directions to ensure members have timely access to the most appropriate environment as medically necessary. We coordinate care among the member's primary care physician, psychiatrist and behavioral health therapist.

New Directions UM staff are available 24/7/365. Please refer to the appendix in this manual for the appropriate plan and phone number to call to address questions about the UM process, send outbound communication regarding UM inquiries, connect providers with clinical peers, or initiate reviews with external or independent review organizations. New Directions staff will identify themselves by name, title and organization when initiating or returning calls regarding UM issues. New Directions offers TDD/TYY and language assistance services for members, providers and facilities to discuss UM issues.

## Conducting Clinical Utilization Management (UM) Review

Utilization managers apply the appropriate clinical review criteria to the available health information when making a benefit determination for the requested treatment and/or level of care.

**a)** Benefit determinations for pre-service, urgent and concurrent reviews are based solely on the health information available to New Directions at the time of the benefit determination.

**b)** Benefit determinations for post-service reviews are based solely on the health information available to the provider in the medical record at the time the care was provided.

If Utilization Managers do not have enough clinical information to make a medical necessity determination, an extension of time may be given to the provider to supply additional clinical information. If the provider does not submit the additional clinical information needed even after an extension, the case will be sent to a physician reviewer to complete a peer review with the information that was provided.

New Directions bases decisions about utilization of services only on eligibility, coverage and appropriateness of the care and service. There are no financial incentives for decisions that result in under-utilization of services or care. New Directions does not reward, hire, promote or terminate individuals for issuing denials of coverage.

Members may contact New Directions at the phone number on their insurance card to obtain a referral to a network provider. New Directions will assist in identifying appropriate providers in the member's area and may offer additional assistance with making a timely appointment with the appropriate provider.

Benefit information, eligibility and any requirements for pre-notification or authorization for coverage specific to the plan are included on the plan fact sheets in the appendix.

## Clinical Peers

Clinical reviewers and clinical peers are available any instance a provider has a concern about access to services, an authorization for services, a UM decision, a level of care recommendation or other matters relevant to member care. It is not necessary for a claim to reach the formal denial or appeal process for such dialogue to take place. External and independent review organizations are also available.

## UM Process Limitations

Please also be aware that New Directions UM process is designed to comply with the requirements set forth by federal and state statutes and regulations, accreditation standards and plan requirements. In addition, New Directions, as well as providers and facilities, are required to abide by federal and state confidentiality laws with disclosure of a member's information.

In compliance with confidentiality laws, New Directions will not conduct the UM process in any manner with third party billing or management companies unless they provide written authorization, using the applicable plan's Authorized Representative Form. This authorization is required even if the third-party billing or management company has entered into a Qualified Service Organization Agreement with a provider or facility. New Directions will not accept clinical information from, or disclose clinical information to, these companies without such authorization.

## Treatment Record Reviews

Providers must cooperate with treatment record reviews and audits conducted by New Directions and associated record requests. New Directions may conduct reviews and audits on an unplanned basis as part of continuous quality improvement and/or monitoring activities. Record review requirements and access to records are detailed in section 7 of your individual provider agreement with New Directions:

7. INSPECTION OF RECORDS AND DATA ACCESS

    7.1 Access to Information. Provider shall grant to New Directions, and payor, access to all data and information obtained, created, or collected by provider

related to members including, but not limited to, medical records, books, and papers relating to professional and ancillary care provided to members and financial, accounting, and administrative records, physician bylaws, books and papers ("Information"), to the extent permitted by and otherwise consistent with applicable laws. As applicable, provider shall obtain all required approvals and consents to allow provider to disclose such information to New Directions, and payor. New Directions, and payor, will have reasonable, unlimited, and free access to Information in electronic or other form, and will not be required to pay any access, transaction, or other fees to obtain such Information for claims adjudication, quality improvement activities, utilization review, professional review activities, audit, fraud and abuse investigations, and other similar health care operations of New Directions, or payor. Information must be provided within the time frame required by New Directions, or payor, which will be reasonable based on the purpose and volume of the request.

7.2 Audits, Evaluations, and Inspections. Provider shall cooperate and comply with any audits, evaluations, and inspections conducted by New Directions or designee, a payor, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services, a State Department of Insurance, the Center for Consumer Information and Insurer Oversight, the Comptroller General and all other governmental and accrediting agencies to which New Directions and a payor are subject. Cooperation and compliance including but is not limited to provider providing access to any medical records, governance documents books, contracts, financial records, protected health information, and other documents, whether in electronic or paper format, that are relevant to:

- The services, and Covered Services, performed under this Agreement;
- The determination that services performed are Covered Services;
- Reconciliation and coordination of benefit liabilities;
- Determination of amounts payable;
- Medical audit or review;
- Utilization management, quality improvement, care transitions, and other clinical program activities;
- Financial transactions associated with this agreement;
- Overpayment, underpayment, and documentation reviews; and
- Other relevant matters as such person conducting the audit, evaluation, or inspection deems necessary.

## Guidelines for Treatment Record Documentation

The following guidelines were developed for treatment records review, and to promote orderliness, security, confidentiality and adequate documentation. Providers may be asked to submit several medical records for audit in accordance with these guidelines. A passing score is considered 80 percent or higher.

1. **Confidentiality**: (a) Treatment records are securely stored (b) treatment records are only accessible by authorized personnel (c) office staff receives periodic training in confidentiality of patient information.

2. **Personal/Biographical Information**: Personal/biographical information is documented in a consistent location in the treatment record. Information includes:

    - Name or ID number on each page
    - Date of birth
    - Home address
    - Home/work telephone numbers
    - Gender
    - Employer or school
    - Marital or legal status
    - Appropriate consent forms/guardianship information
    - Emergency contact information

3. **Comprehensive Treatment Record Organization**: A comprehensive medical record is defined as a single all-inclusive record of health information that is comprised of all clinical patient information available to the provider or facility. The internal information from the provider is integrated with external information.

    a. Practices that have satellite offices must have at least one location that maintains a comprehensive treatment record.

    b. Providers must establish a separate record for each member. All contents of the paper or hard copy treatment record are in an established format and sequencing, either in chronological or reverse chronological order.

    c.

    d. An Electronic Medical Record (EMR) may encompass multiple applications to form a comprehensive record. For example, if demographic information such as home/work phone number is stored in one application, and follow-up visit information is stored separately from the main EMR, all applications must be accessible to the clinical staff from an individual workstation.

4. **Allergies**: Documentation of medication allergies is clearly noted. If the patient has no known allergies, this is noted in the treatment record – typically as NKA (no known allergies) or NKDA (no known drug allergies). Physician and nurse practitioner records also clearly describe the reactions associated with allergies.

5. **Special Status Situations**: Special status situations include conditions where the patient is at imminent risk of harm, has suicidal or homicidal ideation with a

plan, or is unable to conduct activities of daily living. Observations of these situations and prompt referral to the appropriate level of care are documented in the record. If the situation requires mandated reporting, please ensure the report is documented in the medical record as well.

6. **Medication Management**: Records contain information about medication. This information includes:
   Medication prescribed, including quantity or documentation of no medication
   Dosages and usage instructions of each medication (physician and nurse practitioner records)
   Dates of initial prescription or refills (physician and nurse practitioner records)
   Herbal medications or over-the-counter medications

7. **Informed consent**: Records must include evidence informed consent, indicating that the patient or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment, alternative treatments and the risks of treatment and declining treatment.

8. **Alcohol, Tobacco, And Substance Use and/or Abuse**:
   Documentation includes past and present use of cigarettes, alcohol, and prescribed, illicit, and over-the-counter drugs, including frequency and quantity.

9. **Mental Status Evaluation**: The treatment record contains evidence of at least one mental status evaluation/examination (e.g., patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory and impulse control).

10. **History**: A psychiatric and medical history was obtained and documented in the record outlining the patient's past treatment and response (or lack thereof). The history consists of:
    - Relevant medical and psychiatric conditions
    - Previous treatment dates
    - Therapeutic interventions and responses
    - Sources of clinical data (e.g., self, mother, spouse, past records)
    - Relevant family information
    - Consultation reports, if available/applicable (e.g., psychological testing)
    - Lab test results, if applicable, in physician and nurse practitioner records (i.e., Lithium, Depakote, Tegretol levels)

11. **Minor Patients Treatment Records**: Records of minor patients (under 18 years of age) contain documentation of prenatal and parental events, complete developmental histories (physical, psychological, social, intellectual, and academic) and evidence of family involvement in care within 60 days of the initial visit. When a minor is prescribed a psychotropic medication, documentation reflects parental consent and that the parent or legal guardian is informed about the medication, its purpose, side effects, risks and treatment alternatives.

12. **Diagnostic Testing**: All diagnostic testing, reports and their interpretations are present (e.g., psychological testing reports, and neuropsychological testing reports, and laboratory reports).

13. **Treatment Plan**: Within the first 3 visits, the treatment plan contains (a) specific measurable goals, (b) documentation that the treatment plan and/or goals were discussed with the patient, (c) estimated time frames for goal attainment or problem resolution, and (d) documentation of the patient's strengths and limitations in achieving goals. This personalized treatment plan for each individual member should guide the overall treatment process.

14. **Diagnosis**: The treatment record documents a DSM-V or ICD-10 diagnosis or clinical impression within the first three visits. "Deferred" or "Rule out" diagnosis is acceptable but must be revised within 3 visits. In order to reflect the member's appropriate Risk Adjustment Factor under the Affordable Care Act, the member's diagnosis needs to include all the diagnoses impacting the member, reflecting the severity of the patient's overall illness.
    i.
15. **Treatment Record Notes**: Each face-to-face encounter note contains all of the following: (a) reason for the patient's visit (b) objective and subjective documentation of the patient's presentation (c) goal of the service (d) summary of the intervention/service provided with the member response (e) an updated treatment plan, and (f) diagnosis being treated during service.

    Treatment Record Notes must support the medical necessity of the service provided and support the code that is billed. Documentation for each visit must stand alone and with all required documentation elements being contained in the encounter note. For example, a sign-in sheet for group therapy should not be needed in addition to the encounter note to support member's group attendance. Likewise, a copy of an appointment book should not be needed in addition to an encounter note to support time.

    i. The treatment record reflects an individualized interaction with the member. Documentation is not repetitive or reflective of rote or cloned charting.

    ii. Documented abnormalities in the assessment or exam (indicated by check mark or narrative) also include an intervention or rationale that reflect the documented abnormality was addressed by the provider.

16. **Group Notes:** Group documentation must be for each specific encounter for the date of service and each session attended, not a collective summary for multiple sessions or dates of service. Documentation must include:
    - Date, start/stop times, and duration of the group
    - Purpose of group

- Objective and subjective documentation of the member's presentation during group (individualized to the member)
- Summary of the intervention utilized
- Member's response to the group
- Provider of group is documented and authenticated with professional degree and/or professional credentials
- Documentation must support medical necessity and be connected to the member's individualized treatment plan

17. **Doctors' Orders for Drug Screens**: Doctors' orders for drug screens must include rationale and the substance tested for. Orders for drug screens should not be standing orders.

18. **Legibility:** For paper records and written notes, the medical record is legible to someone other than the writer. Documentation contains only those terms and abbreviations that are or should be comprehensible to other medical professionals.

19. **Author Identification, Authentication, and Date and Time of Entries:** All entries are dated, including the month, year, start and stop times, and/or duration the member was seen face-to-face by the rendering provider. Entries must also clearly identify the rendering provider; and authenticated (signed) by the individual providing the services with professional degree (e.g., Ph.D., M.D./D.O., LCSW) and/or professional credentials.

    Only handwritten signatures and eligible EMR signatures qualify for authentication. An electronic signature needs to include a unique personal identifier such as a code, biometric or password entered by the author. The signature must be adhered to the document when created and include the author's name, credentials, date of signature and timestamp. For example, a typed signature that lacks the above-listed identifiers would not qualify as authentication.

20. **Date of Rendered Service:** Documentation reflects each service rendered for the day it was rendered. A summary of services for multiple dates of service or multiple members is not acceptable.

21. **Follow-up Appointments:** The medical record documents dates of follow-up appointments or, as appropriate, a discharge plan. Documentation of follow-up with the member has occurred if an appointment was missed.

22. **Continuity and Coordination of Care:** As applicable, the medical record reflects continuity and coordination of care as evidenced by communication with, or review of information from, other behavioral health providers, consultants, ancillary providers and health care institutions.

23. **Coordinating Care with the PCP:** Medical records reflect contact with the member's primary care physician (PCP), as applicable, and follow-up contact as needed.

24. **Appropriate edits to documentation:** Providers should document the services rendered in the member's medical record at the time of service. At times, a provider may determine that the information entered into the medical record is not completely accurate. If revisions need to be made to a medical record, amend and edit the record using the following steps:
    a. To remove information from the record, draw a single line through the words needing removal, ensuring the content is still readable. White-out is not to be used.
    b. The individual amending or editing the record must sign and date the revision.

    Documentation should not be created or edited after receipt of a medical record request for a claim's payment audit for the purposes of receiving payment.

## Request for Psychological/Neuropsychological Testing

**Some plans do not require authorization for psychological or neuropsychological testing. Please review the health plan and the group-specific information in the appendix at the end of this manual.**

For plans that require authorization for psychological or neuropsychological testing, please use the form found on www.ndbh.com. The form is called "Request for Psychological Testing." Complete all fields, including the date of request and testing start date. The total number of testing hours that you are planning should be filled in next to the appropriate CPT code(s) listed on the form.

If you have any questions or want to check the status of your request for psychological testing, please feel free to contact us. Contact information is found in the appendix in the back of this manual.

Psychological testing is considered medically necessary when indicated to improve or enhance psychiatric or psychotherapeutic treatment upon the completion of a clinical evaluation, if required to assist in the differential diagnosis of behavioral or psychiatric conditions, or in the development of treatment recommendations.

Psychological testing is not considered medically necessary when done solely for the purpose of educational or vocational placement. Please refer to the current New Directions Behavioral Health MNC.

Neuropsychological testing is considered to meet the definition of medical necessity when performed for the evaluation of individuals with cognitive dysfunction due to injury, disease, or abnormal development of the brain is comprised of a set of formal

procedures that utilize reliable and valid tests that specifically focus on identification of the presence of brain damage, injury, or dysfunction and any associated functional deficits.

# Non-Medicare Commercial Member and Provider Denial and Appeal Rights

## Philosophy

New Directions takes a population health, member-centric approach that meets members where they are and matches the level of intervention to the members' needs. All services are designed to ensure that members get the right care at the right time with the right provider and that they are connected with needed community supports. New Directions recognizes that the success of delivering care to members and optimizing clinical outcomes relies on collaborative relationships with providers. New Directions is dedicated to working with our provider community to promote the delivery of high-quality care that is member-specific, clinically necessary treatment in the least restrictive environment.

## Medical Necessity Criteria

We want to inform you of two corrections to the New Directions 2021 Medical Necessity Criteria, effective January 1, 2021.
The first correction is the designation of Bernard DiCasimirro D.O. as Chief Medical Officer on page 6.
The second is to correct an oversight in the criteria numbering for Substance Use Disorder Residential/Subacute Rehabilitation (SUDRR), Partial Day Rehabilitation (SUDPHR) and Intensive Outpatient Rehabilitation (SUDIOR) levels of care. The Initial Authorization Request sections for each now correctly state, "Must meet 1-8 and at least one of 9, 10 or 11". They previously incorrectly stated, "Must meet 1-9 and either 10 or 11". Please note that these changes are on the following pages of the 2021 Medical Necessity Criteria: Pages 35, 39 and 43. There are no language changes in these criteria sets.

| **Previous SUDRR Initial Authorization Request** | **Current SUDRR Initial Authorization Request** |
|---|---|
| *Must meet 1-9 and either 10 or 11* | *Must meet 1-8 and at least one of 9, 10 or 11* |
| **Previous SUDPHR Initial Authorization Request** | **Current SUDPHR Initial Authorization Request** |
| *Must meet 1-9 and either 10 or 11* | *Must meet 1-8 and at least one of 9, 10 or 11* |
| **Previous SUDIOR Initial Authorization Request** | **Current SUDIOR Initial Authorization Request** |
| *Must meet 1-9 and either 10 or 11* | *Must meet 1-8 and at least one of 9, 10 or 11* |

This updated version was uploaded to NDBH.com on February 5th, 2021. Please let us know if you have any concerns or questions.

## Non-Medicare Member and Provider Denial and Appeal Definitions

**Adverse benefit determination**

- A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a member's eligibility to participate in a plan;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- Any cancellation or discontinuance of coverage that has retroactive effect.

**Appeal** – A verbal or written request to contest an adverse benefit determination,

**"Clinical Peer", "Peer Clinical Reviewer" or "Physician Reviewer"** – A Board Certified Physician (MD or DO) or other PhD behavioral health care professional who holds a current, unrestricted license or certificate in a state or territory of the United States to practice and is in the same or similar specialty as that which typically manages the health condition, procedures, or treatment under review. If required by the applicable state, the Clinical Peer is licensed in the state where services were rendered. Unless expressly allowed by state or federal law or regulation, the Clinical Peer is in a state or territory of the United States when conducting a peer clinical review or an appeals consideration. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the treating provider).

**"Doc-to-Doc" or "Peer-to-Peer" Conversation -** Synonymous terms, defined as a telephonic clinical discussion about the treatment of a member, conducted between a Clinical Peer and the practitioner who is directing the care of the member, who is typically the attending physician for the member.

**Expedited Appeal** – Review of an adverse benefit determination of an urgent care request involving an admission, continued stay, or other health care service from which Member has not been discharged, and it has been determined that the member has a medical condition where the time frame for completing a standard external appeal would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function.

**Independent Review Organization (IRO) -** An external review company that conducts impartial third party external reviews of behavioral health and substance use services to determine the appropriateness of care based on medical necessity criteria, level of care requested, and effectiveness of a requested service. IRO-employed Clinical Peers are board certified, and independently licensed. These reviewers are not affiliated with New Directions.

**Initial Clinical Review** – Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but may not make an adverse benefit determination.

**Medical Necessity or Medically Necessary**- Please refer to the controlling specific health plan and/or group documents for the definition of Medical Necessity.

**Initial Peer Review** - A Peer-to-Peer Conversation that occurs when care management staff cannot approve the request for services based on the available clinical information.

**Urgent Appeal Criteria**: An appeal request can be considered urgent if a provider with knowledge of the member's condition determines that, if services are not authorized, the life or health of the member, or the ability of the member to regain maximum function, could seriously be jeopardized.

## Clinical Peer Review Process

**Initial Peer Review** - When Care Management staff cannot approve the request for services based on the available clinical information, the case is sent to a Clinical Peer for review. The Clinical Peer offers to conduct a peer-to-peer conversation with the Attending Physician or Practitioner directing the member's care in order to obtain or clarify the information to be used in the benefit determination. Attending providers may not delegate this responsibility, designate a representative or use a third-party billing/management company to participate in the peer-to peer conversation. If the discussion takes place and a decision is reached, this part of the process ends. The next step for the provider and/or member is to request an appeal (see Appealing Adverse Benefit Determination section below).
For Inpatient and Residential services, peer-to-peer conversations are available only to the Attending provider directly involved with the member's care.
For Partial Hospitalization, Intensive Outpatient and Outpatient services, the member's primary provider/clinician may request and participate in the peer-to-peer conversations.

**Notification of Adverse Benefit Determination-** If the Initial Peer Review results in an Adverse Benefit Determination of the requested service based on lack of medical necessity, the requesting provider and/or facility, as well as the member, are notified of the adverse benefit determination.
Notification of the adverse benefit determination is given verbally to the provider and/or facility by Care Management staff at New Directions. Written notification is also provided to the member, provider and/or facility. Written notification provides pertinent information regarding the adverse benefit determination including:

a. Information identifying the adverse benefit determination

b. Date(s) of the service
c. Name of provider/facility
d. Amount of the claim (if known or applicable)
e. The availability of the diagnosis and treatment codes and their corresponding meanings, upon request
f. Discussion of the pertinent facts about the member's condition and the contractual or clinical reason and rationale for the adverse benefit determination and specific reference to the Clinical Review Criteria or benefit provision used in the decision
g. The name, qualifications, and title of the Clinical Peer and of the person making the adverse benefit determination
h. Denial code and its corresponding meaning
i. The benefit provision, guideline, standard, or criteria used in making the adverse benefit determination, which is available free of charge, upon request
j. A statement that the requestor, provider, or facility is entitled to receive, upon request and free of charge, how to request, copies of all documents, records, and other information relevant to the adverse benefit determination
k. A description of and how to pursue an internal appeal
l. A description of and how to pursue an external appeal
m. Contact information for an office of health insurance consumer assistance or ombudsman, if available; and
n. The telephone number to be called if there are any questions

**Please note:** New Directions follows URAC and NCQA standards with regards to conducting peer-to-peer conversations. Prior to the initiation of the appeal process, New Directions offers attending physicians and treating practitioners the opportunity to have a clinical discussion with the clinical peer reviewer. Please refer to the respective Health Plan for specific requirements regarding peer-to-peer conversations.

## Appealing Adverse Benefit Determinations

New Directions provides Members/Member representatives, Providers and Facilities the right to appeal adverse benefit determinations in instances where medical necessity criteria were not met.* Claim denials unrelated to medical necessity criteria (e.g., outside of timely filing, coding errors, contractual payment issues, etc.) have a different claims dispute process. Please refer to the Claims Dispute section below for more information about claims disputes.
**Medical necessity appeal inquiries for Medicare and Federal plans should contact the respective health plan.*

Appeal rights and procedures can vary with each policy. Please refer to the initial denial letter for specific appeal rights including but not limited to: what, if any, appeal rights are available, who can request an appeal, where to send appeal requests, and time frames regarding appeal requests and responses. New Directions' role in appeals varies

by plan and group. The information in this document is to be used as a general reference guide.
Appeals can be requested telephonically or in writing. Written requests should include the following information:

- Member's name, certification/identification number, date of birth
- Date(s) of service and procedure/service that is being appealed
- Treating practitioner's name and contact information, including phone and fax number
- Specific reason(s)/rationale for the appeal request; an explanation of why New Directions should reevaluate the adverse benefit determination; and
- Any relevant clinical information that supports the appeal request, such as medical records or other supporting documentation

| Dispute Type | Who Can Request | Submission and Timeframes |
|---|---|---|
| **Expedited Appeal**<br>Used when there is disagreement with an adverse benefit determination based on medical necessity criteria. The expedited appeal option is available when a medical necessity based adverse benefit determination could seriously jeopardize the life or health of the Member. The Member must still be receiving treatment at the requested level of care, and urgency must be demonstrated. | Members/ authorized delegates, providers, facilities (In some instances, an Appointment of Representative (AOR)* form may be required) | **Submission**<br>See Appendix<br><br>**To Request**<br>180 days from the date of the denial<br>(see appendix for policy specific rules on timely filing and submission information)<br><br>**NDBH Response**<br>72 hours |

| | | |
|---|---|---|
| **Standard Appeal**<br>Used when there is disagreement with an adverse benefit determination that was based on medical necessity criteria. The standard appeal option is available for cases that do not meet the criteria to expedite the appeals process. | Members/ authorized delegates, providers, facilities<br>(In some instances, an AOR* form may be required) | **Submission**<br>**Online:** https://webpass.ndbh.com/<br><br>**Phone:** See appendix<br>**Fax:** 816-237-2382<br><br>**Mail:**<br>NDBH – Attention Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729<br><br>**To Request**<br>180 days from the date of the denial (see appendix for policy specific rules on timely filing)<br><br>**NDBH Response**<br>30 calendar days |
| **Claims Dispute**<br>Used to dispute a claim that has been denied for reasons other than not meeting medical necessity criteria. (e.g., contractual payment,<br>coding, and timely filing issues) | Members/ authorized delegates, providers, facilities | Contact the Respective Health Plan for Details |

*AOR gives a provider/facility permission to request an appeal on a member's behalf.

## Non-Medical Necessity Related Claims Dispute Resolution

New Directions Behavioral Health recognizes there may be times when participating providers disagree with the way a claim was adjudicated. If a claim issue cannot be resolved through an initial claim adjustment request, then a written claim dispute inquiry may be needed. This type of request is different than an appeal or grievance. Disputes are defined as a written request from a participating network provider questioning (or disputing) an adjusted claim that was based upon one of the following reasons:

- Reimbursement concerns (the allowed amount is different than a contracted fee schedule amount)
- Authorization penalties
- Maximum daily benefit denials
- Timely filing denials
- Claim bundling/unbundling

- Refund/recoupment of monies

New Directions is committed to provide health plan claim dispute guidance. See appropriate tables noted below.

## Blue Cross Blue Shield Alabama

| BCBSAL Dispute Information (Excludes Medicare and FEP plans) * | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Services:<br>Facilities: 800-760-6852<br>Participating Providers: 877-231-7239<br><br>Online: https://providers.bcbsal.org<br>Portal/Web/pa/resources/policies&guidelines/<br>Provider Appeals<br><br>Mail:<br>Blue Cross and Blue Shield of Alabama Appeals<br>PO Box 10408<br>Birmingham, AL 35202-9562<br>Fax: 205-220-9562 |

## Arkansas Blue Cross Blue Shield (ABCBS) Commercial HMO and PPO

| ABCBS Dispute Information (Excludes Medicare and FEP plans) | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Services: 877-345-5976<br><br>Online: https://www.arkansasbluecross.com/providers<br>Select: View Forms, select Claim Reconsideration Request Form<br><br>Mail:<br>Arkansas Blue Cross and Blue Shield<br>Attn: Medical Re-Review<br>PO Box 3688<br>Little Rock, AR 72203-3688 |

## Arkansas Blue Cross Blue Shield (ABCBS) Federal Employee Program (FEP) (including State of Arkansas Employees)

All claim dispute inquiries should be directed towards Arkansas Blue Cross Blue Shield FEP at phone number 800-482-6655.

## Arkansas Blue Cross Blue Shield (ABCBS) Medicare Advantage (MA)

All claim dispute inquiries should be directed towards Arkansas Blue Cross Blue Shield at phone number 800-827-4814.

## Walmart through Arkansas Blue Cross Blue Shield/Blue Advantage Administrators (BAA)

| Walmart Dispute Information | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Services: 866-823-3790<br><br>Online: https://blueadvantagearkansas.com/contact/customer_service.aspx<br>Select Provider, select Email us (customer service link)<br><br>Mail:<br>Blue Advantage Administrators<br>PO Box 1460<br>Little Rock, AR 72203 |

## Florida Blue PPO including Medicare Advantage

| Florida Blue Dispute Information (Excludes Medicare and FEP plans) | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Services: 800-727-2227<br><br>Online:<br>https://floridablue.com/providers/tools-resources/provider-manual<br><br>Mail:<br>Florida Blue<br>Provider Disputes Department<br>PO Box 43237<br>Jacksonville, FL 32203-3237 |

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## Florida Blue HMO including Medicare Advantage and BlueMedicare Classic Plus HMO available in Hillsborough and Palm Beach Counties

| Florida Blue Dispute Information (Excludes Medicare and FEP plans) | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit Request**<br>Provider Services: 800-727-2227<br><br>Online:<br>https://floridablue.com/providers/tools-resources/provider-manual<br><br>Mail:<br>Florida Blue<br>Provider Disputes Department<br>PO Box 43237<br>Jacksonville, FL 32203-3237 |

Please see the separate appendix section on Florida Blue Federal Employee Program policies.

## Florida Blue Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Florida Blue at 800-333-2227; (https://fepblue.org).

## Florida Blue Medicare Preferred HMO (Florida Blue and BeHealthy)

All claim dispute inquiries should be directed towards Florida Blue at 800-333-2227.

## Blue Cross Blue Shield of Kansas (BCBSKS) PPO

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

## Blue Cross Blue Shield of Kansas (BCBSKS) Solutions/EPO (Exclusive Provider Organization)

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

## Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

## Blue Cross Blue Shield of Kansas (BCBSKS) Medicare Advantage

All claim dispute inquiries should be directed towards Blue Cross Blue Shield of Kansas at (816) 395-3929.

## Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO

| **Blue KC Dispute Information (Excludes Medicare and FEP plans)** | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Hotline: (816) 395-3929<br>Provider claim inquiry: (800) 432-3990<br><br>Online: https://providers.bluekc.com<br><br>For efficient handling of a written request, please complete a Claim Inquiry form. There is an interactive PDF copy of the form in the *Forms* section on our provider portal (see *Contact* \| *Resource Directory*). |

Please refer to the separate appendix sections on Blue KC Medicare and Federal policies.

## Blue Cross Blue Shield of Kansas City (Blue KC) Medicare

All claim dispute inquiries should be directed towards Blue KC at (816) 395-3929.

## Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care, Preferred-Care Blue, BlueSelect & BlueSelect Plus PPO

| Blue KC Dispute Information (Excludes Medicare and FEP plans) | |
|---|---|
| **Claim Dispute**<br>A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | **How to Submit a Request**<br><br>Provider Services: (816) 395-3929, opt 3<br><br>Online: https://providers.bluekc.com/<br><br>For efficient handling of a written request, please complete a Claim Inquiry form. There is an interactive PDF copy of the form in the Forms section on our provider portal (see Contact \| Resource Directory). |

Inquiry disputes for Medicare and Federal plans should be directed towards Blue KC. Please see the separate appendix sections on Blue KC Medicare and Federal policies.

## Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP)

All claim dispute inquiries should be directed towards Blue KC at phone number 800-221-2362.

## Blue Cross and Blue Shield of Michigan (BCBSM) including United Auto Workers Retiree Medical Benefits Trust (URMBT), General Motors (GM) and State of Michigan (SOM)

| BCBSM Dispute Information |
|---|

| Claim Dispute | How to Submit a Request |
|---|---|
| A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | Provider Services:<br><br>Online:<br>https://bcbsm.com/providers/quick-links/manuals.html<br><br>Mail:<br>Blue Cross Complete Claim Appeals<br>PO Box 7355<br>London, KY 40742-7355 |

## Blue Cross Blue Shield of Louisiana (BCBSLA)

| BCBSLA Dispute Information (Excludes Medicare and FEP plans) | |
|---|---|
| **Claim Dispute** | **How to Submit a Request** |
| A written request from a provider for reconsideration of a claim payment, reduction of payment or denial of payment for reasons other than not meeting medical necessity criteria (e.g., timely filing issues, coding, contractual issues, or clinical editing.)<br><br>Claim disputes do not include appeals on behalf of subscribers. This type of appeal is processed in the appropriate Appeals Department - refer to the Member Appeals section of the manual. | Provider Services: (800) 922-8866<br><br>Online:<br>https://providers.bcbsla.com/-/media/Files/Providers/<br><br>Provider Dispute Form: A printable PDF form is available online at www.BCBSLA.com/providers, go to "Resources" and "Forms"<br>Mail:<br>BCBSLA Provider Disputes<br>P.O. Box 98021<br>Baton Rouge, LA 70898-9021<br>(800)991-5638 |

# Section 6: Clinical Programs

## Key Changes Index

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## Philosophy

New Directions' care management philosophy is based on a member-driven approach where we seek to ensure the following:

- A member's needs are determined at the point of access, making certain that member's in need of behavioral health services have access to the full continuum of care.
- Discharge planning begins at the time of admission to ensure clinically appropriate aftercare.
- Recovery is the single most important goal for the behavioral health service delivery system that requires providing member-specific, clinically necessary treatment in the least restrictive environment available.
- A member's treatment is always guided by an individualized treatment plan.
- Coordination of care that requires sharing relevant clinical information is done with appropriate respect for privacy, consistent with all New Directions' policies and applicable laws governing member confidentiality.
- Timely outpatient treatment for behavioral health disorders contributes to symptom reduction and maintenance of treatment outcomes.

## Care Management Program

New Directions' Care Management program collaborates with providers and community health resources to assess, plan, facilitate services and advocate for members. Such

collaboration promotes optimal health outcomes. Our program incorporates member education, improves provider awareness, minimizes fragmentation of care within the health care delivery system and addresses the physical and behavioral health needs of the member.

By serving as a single point of contact, care managers use evidence-based practices to engage members and partner with providers to assist with adherence to treatment and promote recovery. Care Management is a service with an emphasis on:

- Supporting members' efforts to take an active role in developing their treatment plans
- Using a member-centric holistic approach during transitions of levels of care
- Coordinating referrals to providers, community resources and caregivers
- Improving member resiliency, self-management and self-care
- Empowering members to adhere to their treatment plan
- Assisting members to achieve time-limited, individualized, attainable goals

Care Managers are licensed clinicians with expertise in care coordination who serve to empower members to understand how to self-manage their health condition and support them in accessing high-quality health care.

As a New Directions provider, you may request Care Management services for a member. Please see plan or group-specific contact information in the appendix in the back of this manual.

## Care Transitions Activities

Readmissions often occur when members:

- Lack preparedness for self-management roles
- Do not know their discharge plans
- Cannot access providers when problems arise
- Receive minimal input regarding their treatment plans
- Suffer medication errors
- Do not have adequate follow-up treatment

New Directions' Care Transitions activities focus on providing a better member experience, improving the health of populations, and reducing the costs of services by avoiding readmissions and improving the quality of service provided to the member.

Adequate Care Transition activities achieve multiple goals:

- Ensures that members and member support systems understand, and are actively engaged, in the member's individualized treatment plan
- Coordinates care with the member's outpatient behavioral and medical providers
- Addresses barriers to treatment adherence

- Verifies that follow-up care is timely and appropriate to the member's needs.

New Directions' Care Transitions activities:

- Help providers and the member understand the importance of post-hospitalization aftercare
- Increase the scheduling of and attendance at post-discharge follow-up appointments within 7 days
- Increase member understanding, participation and adherence to their treatment plan

## Member Self-Management and Preventive Health Tools

New Directions offers self-management tools, derived from scientific evidence, that provide members with information in the areas of emotional well-being, relationships and health, including:

- Smoking and tobacco use cessation
- Diet, fitness and nutrition
- Healthy eating
- Managing stress
- Addiction
- Emotional health assessments
- Recovery and resiliency
- Treatment monitoring

These materials are available through the www.ndbh.com website and have been evaluated for language that is easy to understand, taking members special needs into account. Self-management tools are reviewed every two years and are updated more frequently if new evidence is available.

Disease-specific preventive health and education tools are also available to providers and members through www.ndbh.com. Evidence-based information is available in the areas of depression, bipolar disorder, ADHD, Autism and other common behavioral health conditions to help members navigate through diagnosis, treatment, questions and concerns. If you would like more information, please see plan or group specific contact information in the appendix in the back of this manual.

# Section 7: Clinical Practice Guidelines

## Key Changes Index

| SECTION | PAGE | CONTENT CHANGE |
|---|---|---|
| 7 | 57-75 | • All CPGs Updated except for "Eating Disorders" |
| | | |
| | | |

## About Clinical Practice Guidelines

New Directions is committed to offering providers information that aligns with evidence-based practice guidelines. We rely on generally accepted standards of medical practice, as defined by credible scientific evidence published in peer-reviewed medical literature and recognized by the appropriate medical community. After gaining input from New Directions clinical staff and the provider community, New Directions' Chief Medical Officer and medical staff conducted research and analysis to develop Clinical Practice Guidelines (CPG) and medical policies.

CPGs provide concise summaries of practice guidelines recommended by New Directions. By providing these guidelines, New Directions encourages all providers to stay updated on best practices and continue improving clinical effectiveness to provide members with the best care possible.

Current CPGs are available on the New Directions' **website** or by mail if requested. CPGs are available for:

**Attention Deficit Hyperactivity Disorder (ADHD)**
- Child and adolescent

**Adult Substance Use**
- Initial assessment

**Adult Bipolar Disorder**

- Acute episode
- Maintenance episode

**Major Depression**

- Initial outpatient treatment of adults

**Eating Disorders**

- Assessment and treatment

**Autism Spectrum Disorders**

- Treatment

**Schizophrenia**

- Treatment

**Opioid Use Disorder**

- Assessment and treatment

**Suicide Risk Assessment**

- Initial assessment

**Anxiety Disorders in Adults (New in 2021)**

- Assessment and treatment

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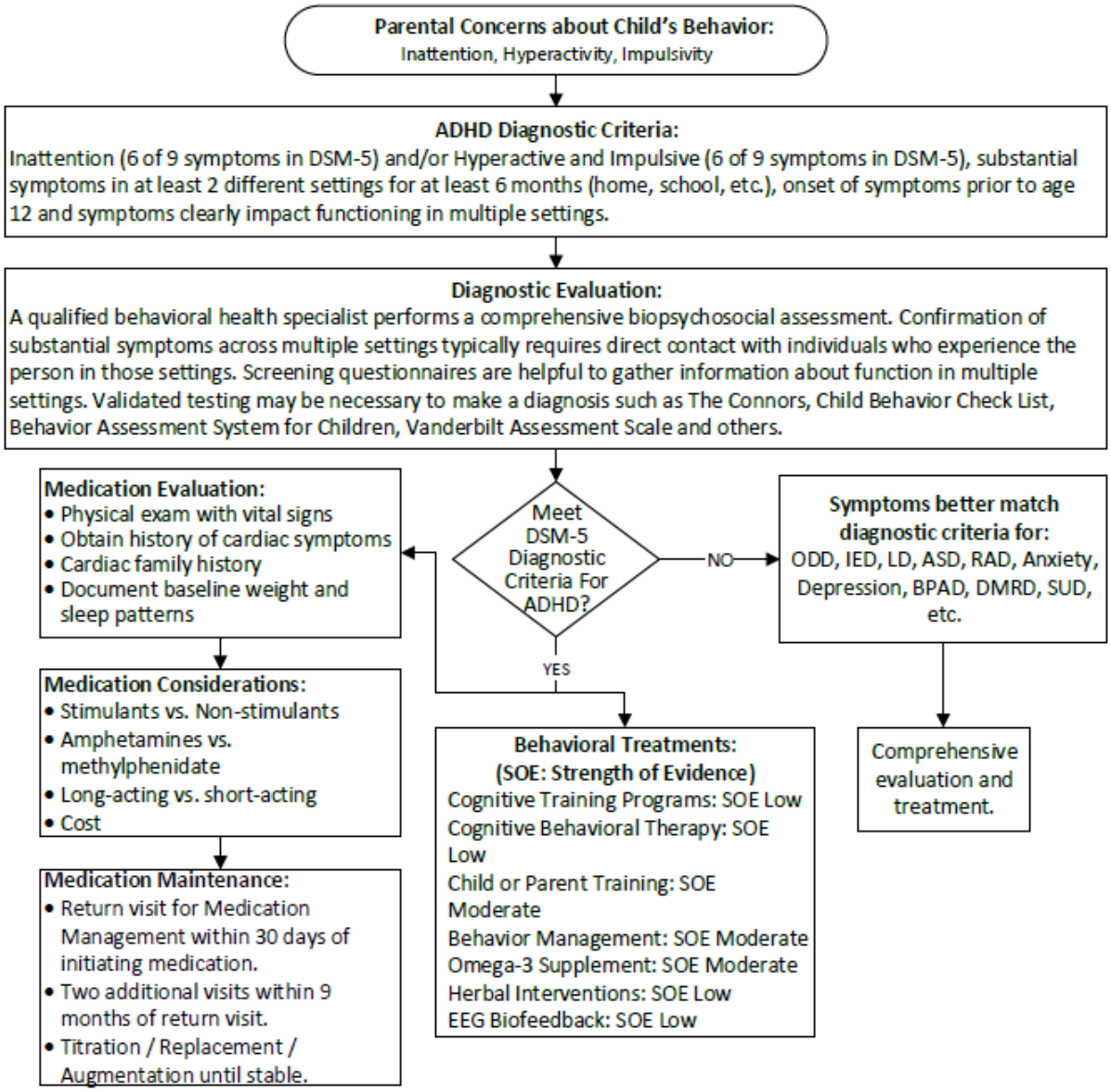
# ADHD Child and Adolescent Clinical Guideline





Kemper AR, Maslow GR, Hill S, Namdari B, Allen LaPointe NM, Goode AP, Coeytaux RR, Befus D, Kosinski AS, Bowen SE, McBroom AJ, Lallinger KR, Sanders GD. Attention Deficit Hyperactivity Disorder: Diagnosis and Treatment in Children and Adolescents. Comparative Effectiveness Review No. 203. (Prepared by the Duke University Evidence-based Practice Center under Contract No. 290-2015-00004-I.) AHRQ Publication No. 18-EHC005-EF. Rockville, MD: Agency for Healthcare Research and Quality; January 2018. Posted final reports are located on the Effective Health Care Program search page. DOI: https://doi.org/10.23970/AHRQEPCCER203.

Attention deficit hyperactivity disorder: diagnosis and management. National Institute for Health and Care Excellence (NICE) Clinical guideline [NG87] Published Date: March 2018. Last Updated: September, 2019. https://www.nice.org.uk/guidance/ng87

Treatment of ADHD. (Last Reviewed: September 21, 2020). Retrieved: January 25, 2021, from https://www.cdc.gov/ncbddd/adhd/treatment.html

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.


Adopted May 2000. Revised: 9/2008, 1/2011, 11/2011, 11/2013, 12/2015, 6/2017, 2/2018, 6/2018, 6/2019, 6/2020. Reviewed annually.

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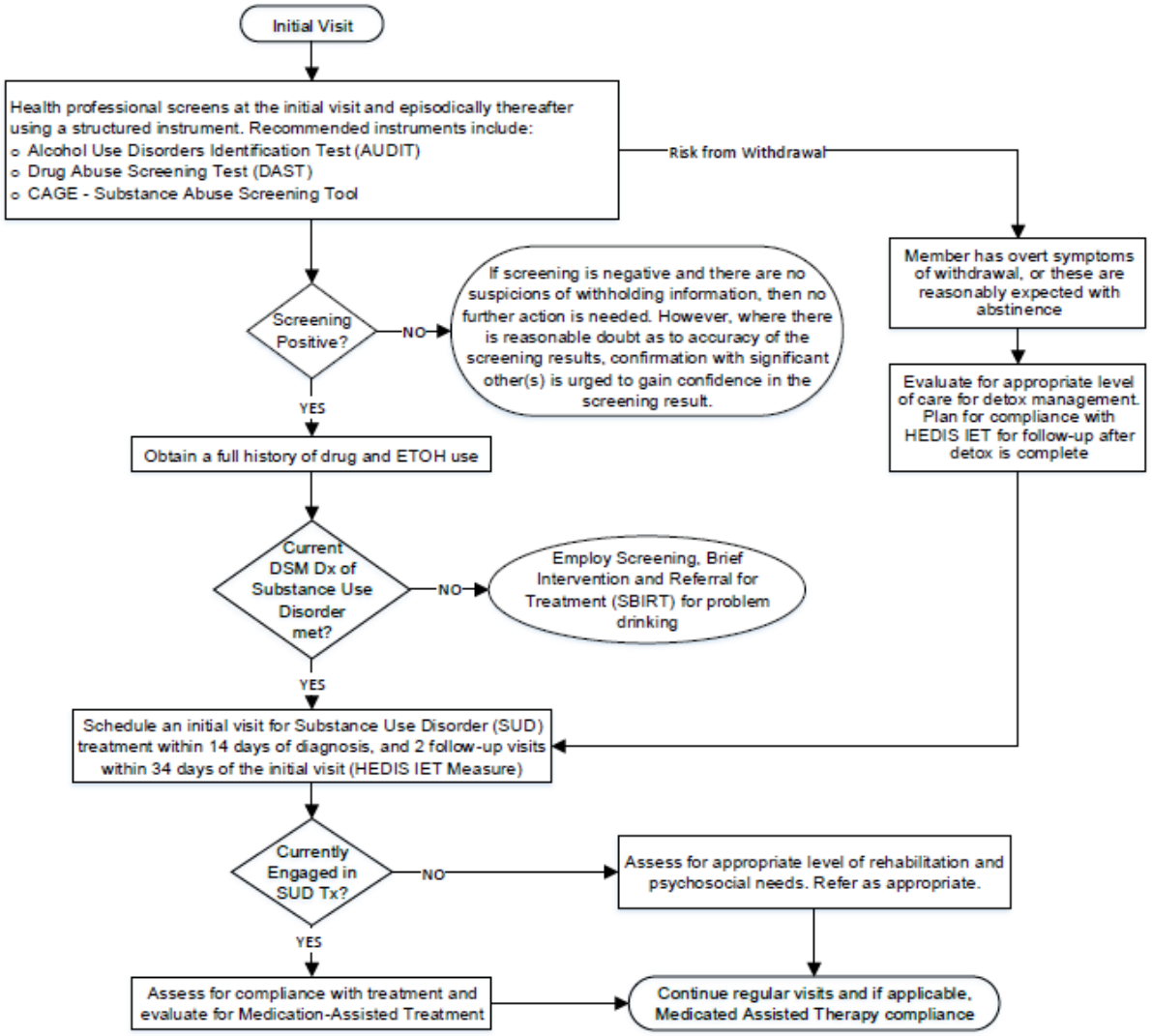
# Adult Substance Abuse Initial Assessment Clinical Guideline




**Screen:** Periodically and routinely screen patients for substance use as well as for substance use dependence. Screening requires only two to four minutes. Use the DAST to screen for drug use. This tool profiles the frequency of substance use behavior. Use the AUDIT-C alone or in combination with the CAGE to screen for alcohol use. AUDIT-C is designed to identify hazardous drinking and focuses on recent drinking behaviors. The CAGE is better at detecting alcohol dependence. These screening tools and scoring instructions can be found at: https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.

**Healthcare Effectiveness Data and Information Set (HEDIS)** is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) is a HEDIS measure. Members meet the measure by initiating treatment within 14 days of (Alcohol or Other Drug) AOD diagnosis and have two or more additional services with a diagnosis of AOD within 34 days of the initiation visit. http://www.ncqa.org/hedis-quality-measurement/hedis-measures

**Screening, Brief Intervention, and Referral to Treatment (SBIRT)** is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse and dependence on alcohol and illicit drugs. https://www.samhsa.gov/sbirt.

**References:**

Drug Misuse Prevention: Targeted Interventions. National Institute for Health and Care Excellence (NICE) Clinical guideline [NG64] Published Date: 2017. https://www.nice.org.uk/guidance/ng64/resources/drug-misuse-prevention-targeted-interventions-pdf-1837573781733

Drug Misuse in over 16s: Psychosocial Interventions. National Institute for Health and Care Excellence (NICE) Clinical guideline [CG51] Original Published Date: 2007. Last Updated: July 2016. https://www.nice.org.uk/guidance/cg51

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Adopted: 12/05. Revised: 06/06, 04/08, 12/09, 04/11, 01/12, 08/14, 06/17, 06/19, 06/20. Reviewed annually.

## Bipolar Disorder Treatment Guideline – Acute Episode

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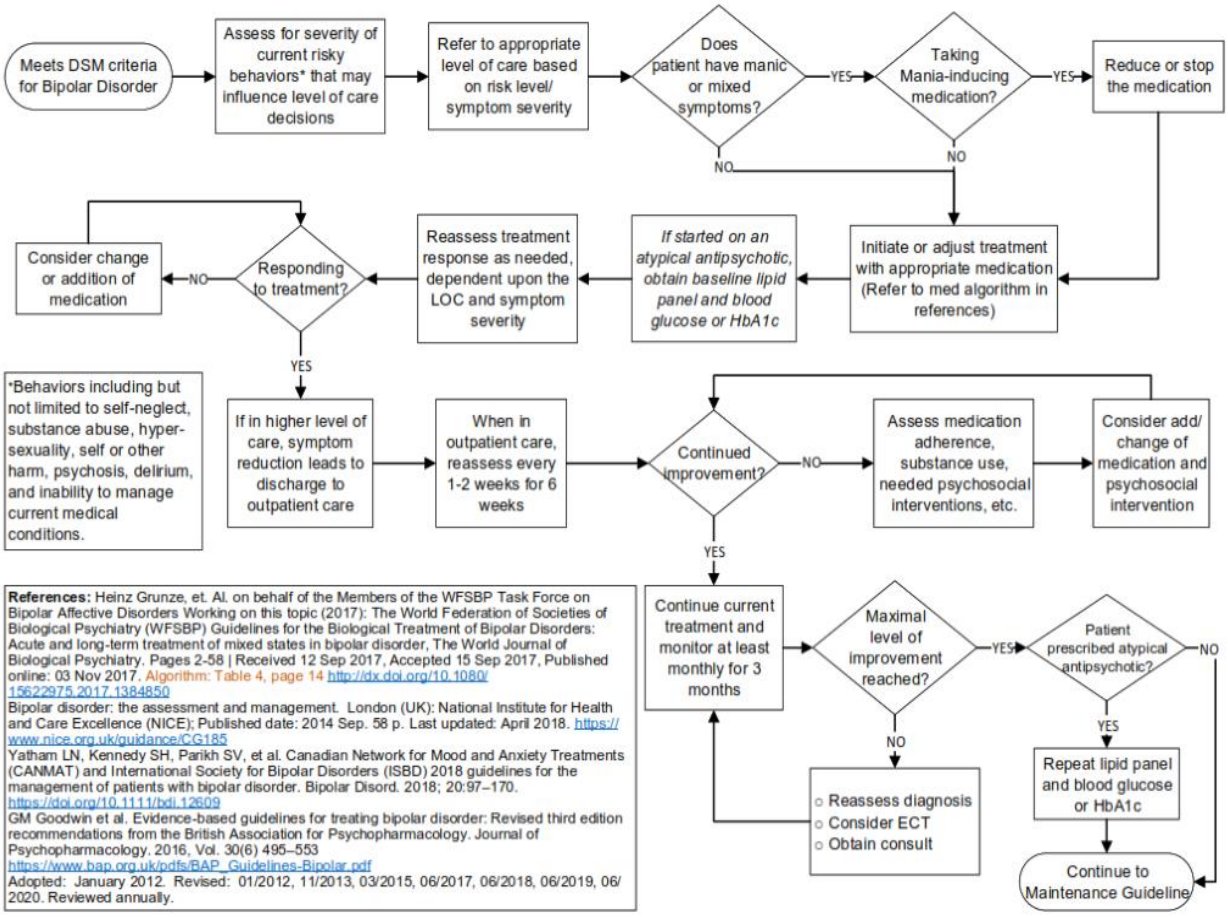



**References:** Heinz Grunze, et. Al. on behalf of the Members of the WFSBP Task Force on Bipolar Affective Disorders Working on this topic (2017): The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Acute and long-term treatment of mixed states in bipolar disorder, The World Journal of Biological Psychiatry. Pages 2-58 | Received 12 Sep 2017, Accepted 15 Sep 2017, Published online: 03 Nov 2017. Algorithm: Table 4, page 14 http://dx.doi.org/10.1080/15622975.2017.1384850

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GM Goodwin et al. Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology. Journal of Psychopharmacology. 2016, Vol. 30(6) 495–553 https://www.bap.org.uk/pdfs/BAP_Guidelines-Bipolar.pdf


Adopted: January 2012. Revised: 01/2012, 11/2013, 03/2015, 06/2017, 06/2018, 06/2019, 06/2020. Reviewed annually.

## Bipolar Disorder Treatment Guideline – Maintenance Episodes

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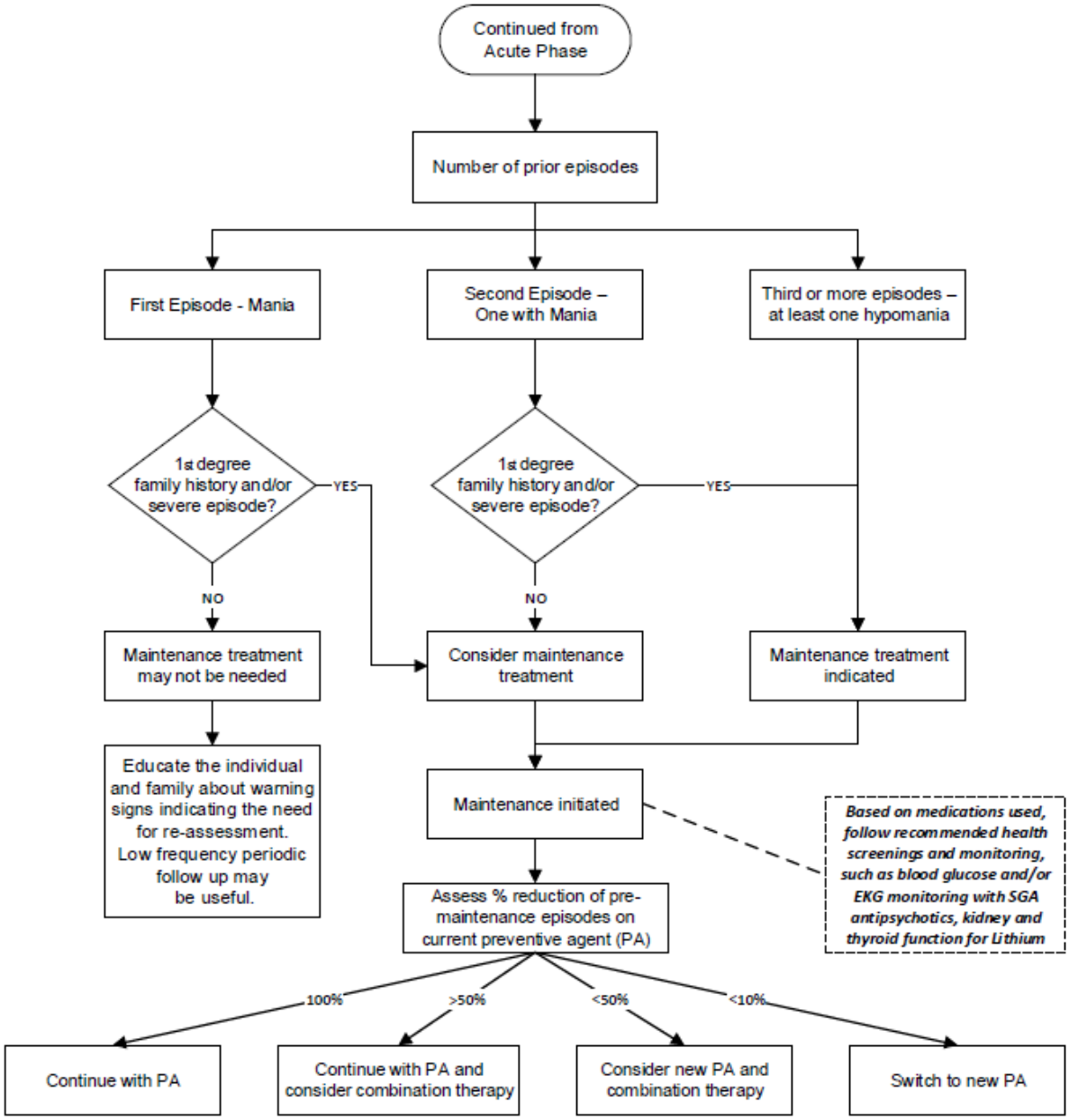


**For specific maintenance medication selection and monitoring, please go to:** Heinz Grunze, et. Al. on behalf of the Members of the WFSBP Task Force on Bipolar Affective Disorders Working on this topic (2017): The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Acute and long-term treatment of mixed states in bipolar disorder, The World Journal of Biological Psychiatry. Pages 2-58 | Received 12 Sep 2017, Accepted 15 Sep 2017, Published online: 03 Nov 2017.
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Adopted: 10/2015 Revised: 06/2017, 06/2018, 06/2021. Reviewed annually.

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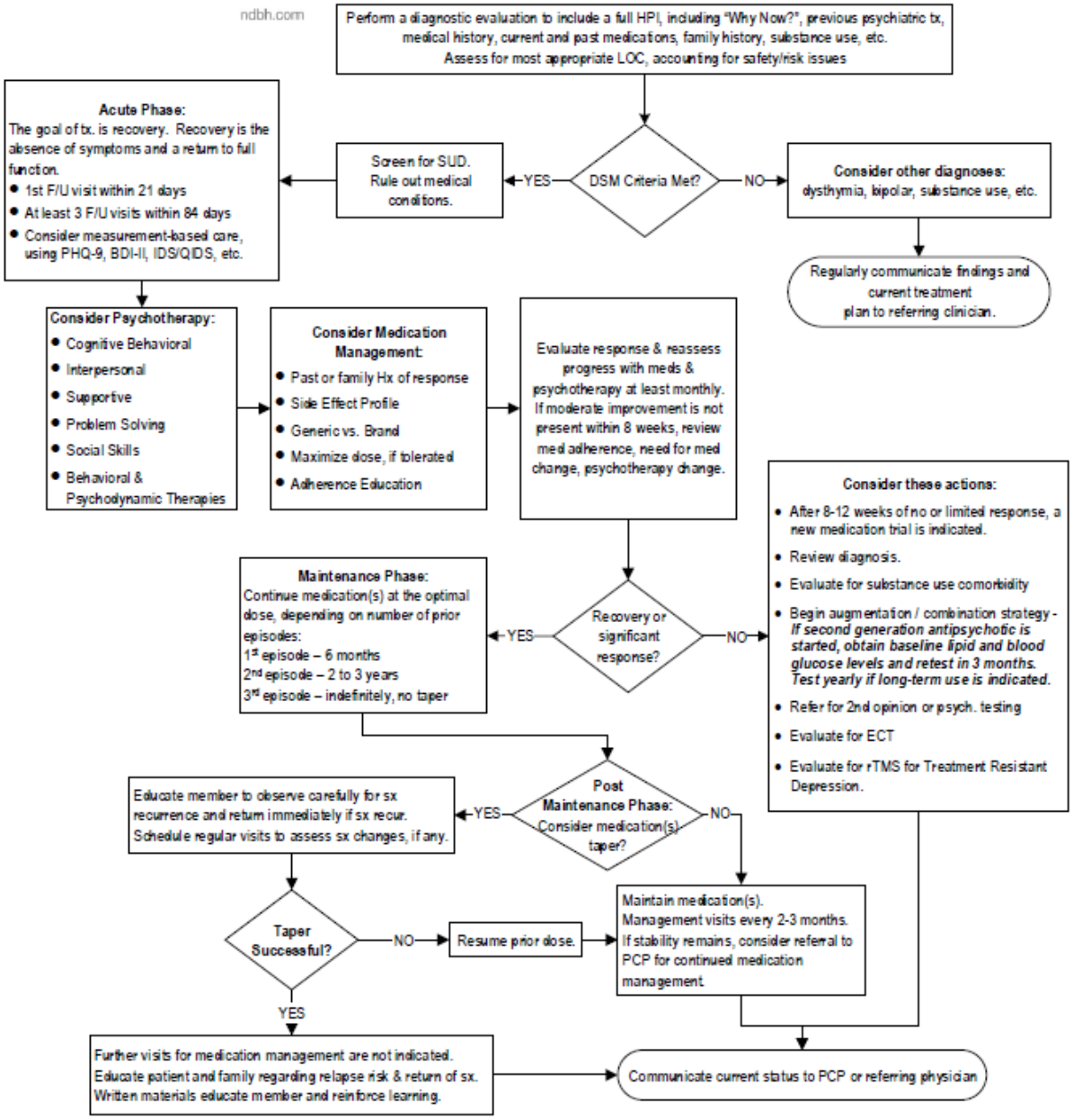
# Major Depression Guideline for Initial Outpatient Treatment of Adults





**Sources:**

2019–2020 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (2020). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration. http://floridabhcenter.org/documents/2019%20Psychotherapeutic%20Medication%20Guidelines%20for%20Adults%20with%20References_06-04-20.pdf

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Developed and adapted by New Directions Behavioral Health. Adopted 5/00. Revised 2/02; 6/05, 6/06, 1/11, 12/12, 7/13, 11/13, 2/15, 11/16, 6/17, 6/18, 6/20. Reviewed annually.

# INTRODUCTION TO NEW DIRECTIONS' ADOPTED CLINICAL PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF EATING DISORDERS

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. Our members have a wide range of mental health diagnoses, including eating disorders. New Directions is committed to providing guidance to providers to align with evidence-based practice guidelines. Our goal is to improve clinical effectiveness and ensure members receive the best care possible.

Clinical Practice Guidelines (CPG) are used to provide guidance for providers who make decisions about appropriate health care for members. CPGs are not a substitute for sound clinical judgement but are intended to enhance compliance with best practice treatment.

New Directions adopted the CPG for the treatment of eating disorders developed in 2017 by the National Institute for Health and Care Excellence (NICE) and the Canadian Practice Guidelines (2020).

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating related behavior that results in altered consumption or absorption of food and that significantly impairs physical health or psychosocial function. Primary eating disorder diagnoses in the DSM-5™ include anorexia nervosa, bulimia nervosa, binge eating disorder (BED), avoidant/restrictive food intake disorder (ARFID) and other specified/unspecified eating disorders.

**Links and References:**


1. Eating disorders: recognition and treatment. National Institute for Health and Care Excellence (NICE) guideline. Published: 23 May 2017. https://www.nice.org.uk/guidance/NG69
2. Canadian practice guidelines for the treatment of children and adolescents with eating disorders. Couturier et al. Journal of Eating Disorders, 2020, 8:4 https://doi.org/10.1186/s40337-020-0277-8
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.


Adopted: 6/2017
Last Updated: 6/2020
Reviewed annually.

# INTRODUCTION TO NEW DIRECTIONS' ADOPTED CLINICAL PRACTICE GUIDELINE CONCERNING BEHAVIORAL THERAPIES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. The members we serve have a wide range of mental health diagnoses, including Autism Spectrum Disorder (ASD). We are committed to offer guidance to providers so they can align with evidence-based practice guidelines. Our goal is to improve clinical effectiveness and provide members with the best care possible.

ASD is a medical, neurobiological, developmental disorder, characterized by three core deficit areas: social interactions, social communications, and restricted, repetitive patterns of behavior. Behavioral therapies are the main form of treatment for ASD. The primary type of behavioral therapy employed at this point is Applied Behavior Analysis (ABA). Although questions linger about the degree of efficacy of ABA, there is evidence of improvement in certain children. Benefit coverage for behavioral therapies to treat symptoms of ASD is often driven by individual state mandates. However, large self-funded groups have increasingly offered this as a benefit.

New Directions manages ABA benefits for various health plans. ABA is the behavioral treatment approach most commonly used for children with ASD. Health plans for which New Directions currently administers the ASD benefit may consider ABA to be experimental/investigational and, therefore, a non-covered service without a controlling state mandate. Techniques based on ABA include discrete trial training, Incidental teaching, pivotal response training, and verbal behavioral intervention.

ABA involves a structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement. The therapy focuses on developing skills related to behavioral deficits and reducing behavioral excesses. Behavioral deficits may occur in the areas of communication, social and adaptive skills, though can exist in other areas as well. Examples of deficits may include lack of expressive language, inability to request items or actions, limited eye contact with others, and inability to engage in age- appropriate self-help skills such as tooth-brushing or dressing. Examples of behavioral excesses may include, but are not limited to, physical aggression, property destruction, elopement, self- stimulatory behavior, self-injurious behavior, and vocal stereotypy.

New Directions adopted Medical Therapies for Children With Autism Spectrum Disorder—An Update, published in May 2017 by the Agency for Healthcare Research and Quality, as a Clinical Practice Guideline (CPG) for ASD. A link is included below.

New Directions' Autism Resource Program manages the benefits for ABA therapies.

The Program's comprehensive array of services include utilization management and care coordination provided by a team of Board-Certified Behavior Analysts, provider and community outreach, and metrics and reporting. The program's leadership is comprised of licensed and experienced clinicians, including medical doctors with specialty designations in psychiatry, licensed clinical social workers, Board Certified Behavior Analysts®, and certified case managers. A New Directions Medical Director and the Clinical Director of Corporate Projects oversee the program. The program is administered by a centralized unit using well-defined evidence based ASD Medical Policies that incorporates treatment guidelines grounded in clinical research. For further information, please contact the Autism Resource Program at 877-563-9347.

New Directions Case Management program assists members with ASD by promoting continuity of care and engaging members and their families to take an active role in developing a plan of care for the member. Case management assists members in accessing needed services, including the Autism Resource Program, and coordinates referrals to providers, community resources, and caregivers. These services improve member resiliency, self-management, and self-care. New Directions' Case Management program is accredited by URAC® and the National Committee for Quality Assurance (NCQA®).

**Literature Citations:**


1. Williamson E, Sathe NA, Andrews JC, Krishnaswami S, McPheeters ML, Fonnesbeck C, Sanders K, Weitlauf A, Warren Z. Medical Therapies for Children With Autism Spectrum Disorder—An Update. Comparative Effectiveness Review No. 189. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2015-00003-I.) AHRQ Publication No. 17-EHC009-EF. Rockville, MD: Agency for Healthcare Research and Quality; May 2017. www.effectivehealthcare.ahrq.gov/reports/final.cfm. doi: https://doi.org/10.23970/AHRQEPCCER189.

There is the full report, and a shorter executive summary:

   a. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/asd-medical_research-2017.pdf (AHRQ Pub. No. 17-EHC009-EF)
   b. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/asd-medical-executive-170505.pdf (AHRQ Publication No. 17-EHC009-1-EF)

2. Autism spectrum disorder in under 19s: recognition, referral and diagnosis. Clinical guideline [CG128] Published date: September 2011. Last updated: December 2017. https://www.nice.org.uk/guidance/cg128
3. Scottish Intercollegiate Guidelines Network (SIGN). Assessment, diagnosis and interventions for autism spectrum disorders. Edinburgh: SIGN; 2016. (SIGN publication no. 145). [June 2016]. Revalidated August 2019 (Validation summary available at SIGN145_Scoping_Report). Available from URL: https://www.sign.ac.uk/assets/sign145.pdf


Adopted: 06-2017
Last Revised: 06-2021
Reviewed annually

# INTRODUCTION TO NEW DIRECTIONS' ADOPTED CLINICAL PRACTICE GUIDELINE ON SCHIZOPHRENIA

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. The members we serve have a wide range of mental health diagnoses, including schizophrenia (SCZ). We are committed to offer guidance to providers so they can align with evidence-based practice guidelines. Our goal is to improve clinical effectiveness and provide members with the best care possible.

This clinical practice guideline will focus on the treatment of SCZ, including first episode of psychosis (FEP). There is a distinction between psychotic symptoms, which can occur in a wide range of psychiatric illnesses, and psychotic disorders, which are defined in the DSM-5™. Psychotic disorders include schizophrenia, schizoaffective disorder, brief psychotic disorder, psychotic disorder due to another medical condition, etc. There are different symptoms and time frames for these various disorders.

The etiology of SCZ is multifactorial and includes biological, social and psychological components. Onset of this illness is typically gradual and generally thought to involve environmental, genetic, and physiological risk factors.

The outcome of SCZ varies from a single episode of illness to a lifelong disease characterized by severe loss of function and neurological deficits. Intensive and structured and targeted treatment after FEP is increasingly considered to positively impact the course of the disorders.

New Directions has adopted the Practice Guideline (CPG) developed The American Psychiatric Association.

EKG monitoring recommended for members on antipsychotics as all antipsychotics are associated with prolongation of QTc interval.

**Links and References:**


1. The American Psychiatric Association Practice Guideline For The Treatment Of Patients With Schizophrenia, Third Edition, American Psychiatric Association, Practice Guidelines. September 2021. https://doi.org/10.1176/appi.books.9780890424841
2. McDonagh MS, Dana T, Selph S, Devine EB, Cantor A, Bougatsos C, Blazina I, Grusing S, Fu R, Kopelovich SL, Monroe-DeVita M, Haupt DW. Treatments for Schizophrenia in Adults: A Systematic Review. Comparative Effectiveness Review No. 198. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 17(18)-EHC031-EF. Rockville, MD: Agency for Healthcare Research and Quality; October 2017. DOI: https://doi.org/10.23970/AHRQEPCCER198.

3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric association, 2013.

Adopted: 6/2017
Last Updated: 6/2021
Reviewed annually.

## NEW DIRECTIONS' ADOPTED CLINICAL PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF OPIOID USE DISORDER

New Directions Behavioral Health® offers a full range of behavioral health solutions. Our members have a wide range of mental health diagnoses, including Opioid-Related Disorders. New Directions is committed to assisting providers with evidence-based practice guidelines to improve clinical effectiveness and ensure members receive the best care possible.

Clinical Practice Guidelines (CPG) are used to provide guidance for providers who make decisions about appropriate care for members. CPGs are not a substitute for sound clinical judgement but are intended to enhance compliance with best practices. This document is not meant to be a standard of care.

Opioid-Related Disorders in the DSM-5™1 include Opioid Use Disorder (OUD), Opioid Intoxication, Opioid Withdrawal, Other Opioid-Induced Disorders and Unspecified Opioid-Related Disorder. This CPG focuses on Opioid Use Disorder. The DSM-5 defines OUD as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two out of 11 criteria within a 12-month period.

This CPG supports using a stepped and integrated care approach. Treatment intensity is continually adjusted to accommodate individual member needs and circumstances over time and recognizes that many individuals may benefit from the ability to move between treatments. New Directions adopted this CPG for the assessment and treatment of OUD based on guidelines developed by The American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use2. These recommendations are primarily relevant for the clinical management of this disorder in adults, including young adults. The ASAM national practice guideline is outlined below (see references for link to full version).

General Treatment Considerations

- Clinicians and members should engage in shared decision-making.
- Psychosocial services, in conjunction with medication-assisted treatment (MAT), are recommended.
- The course of OUD treatment is varied and there is not a direct pathway from drug use to recovery. Some members may return to use and do not require re-induction on MAT, while others may require re-induction and re-stabilization on MAT.

- OUD is a chronic illness; members may have diverse types and durations of treatment over their lifetimes. Different treatment paths occur in different treatment settings (e.g., intensive outpatient, inpatient) and with different MAT medications, along with ancillary psychosocial and recovery support services.
- When possible, coordinate primary care, behavioral health, and wraparound services as needed and desired by the member to address their medical, social and recovery needs. Members with co-occurring physical, mental, and substance use disorders benefit from collaborative care. Members should be educated about the importance of coordination of care. Providers should gain appropriate consents to coordinate care with other treatment to align treatment plans and reduce fragmentation of care.

Assessment & Diagnosis

- Identify urgent medical or psychiatric conditions and refer to appropriate treatment providers
- Medical history and physical exam o Focus on withdrawal signs and symptoms
- Use scales to measure OUD withdrawal symptoms (i.e., COWS)
- Screen for comorbid medical conditions, such as infectious diseases, acute trauma and pregnancy
- Comprehensive physical assessment
- Laboratory testing including urine drug screen, TB, HIV, Hep B&C, pregnancy testing, and others as indicated
- Contraception query
- Mental health assessment for comorbid mental illness or suicidal or homicidal ideation assessment for other substance use disorders (including nicotine use) and treatment history
- Prescribers should check the Prescription Drug Monitoring Program (PDMP) at the initial assessment and throughout ongoing treatment for the purpose of confirming medication adherence and to monitor for the prescribing of other controlled substances.
- Social & environmental factors assessment
- Prescriber should confirm OUD diagnosis

Treatment for Opioid Use Disorder

Medication Assisted Treatment (MAT) for Opioid Use Disorder

- Educate members on the risk and benefits of MAT, document informed consent, educate members about the increased risk for overdose without MAT, upon discharge from withdrawal management or detox, and educate members on the risks of the drug free approach without pharmacological support.
- Use FDA-approved medications for the treatment for Opioid Use Disorder (methadone, buprenorphine, and naltrexone). All FDA-approved medications for the treatment of OUD should be available to all members.
- Consider member preferences, treatment history, current state of illness & treatment setting to determine medication selection. Treatment setting is as important as medications selected.

- Methadone can only be provided in opioid treatment programs (OTPs) and acute care settings (under limited circumstances).
- Buprenorphine can be prescribed by waivered clinicians in any setting, including OTPs and office-based opioid treatment (OBOT) in accordance with the Federal law.
- Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe medication.

- Medication selection is based on the need to manage withdrawal, adverse events, lack of effectiveness, on-going maintenance (manage cravings and relapse prevention) and to improve member's comfort.
  - Withdrawal Management - medication approaches are preferred for withdrawal management vs. abrupt cessation.
    - Methadone administration should be monitored because unsupervised administration can lead to misuse and diversion until the member's clinical response and behavior demonstrates that prescribing non-monitored doses is appropriate.
    - Buprenorphine should not be initiated until there are objective signs of opioid withdrawal to reduce the risk of precipitated withdrawal.
    - Naltrexone, as an oral standalone treatment, has poor adherence. Combination buprenorphine & low dose oral naltrexone to manage withdrawal & facilitate induction to MAT during rehabilitation.
    - Lofexidine is FDA approved to treat opiate withdrawal. This medicine will reduce the intensity of withdrawal symptoms and should be taken for no more than 14 days.
    - Ultra-rapid opioid detoxification (UROD) is NOT recommended, as it is extremely high risk and currently not proven to be an evidence-based practice.
  - Transitioning from one medication to another medication for the treatment of opioid use disorder may be appropriate if the member experiences dangerous or intolerable side effects or is not successful in attaining or maintaining treatment goals.
  - On-going Maintenance
    - Methadone – There is no recommended pharmacological treatment time limit.
    - Buprenorphine – There is no recommended pharmacological treatment time limit.
    - Naltrexone – There is no recommended pharmacological treatment time limit. Extended-release injectable naltrexone is recommended over the oral formulation.

  - Utilize treatment contracts, pill counts, calls backs or other strategies to support adherence and minimize diversion
  - Members who discontinue medication treatment should be made aware of the risks associated with opioid overdose, and especially the increased risk of overdose death if they return to illicit opioid use. Opioid overdose prevention with naloxone should be discussed with member and family.
  - Educate members about the importance of safe storage of MAT medication

- Clinics that provide buprenorphine or naltrexone do not need special emergency protocols, crash carts or other special equipment.
- It is recommended prescribers should have injectable or intranasal naloxone on-site. Clinics that administer naltrexone or buprenorphine should have a written policy and procedure for responding to precipitated withdrawal and medication allergies.
- Make naloxone available to all members with OUD upon initiation of treatment and upon discharge (including co-prescribing naloxone with MAT), as well as encouraging family members to have access to and learn how to administer naloxone.
- On-call services and backup during absences should be available either directly or through contracts or cooperative agreements with other local providers with waivers.
- Qualified medical staff can offer routine medical and psychiatric coverage even without a buprenorphine waiver.
- Benzodiazepine (illicit and prescription) and alcohol use are common in members with OUD, which can present clinical challenges, such as increased risk of respiratory depression and unintentional overdose or death. The prescribing of benzodiazepines or other sedative-hypnotics should be used with caution in members with opioid use disorder, and particularly for members who are prescribed methadone or buprenorphine.
- Members should be offered or referred to psychosocial treatment based on their individual needs. However, a member's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay MAT.
- Motivational interviewing or enhancement can be used to encourage engage in psychosocial treatment services.
- Strategies directed at relapse prevention are an important part of addiction treatment

Emergency Protocols and Safety Concerns:

- Members who discontinue medication treatment should be made aware of the risks associated with opioid overdose, and especially the increased risk of overdose death if they return to illicit opioid use. Opioid overdose prevention with naloxone should be discussed with member and family.
- Educate members about the importance of safe storage of MAT medication
- Clinics that provide buprenorphine or naltrexone do not need special emergency protocols, crash carts or other special equipment.
- It is recommended prescribers should have injectable or intranasal naloxone on-site. Clinics that administer naltrexone or buprenorphine should have a written policy and procedure for responding to precipitated withdrawal and medication allergies.
- Make naloxone available to all members with OUD upon initiation of treatment and upon discharge (including co-prescribing naloxone with MAT), as well as

encouraging family members to have access to and learn how to administer naloxone.
- On-call services and backup during absences should be available either directly or through contracts or cooperative agreements with other local providers with waivers.
- Qualified medical staff can offer routine medical and psychiatric coverage even without a buprenorphine waiver.
- Benzodiazepine (illicit and prescription) and alcohol use are common in members with OUD, which can present clinical challenges, such as increased risk of respiratory depression and unintentional overdose or death. The prescribing of benzodiazepines or other sedative-hypnotics should be used with caution in members with opioid use disorder, and particularly for members who are prescribed methadone or buprenorphine.

Psychosocial Treatment for Opioid Use Disorder:

- Members should be offered or referred to psychosocial treatment based on their individual needs. However, a member's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay MAT.
- Motivational interviewing or enhancement can be used to encourage engage in psychosocial treatment services.
- Strategies directed at relapse prevention are an important part of addiction treatment and should be included in plan of care.
- Psychosocial treatment in conjunction with opioid withdrawal management is recommended and at a minimum should include:
  - Psychosocial needs assessment
  - Supportive individual and/or group counseling
  - Linkages to existing support systems
  - Referrals to community services, social services, and recovery support services (RSS)
  - Tobacco cessation counseling
- Determine frequency of urine drug testing. Drug testing should be used to monitor medication adherence and use of illicit and controlled substances.
- Medical providers should collaborate with behavioral providers.
- Offer education to members and families to combat stigma associated with addiction.

Populations that Require Special Management:

- Pregnant women
- Adolescents
- Individuals with chronic pain
- Co-occurring psychiatric disorders
- In criminal justice system

Members may experience forced treatment termination (e.g., insurance lapse, time in controlled environments that disallow or discriminate against OUD medication like cases in family and drug courts, parole and probation). Recommendations regarding forced treatment termination:

- Develop a policy for termination that the member is made aware of at the initiation of treatment
- Prior to making decision about termination, discuss concerns with member
- Amount of time for termination can vary, in general 30 days is considered a reasonable amount of time, however it is important to verify with state medical boards
- Provide a clear date that treatment will end
- Provide a rationale for termination
- Explain the termination directly and do not delegate to other staff
- Provide education and recommendations regarding treatment moving forward
- Assist with providing referrals to locate a new provider for a transition of care and ensure connection to care, when appropriate
- Inform all staff of the termination
- Keep accurate and detailed documentation
- Provide medical records and send copies to the new provider

**Additional guidance for evidence-based practices in the treatment of substance use disorders can be found within our publication, "Guiding principles in the treatment of substance use disorders"3.**

Links and References:


1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
2. White et al. The ASAM (American Society of Addiction Medicine) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update, 2020,
3. American Society of Addiction Medicine. Adopted by the ASAM Board of Directors December 18, 2019 https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
4. New Directions. Guiding principles in the treatment of substance use disorders. https://www.ndbh.com/docs/ContentManaged/Providers/Resources/Guiding_principles_in_the_treatment_of_SUD_Final2.pdf


Adopted: 12/2019
Last Updated: 06/2021
Reviewed annually

# INTRODUCTION TO NEW DIRECTIONS' ADOPTED CLINICAL PRACTICE GUIDELINE CONCERNING SUICIDE RISK ASSESSMENT

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. The members we serve have a wide range of mental health diagnoses. We are committed to offer guidance to providers about evidence-based practice guidelines. Our goal is to improve clinical effectiveness and provide members with the best care possible. This Clinical Practice Guideline (CPG) is focused on the identification of suicide risk factors, practical and effective safety planning interventions and the role of behavioral health professionals in assessing, intervening and treating suicidal individuals. The goal is to increase member safety, reduce risk and provide competent treatment at the least restrictive level of care to promote wellness and recovery.

New Directions adopted the Department of Veterans Affairs / Department of Defense's (VA/DoD) Clinical Practice Guideline for The Assessment and Management of Patients at Risk for Suicide; Version 2.0 (2019) and National Action Alliance for Suicide Prevention's Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe (2018) as the CPGs for Suicide Risk Assessment.

**Evidence-Based Treatment (EBT) and Best Practices**
Healthcare providers play a crucial role in detecting suicide ideation. Even the most thorough screening and assessment is not able to predict that a member might take his or her own life.

It is essential that all members be thoroughly assessed for suicidal ideation and ensure safety with appropriate actions. While screening and assessment should be standardized, every member is unique. It is incumbent on the clinician to use the screening and assessment processes to establish a collaborative relationship with the member and to ensure his or her safety and well-being.

**Screening**
Screening for suicide risk is a recommended practice for primary care, hospital and emergency department care, behavioral health care and crisis response care. Complete a thorough suicide risk assessment using a brief, evidence-based, standardized tool such as the Columbia-Suicide Severity Rating Scale (CSSRS). Any person who screens positive for possible suicide risk should be formally assessed by behavioral health clinicians.

**Assessment**
Conduct an in-depth suicide risk assessment with individuals who have screened positive for suicidal ideation. Assessment should be standardized to promote a structured, complete and consistent process.

Assess for suicidal ideation, plans, means availability, presence of acute risk factors, history of suicide attempts, as well as for the presence of protective factors. Use direct and specific questions to identify and evaluate suicidal ideation, plan, rehearsals, attempts and intent. Review each member's personal and family medical history. Clinicians also need to be alert to the possibility that a member may be suicidal, despite denying such.

**Risk-Formulation**
Screening and assessment information should be synthesized by an appropriately trained clinician into a risk-formulation that describes the person's risk and serves as the basis for treatment and safety planning.

**Determine Disposition and Interventions**
The risk-formulation should guide interventions. The American Psychiatric Association (2016) states that "when a patient is judged to be at risk, the clinician may use information obtained during the evaluation to determine an appropriate treatment setting and formulate an individualized treatment plan that addresses specific modifiable risk factors and may include heightened observation." The Suicide Prevention Resource Center (2015) states "provide humane and patient-centered care that reduces the need for patient restraint and uses the least restrictive methods possible for keeping patients safe."

When a member develops significant self-destructive impulses, contact with family and/or signification others to alert them to the condition and to build an alliance to help manage this situation is recommended, following privacy guidelines.

Consider potential beneficial and adverse effects of each treatment option along with information about the member's preferences.

Developing a safety plan for what to do when members are suicidal can be helpful and engages the member in identifying ways to actively manage their suicidal behaviors.

Post inpatient hospitalization is a high-risk phase for these members and follow up appointments should be a priority within the first week of discharge.

Individuals with an identified suicide risk should consult with their medical professional to determine if medication is an appropriate treatment option.

Some research has shown that Electroconvulsive Therapy (ECT) can reduce thoughts of and desire to attempt suicide.

Psychotherapies are recommended to manage and reduce suicidal behaviors. These include but are not limited to:

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)

**Medications with FDA Approval to Reduce Suicidal Behavior**

- Lithium Carbonate
- Clozapine

**Resources**

Provide resources, including but not limited to community referrals, crisis line phone numbers, and educational information to all members in a manner that meets their needs (hard copy, electronic, etc.). Two recommended resources:

- https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
- https://zerosuicide.edc.org

**Documentation**

Documentation of decisions regarding the care and referral of members is an important part of quality care. Documentation enables providers to demonstrate the thoroughness of the work performed in the identification, assessment and intervention to manage a member's suicide risk. Carefully and thoroughly document completed, comprehensive evaluations that demonstrate the identification of risk factors, protective factors, additional supporting information, and assessment of the member's suicide risk. If additional courses of action are considered by the clinician, but not chosen, it would be wise to document these and a rationale for the decision not to include in the treatment approach.

Take steps to ensure member privacy as appropriate. Keep abreast of laws and standards regarding confidentiality, member consent, and the release of information. Consult a legal professional, as appropriate.

**References:**


1. Department of Veterans Affairs / Department of Defense (VA/DoD) Clinical Practice Guideline for The Assessment and Management of Patients at Risk for Suicide; Version 2.0 – May 2019. https://www.healthquality.va.gov/guidelines/MH/srb/.
2. National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf


Adopted: 06-2020
Last Updated: 6/2021
Reviewed annually

# NEW DIRECTIONS' CLINICAL PRACTICE GUIDELINE CONCERNING ASSESSMENT AND TREATMENT OF ANXIETY DISORDERS IN ADULTS

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. The members we serve have a wide range of mental health diagnoses, including Anxiety Disorders. We are committed to offer guidance to providers so they can align with evidence-based practice guidelines. Our goal is to improve clinical effectiveness and provide members with the best care possible. This guideline covers panic disorder, social anxiety disorder (SAD) and generalized anxiety disorder (GAD).

**Initial Assessment for a Member Presenting with Anxiety Symptoms:**
There are a variety of screening tools that can provide measurement of symptoms and monitor treatment outcomes. These measurement tools can assist in discerning between the different anxiety disorders in DSM-5, establishing a primary diagnosis (anxiety disorders are often comorbid with each other) and identifying other comorbid disorders. There are well-established diagnostic interviews (see STRUCTURED CLINICAL INTERVIEW below) that generate a reliable and valid diagnosis and have been shown to reduce treatment duration and improve treatment outcomes.

Core symptoms of anxiety are excessive fear, feeling nervous and physical signs and symptoms associated with an increased autonomic nervous system response. These symptoms contribute to behavioral disturbances and dysfunction seen in the disorder. Although fear and nervousness are often internal, the related behavioral disturbances are usually observable: avoidance of places, fear of separation, fear of being scrutinized by others, etc. Many anxiety disorders develop in childhood and adolescence. Females are affected more than males. Anxiety disorders differ from normative fear or anxiety by being excessive and persistent, considered to usually be greater than six months duration and resulting in significant dysfunction.

The practitioner should conduct a comprehensive assessment that does not rely solely on the number, severity and duration of symptoms, but also considers the degree of distress and functional impairment. The aims of assessment are as follows:

- To establish a therapeutic relationship
- To determine if the symptoms are best explained as persistent and excessive anxiety
- To determine the scope and severity of the anxiety
- To determine if DSM-5 diagnostic criteria are met for one or more anxiety disorders
- To consider differential diagnoses if symptoms are not best explained as anxiety or if DSM-5 criteria are not met
- To identify comorbid disorders (Major Depression, Substance Use, etc.) that anxiety may accompany and effect treatment strategies

- To assess psychosocial and lifestyle factors that could predispose and perpetuate the anxiety disorder
- To assess the capacity of the individual to benefit from self-help material independent of the clinician
- To identify response or lack of response in previous treatment
- To assess for presence or absence of self-harm
- To develop an initial treatment plan

**Treatments for Anxiety Disorders:**
Initially, treatment interventions are to address urgent issues like suicidal thoughts and substance use. Initial treatment plan should be developed in collaboration with the member, including psychoeducation on the disorder and treatment options. The initial treatment plan is based on the severity of the disorder, previous response to treatment, availability of psychosocial supports and the member's preferences. Recommended initial treatment options should be based on the severity of symptoms and include cognitive behavioral therapy (CBT) and/or medication.

CBT is recommended for all severity levels. CBT can be delivered face-to-face by an experienced clinician or as guided digital CBT (dCBT), which is CBT accessed by computer, tablet or smartphone application. CBT with an experienced therapist has been studied more than other psychological therapies. The body of evidence suggests that CBT (delivered face-to-face by an experienced clinician or as guided digital CBT) produces no serious adverse effects. However, the nature of CBT treatment involves arousal management, graded exposure, safety response inhibition and other strategies that are uncomfortable for members. CBT may be ineffective or emotionally distressing, both of which may lead to treatment discontinuation and negative attitudes to further trials of CBT. CBT may increase symptomatic distress in the short term, and there is a dropout rate similar to that of antidepressant pharmacotherapy. Cost and access are frequently problematic for members. Monitor for problems and barriers.

Medication should be considered if severity is moderate to severe. Antidepressants, especially the SSRIs (selective serotonin reuptake inhibitor) and, to a lesser extent the SNRIs (serotonin–noradrenaline reuptake inhibitor), are the first-line medications on the bases of efficacy, overall safety and low misuse potential. Pharmacotherapy for anxiety disorders should always be accompanied by instructions for graded exposure to feared situations.

**Other Considerations for Medication with an SSRI** (or an SNRI if SSRIs are ineffective or not tolerated)

People with anxiety are very aware of and concerned about bodily symptoms. They should receive careful education about likely adverse effects (sexual dysfunction, possible weight gain and a sense of apathy commonly occur) and warned that side effects usually occur early in treatment, before benefits are seen. Slow titration of dose is useful to manage this, but gradual dose increases are essential.

In addition, in younger people, there has been an association of SSRIs with suicidal thoughts, but not completed suicide. Clinicians should use particular caution in prescribing any antidepressant in childhood or adolescence.

Tricyclic antidepressants (TCAs) have demonstrated efficacy but their use raises concerns about side effects, tolerability and danger in overdose. TCAs should generally be reserved for patients who have not responded to, or been unable to tolerate, SSRIs and SNRIs.

The irreversible monoamine oxidase inhibitors (MAOIs) have proven efficacy. However, their use in the treatment of these disorders has been limited, due to significant potential adverse effects, the need for dietary restrictions, toxicity in overdose and important pharmacokinetic interactions.

Benzodiazepines have well established anxiolytic effects, but there is concern about their use because of adverse effects (e.g. cognitive impairment, falls and sedation), tolerance and dependence. There is also a potential for abuse. While it is difficult to predict which members will develop a pattern of medication abuse, benzodiazepines should be avoided in those with a previous or current history of substance use. Finally, these medications may interfere with the CBT approach to treatment, especially PRN medication usage. Benzodiazepines may also result in increased sensitivity to feelings of anxiety, requiring high doses and worsening anxiety when discontinued. For all these reasons, they should rarely be a frontline treatment.

Buspirone is a non-sedating anxiolytic, which is indicated for GAD. It appears to work best in mild to moderate cases. It may also useful as an adjunctive medication in the treatment of Panic and Social Anxiety Disorder.

**Evidence-Based/FDA-Approved Medications**

| | Panic Disorder | GAD | SAD |
|---|---|---|---|
| sertraline | FDA | | FDA |
| paroxetine | FDA | FDA | FDA |
| citalopram | | | |
| escitalopram | | FDA | |
| fluoxetine | FDA | | |
| fluvoxamine | | | |
| venlafaxine | FDA | FDA | FDA |
| duloxetine | | FDA | |
| imipramine | FDA | | |
| clomipramine | FDA | | |
| phenelzine | FDA | | |
| tranylcypromine | FDA | | |

It will usually take 4-6 weeks to see improvement, whether cognitive behavioral therapy (CBT) or a medication is used.

The practitioner should reassess the member for severity and duration of symptoms, degree of distress and functional impairment at that point. Keep in mind that symptoms may increase while seeing iterative improvements in functioning – these two things can happen simultaneously. If there is at least partial improvement in either symptom intensity or functionality, continue treatment and monitor for continued progress and potential adverse effects until member is significantly better or has stabilized. If continued treatment does not lead to a degree of overall improvement, or if there is no progress or symptoms worsen after the initial 4-6 weeks, consider and explore the following:

- Check adherence and review therapeutic engagement
- Rule out medication related effects as a cause for current symptoms
- Review treatment goals and expectations
- Verify that treatment provided was consistent with guidelines
- Re-evaluate case conceptualization and re-assess comorbidities (e.g. depression, substance misuse, personality difficulties)
- Modify treatment according to initial treatment choice. Examples: If initial treatment was dCBT, then change to face-to-face CBT or add medication. If initial treatment was face-to-face CBT, then add medication. If initial treatment was medication, then add CBT or increase medication dose or both.

Anxiety disorders are common, complex and often with multiple comorbidities. They are treatable. In independent clinical trials, both CBT and SSRIs/SNRIs led to loss of diagnosis in about half of the participants.

**STRUCTURED CLINICAL INTERVIEW MEASURES[1]:**

- Structured Clinical Interview for Axis 1 DSM-IV Disorders (First et al., 1997)
- Anxiety Disorders Interview Schedule (Brown and Barlow, 2014)
- Composite International Diagnostic Interview (Kessler and Ustun, 2004)
- Mini-International Neuropsychiatric Interview (Sheehan et al., 1998)

**Literature Citations:**


1. Andrews, G., Bell, C., Boyce, P., Gale, C., Lampe, L., Marwat, O., … Wilkins, G. (2018). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder. *Australian & New Zealand Journal of Psychiatry*, *52*(12), 1109–1172. https://doi.org/10.1177/0004867418799453
2. Generalised anxiety disorder and panic disorder in adults: management. NICE (National Institute for Health and Care Excellence) Clinical guideline [CG113] Published date: 26 January 2011. Last updated: 26 July 2019. https://www.nice.org.uk/guidance/cg113
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.


Adopted: 12-2020
Reviewed Annually.

# Section 8: Clinical Practice Bulletins

## Key Changes Index

| SECTION | PAGE | CONTENT CHANGE |
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New Directions is committed to partnership with our providers and facilities in their treatment of members with substance use and mental health disorders. This partnership ensures members have access to timely, appropriate treatment. One of our roles in this partnership is to provide up-to-date, evidence-based best practice provider resource tools and models. Best practice models are no substitute for sound clinical judgment but are intended to enhance compliance with current best practice treatments with a focus on positive member outcomes.

Click on the links below to access New Directions Clinical Best Practice Resources:

Guiding principles in the treatment of Substance Use Disorders

Provider Telehealth Care Standards - To access the Provider Telehealth Care Standards document, please visit the provider section of our website → select the applicable health plan → click “Provider Resources” → view “Telehealth” documents.

# Section 9: Fraud, Waste and Abuse

## Key Changes Index

| SECTION | PAGE | CONTENT CHANGE |
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## New Directions Policy

New Directions is committed to preventing, identifying, investigating and reporting fraud and abuse. The Compliance Department provides education on what types of activities constitute fraud and abuse. Examples are outlined below. New Directions regularly monitors and audits claims, and reports cases of fraud and/or abuse to the appropriate Plan or governmental agency. New Directions expects its Providers and Facilities to comply with all applicable state and federal laws pertaining to fraud and abuse.

## Definitions

"**Fraud**" means an intentional deception or misrepresentation made by a person/entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, or some other person/entity. It includes any act that constitutes fraud under applicable federal and state law.

"**Waste**" means the unintentional, thoughtless or careless expenditures, consumption, mismanagement, use or squandering of health plan, federal or state resources. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

"**Abuse**" means practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the health plan and/or government programs, in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the health plan, Medicare, or FEP programs.

Examples of fraud and abuse include:

- Billing for services or procedures that have not been provided
- Submitting false information about services performed up-coding services provided
- Making a false statement or misrepresenting a material fact in any application for any benefit or payment
- Presenting a claim for services when the individual who furnished the service was not appropriately licensed
- Failing to return an overpayment within 60 days after the later of either the date on which the overpayment was identified or the date any corresponding cost report was due
- Providing or ordering medically unnecessary services or tests

## Audits

New Directions performs random audits of provider and facility claims and medical records to identify fraudulent billing practices. Other entities also conduct audits. No specific intent to defraud is required to find that a violation of a law occurred. The OIG has developed the Compliance Resource Portal, which is an excellent resource on fraud and abuse.

New Directions expects its providers and facilities will fully cooperate and participate with all audit requests. This includes, but is not limited to, allowing New Directions access to member treatment records and progress notes, and permitting New Directions to conduct on-site audits or desk reviews.

## Claim Recoupment and Appeals

Upon the results of a claim audit analysis and/or Claims Integrity review, New Directions reserves the right to recoup claims that may have been paid incorrectly or paid pursuant to billing practices that did not adhere to New Directions' or the applicable plan's billing policies and procedures.

Post-payment audit appeals:

A. First-Level appeal: Services denied as a part of the post-pay audit process may be appealed in writing within 45 days of receipt of the findings. Written notification of appeal, specific claim lines being appealed, and any additional supporting

documentation should be provided with the appeal. The appeal will be reviewed by a member of New Directions Claims Integrity Management. Documentation with edits or corrections will not be accepted as part of the appeal. Submit the appeal as instructed in the letter containing the determination.

B. Second-Level Appeal: A provider may request a second and final appeal in writing within 45 days of receipt of the first-level appeal determination. Written notification of appeal, specific claim lines being appealed, and any additional supporting documentation should be provided with the appeal. The second and final appeal determination will be made by a New Directions Medical Director or Independent Review Organization (IRO) within 45 days of receipt of the appeal. Documentation with edits or corrections will not be accepted as part of the appeal. Submit the appeal as instructed in the letter containing the determination.

## Excluded Persons

Providers and facilities who participate in federally funded health care programs must determine whether their employees and contractors are excluded from participating in such programs. It is considered fraud for a provider or facility that has been excluded from a federally funded health care program to submit a claim for services. The Department of Health and Human Services (HHS), through the Office of Inspector General (OIG), maintains the List of Excluded Individuals/Entities (LEIE). This list may be accessed online here. Providers and facilities are required to search this website at least monthly to identify workforce members who are excluded from Federally funded health care programs. Excluded individuals must be promptly removed from work involving Federal and State health care programs.

# Section 10: Billing Assistance

## Key Changes Index

| SECTION | PAGE | CONTENT CHANGE |
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## Billing and Missed Appointments

New Directions does not authorize payment to providers for missed appointments, nor may a member be billed unless he or she has agreed, in writing and prior to beginning treatment with the provider, to pay out of pocket for any missed appointments.

## Psychiatric Diagnostic Evaluations

For psychiatric diagnostic evaluation with medical services, routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not considered medically necessary. A psychiatric diagnostic evaluation can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

## Medication-Assisted Treatment (MAT) Services

MAT services are only reimbursable in an outpatient setting. Facilities may not be reimbursed when the MAT services are conducted in a facility setting, such as Acute Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Services.

## Maximum Visits per Day

Benefits will be authorized for only 1 professional unit per day unless a plan specifies otherwise, except for the following combined services:

- Outpatient psychotherapy or group therapy with a non-psychiatrist provider plus medication management with a psychiatrist on the same day
- Outpatient psychotherapy or evaluation plus psychological testing on the same day
- Outpatient individual psychotherapy and group therapy on the same day by different providers

## Concurrent and Overlapping Services

Providers should not bill concurrent services, including two or more direct services being delivered at the same time to the same member. Additionally, providers should not deliver overlapping services, meaning delivering non-group services to more than one Member at the same time.

## Billing Submission

Ensure that documentation supports the number of units and/or time-based coding billed.

Services may only be billed in whole units. Partial units will not be accepted. For time-based codes, please refer to the CPT time rule below. Only the provider rendering the face-to-face session with a member can bill for that service. Unless present for the entire session, providers may not bill for services rendered by interns and provisionally licensed providers. Applied Behavior Analysis (ABA) services documentation guidelines are provided within this section.

## CPT Time Rule

Please refer to the most recent version of the CPT Manual for the latest information regarding billing codes. According to the CPT Manual, time is defined as the face-to-face time spent with the member. A unit of time is attained when the midpoint is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty). A second hour is attained when 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.

Coding Outpatient Psychotherapy Sessions Provided Without E/M Services

| Actual length of session | Code As | Code Description |
|---|---|---|
| 0-15 minutes | Not reported | - |
| 16-37 minutes | 90832 | 30 minutes |
| 38-52 minutes | 90834 | 45 minutes |
| 53-89 minutes | 90837 | 60 minutes |

*2017 CPT Manual, Page xv-xvi*

## Common Billable CPT and Revenue Codes

Below is a list of commonly billed codes. Please refer to the most recent version of the CPT Manual and your fee schedule regarding qualified providers for each service.

| Service Code | Treatment Description |
|---|---|
| **Psychotherapy Service Codes** | |
| +90785 | Interactive complexity |
| 90791 | Psychiatric diagnostic evaluation (no medical services) |
| 90792 | Psychiatric diagnostic evaluation (with medical services) |
| 90832 | Psychotherapy, 30 minutes with patient |
| +90833 | Psychotherapy, 30 minutes with patient with E/M Service |
| 90834 | Psychotherapy, 45 minutes with patient |
| +90836 | Psychotherapy, 45 minutes with patient when performed with E/M Service |
| 90837 | Psychotherapy, 60 minutes with patient |
| +90838 | Psychotherapy, 60 minutes with patient when performed with E/M Service |
| 90839 | Psychotherapy for crisis, first 60 minutes |
| +90840 | Psychotherapy for crisis, each additional 30 minutes |
| 90845 | Psychoanalysis |
| 90846 | Family Psychotherapy without Patient Present, 50 minutes |

| | |
|---|---|
| 90847 | Family Psychotherapy with Patient Present, 50 minutes |
| 90853 | Group Psychotherapy |

**Psychotherapy and Psych Testing Codes**

| Service Code | Treatment Description |
|---|---|

**Psychological/Neuropsychological Testing**

Test Evaluation Services

| | |
|---|---|
| **96130** | Psychological Testing Evaluation services by physician or qualifying health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member (s) or caregiver (s), when performed, first hour |
| **+96131** | Each additional hour (List separately in addition to code for primary procedure) |
| **96132** | Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member (s) or caregiver (s), when performed, first hour |
| **+96133** | Each additional hour (List separately in addition to code for primary procedure) |

Test Administration and Scoring

| | |
|---|---|
| **96136** | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes |
| **+96137** | Each additional 30 minutes (List separately in addition to code for primary procedure) |
| **96138** | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes |

| | |
|---|---|
| **+96139** | Each additional 30 minutes (List separately in addition to code for primary procedure) |

Automated Testing and Result

| | |
|---|---|
| **96146** | Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only |

Neurobehavioral Status Exam

| | |
|---|---|
| **96116** | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour |
| **+96121** | Each additional hour (List separately in addition to code for primary procedure) |

"+" Indicates an Add-On Code to be reported with another code
*APA 2019 Psychological and Neuropsychological Testing CPT Codes & Descriptions may be accessed ***here***

## ABA CPT Code Crosswalk

| Codes Prior to 01/01/19 | Units Prior to 01/01/19 | Mapped Codes as of 01/01/19 | Units | Current Descriptor | Mapping Notes |
|---|---|---|---|---|---|
| **0359T** | Untimed | **97151** | 15 min | Behavior identification assessment (15min) | Treatment Assessment |
| **0360T/0361T** | 30 min | **97152** | 15 min | Behavior identification supporting assessment (15min) | Additional observation |
| **0362T/0363T** | 30 min | **0362T** | 15 min | Behavior identification supporting assessment with four components (15min) | Exposure Code - observation |

| | | | | | |
|---|---|---|---|---|---|
| **0364T/0365T** | 30 min | **97153** | 15 min | Adaptive behavior treatment by protocol (15min) | 1:1 by protocol |
| **0366T/0367T** | 30 min | **97154** | 15 min | Group adaptive behavior treatment by protocol (15m) | Group by protocol |
| **0368T/0369T** | 30 min | **97155** | 15 min | Adaptive behavior treatment with protocol modification (15min) | 1:1 or tech supervision with protocol modification |
| **0368T/0369T** | 30 min | **97156** | 15 min | Mapped to 0370T for parent training aspect | Parent training with patient present |
| **0370T** | 1 hour | **97156** | 15 min | Family adaptive behavior treatment guidance (15 min) | Parent training w/o patient present |
| **0371T** | 1 hour | **97157** | 15 min | Multiple-family group adaptive behavior treatment guidance (15 min) | Group parent training |
| **0372T** | 1 hour | **97158** | 15 min | Group adaptive behavior treatment with protocol modification (15m) | Group Treatment with protocol modification |
| **0373T/0374T** | 1 hour/30 min | **0373T** | 15 min | Adaptive behavior treatment with protocol modification with four components (15min) | Exposure Code - Treatment with protocol modification |

| **ABA DOCUMENTATION REQUIREMENTS** | |
|---|---|
| **REQUEST FOR AUTHORIZATION AND TREATMENT PLAN** | A comprehensive medical record is submitted by the Behavior Analyst to request authorization that includes:<br>• All initial assessments performed by the BCBA. Preferred assessments include the ABLLS, VB-MAPP, and any other developmental measurements employed;<br>• Individualized treatment plan with measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD*;*<br>• Goals should be written with measurable criteria such that they can be reasonably achieved within six months;<br>• Goals should include documentation of core symptoms of ASD in the treatment plan, date of treatment introduction, estimated date of mastery, and a specific plan for generalization of skills;<br>• Functional Behavior Assessment to address targeted problematic behaviors and provide data to measure progress, as clinically indicated; (f) Documentation of treatment participants, procedures and setting. |

| | |
|---|---|
| **GENERAL GUIDELINES FOR TREATMENT NOTES** | A service is an action taken by a qualified provider in order to alleviate maladaptive behaviors including impaired social skills and communication, destructive behaviors or additional functional limitations.<br><br>• Each service billed must have face-to-face encounter note that contains:<br>o reason for the member's visit;<br>o objective and subjective documentation of the patient's presentation;<br>o goal of the service rendered on the date billed and how it is connected to the treatment plan;<br>o procedure code and specific service rendered;<br>o date of service with start/stop time and/or duration of service that matches units and time-based CPT code billed;<br>o summary of the intervention/service provided with the member response;<br>o documentation of coordination of care (when applicable);<br>o identified rendering provider including BCBA, line therapists, and behavioral technicians;<br>o signature of rendering provider with professional degree and/or professional credentials;<br>o no repetitive, rote, or cloned charting;<br>o only those terms and abbreviations that are or should be comprehensible to other medical professionals; (l) and is legible. |

| | **TIMED BASED CPT CODES** |
|---|---|
| **CPT DEFINITION OF TIME SPENT WITH PATIENT THAT IS ELIGIBLE FOR REIMBURSEMENT** | Face-to-face time is for direct services with interventions and includes:<br>a. Time spent with patient<br>b. Time spent with family<br>c. Time spent with patient and family<br>The non-face-to-face time (activities that may occur before, during or after a visit) is included in the work delivering the service for each CPT code reimbursement. These non-face-to-face activities are therefore not eligible for claims submission, independent of face-to-face time. These non-reimbursable events include such activities as: review of records, arranging further services, communicating with the professionals, the patient or the family through written reports and telephone contact, and other non-face-to-face activities. |

## ASSESSMENT CODES

Essential Elements of Applied Behavior Analysis Services:

Development of individualized treatment plan by supervising behavior analyst/Qualified Health Professional

Qualified Healthcare Professionals (QHP) include the following: Licensed Behavior Analyst, Behavior Analyst-Doctoral, Behavior Analyst, or other credentialed professional who is qualified by education and training, and performsapplied behavior analysis within his/her scope of practice.

- Review of file information about client's medical status, prior assessments, prior treatments;
- Stakeholder interviews and rating scales;
- Review of assessments by other professionals;
- Direct observation and measurement of client behavior in structured and unstructured situations
- Determination of baseline levels of adaptive and maladaptive behaviors;
- Functional behavior analysis

| | CPT CODES DESCRIPTIONS |
|---|---|
| **97151 BEHAVIOR IDENTIFICATION ASSESSMENT** | **General Description:** Assessment for treatment plan development<br><br>**Descriptor:** Service administered by a **physician or other qualified healthcare professional**, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.<br><br>Time/Units=per 15 minutes<br>Attended By=client, QHP* |
| **97152 BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT** | **General Description:** Assessment for treatment plan development<br><br>**Descriptor:** Administered by one **technician** under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=client, technician (QHP* may substitute for the technician) |

| | |
|---|---|
| **0362T**<br>**BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT** | **General Description:** Functional analysis of severe maladaptive behaviors in specialized settings<br><br>**Descriptor:** each 15 minutes of **technicians'** time face-to-face with a patient, requiring the following components:<br>• Administered by the **physician or other qualified healthcare professional who is on site** (defined as immediately available and interruptible to provider assistance and direction throughout the performance of the procedure; however, the physician or other QHP does not need to be present in the room when the procedure is performed;<br>• With the assistance of two or more technicians;<br>• For a patient who exhibits destructive behavior;<br>• Completed in an environment that is customized to the patient's behavior.<br><br>Time/Units=per 15 minutes<br>Attended By=client and 2 or more technicians; QHP* |

## TREATMENT CODES

Essential Elements of Applied Behavior Analysis Services:

- Training technicians to
  a) Carry out treatment protocols accurately, frequently, and consistently;
  b) Record data on treatment targets;
  c) Record notes;
  d) Summarize and graph data.
- Training family members and other caregivers to implement selected aspects of treatment plan.
- Ongoing direction of technician.
- Ongoing, frequent review and analysis of direct observational data on treatment targets.
- Modification of treatment targets and protocols based on data.
- Training technicians, family members, and other caregivers to implement revised protocols.

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| **97153**<br>**ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL** | **General Description:** Direct Treatment.<br><br>**Descriptor:** Service administered by Technician under the direction of a physician or other QHP*, face-to-face with one patient, each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=client, technician (QHP* may substitute for the technician) |

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| **0373T**<br>**ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION** | **General Description:** Direct treatment of severe maladaptive behavior in specialized settings.<br><br>**Descriptor:** each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:<br>• Administered by the physician or other QHP* who is on site (defined as immediately available and interruptible to provider assistance and direction throughout the performance of the procedure; however, the physician or other QHP does not need to be present in the room when the procedure is performed.);<br>• With the assistance of two or more technicians;<br>• For a patient who exhibits destructive behavior;<br>• Completed in an environment that is customized to the patient's behavior<br><br>Time/Units=per 15 minutes<br>Attended By=client and 2 or more technicians; QHP* on site |
| **97154**<br>**GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL** | **General Description:** Group Treatment<br><br>**Descriptor:** Service administered by **technician** under the direction of a physician or other QHP*, face-to-face with two or more patients, each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=two or more clients, technician (QHP* may substitute for the technician) |
| **97158**<br>**GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION** | **General Description:** Group Treatment<br><br>**Descriptor:** Service administered by a **physician or other QHP*,** face-to-face with multiple patients, each 15 minutes. Active protocol modification must occur every 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=two or more clients and QHP* |

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| **97155**<br>**ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION** | **General Description:** Direct Treatment by QHP*<br><br>**Descriptor:** Service administered by **physician or other QHP*** which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=client, QHP*, may include technician and/or caregiver |

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| **97156**<br>**FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE** | **General Description:** Family Training<br><br>**Descriptor:** Service administered by **physician or other QHP*** (with or without the patient present), face-to-face with guardians(s)/caregiver(s), each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=caregiver and QHP* |
| **97157**<br>**MULTIPLE-FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE** | **General Description:** Family Training<br><br>**Descriptor:** Service administered by **physician or other QHP*** (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.<br><br>Time/Units=per 15 minutes<br>Attended By=caregivers of two or more clients and QHP* |

# Diagnostic and Billing Codes effective 01/01/19

## ICD-10 Codes

| | |
|---|---|
| **F84.0** | **Autistic Disorder** |
| **F84.3** | **Other Childhood Disintegrative Disorder** |
| **F84.5** | **Asperger Disorder** |
| **F84.8** | **Other Pervasive Developmental Disorder** |
| **F84.9** | **Pervasive Developmental Disorder, unspecified** |

ABA Services that require two or more staff members will only be billed as one service provided by the rendering provider.

**CPT Codes**

All ABA codes are billed in 15-minute units. “If the BCBA or other qualified health care professional personally performs the line technician activities, his or her time engaged in these activities should be included as part of the line technician’s time to meet the components of the code.” AMA CPT, 2019

**97151 BEHAVIOR IDENTIFICATION ASSESSMENT**

- Conducted by BCBA or qualified health care professional
  - Face to face member assessment component
  - Review of history of current and past behavioral functioning
  - Review of previous assessments and health records
  - Interview parent/caregiver to further identify and define deficient adaptive or maladaptive behaviors
  - Administration of non-standardized tests such as VB-MAPP, ABLLS, EFL
  - Administration of standardized tests such as the Vineland, PDDBI, and ABAS
  - Interpretation of results
  - Discussions of findings and recommendations with primary caregiver(s)

- Preparation of report
- Development of care plan and which may include behavior identification supporting assessment (97152) or behavior identification assessment with four required components (0362T)
-

**97152 BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT**

- Face to Face with member
- May include collection of data for functional behavior assessment, functional analysis, or other structured procedures
- Utilized to evaluate deficient adaptive behavior(s) maladaptive behavior(s), or other impaired functioning in the following:
  - Communication: receptive and expressive language, echolalia, lack of pragmatic language, visual understanding, requests and labeling
  - Social behavior: lack of empathy, lack of social reciprocity, little or no functional play skills cooperation, motivation, imitation, play and leisure, and social interactions
  - Ritualistic and repetitive behaviors and self-injurious behaviors
- Line Therapist may complete under direction of BCBA, qualified professional off-site.
- The time that the member is face to face with the line therapist(s) correlates with the physician's or other qualified health care professional's work, which includes: technician direction; analysis of results of testing and data collection; preparation of report and plan of care; and discussion of findings and recommendations with the primary guardian(s)/ caregiver(s)
- Requires clinical rationale for need

**97153 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL**

- May be administered by a line therapist
- Face to face with one member
- BCBA or qualified health care provider directs service by:
  - Designing treatment plan goals and objectives
  - Analyzing data
  - Determining whether use of treatment goals and objectives is producing adequate progress

**97154 GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL**

- May be administered by a line therapist
- Face to face with two or more members
- BCBA or qualified health care provider directs service by:
  - Designing treatment plan- goals and objectives
  - Analyzing data
  - Observation of treatment implementation for potential program revision,
  - Determining whether use of treatment goals and objectives is producing adequate progress
  - Maximum member per group - 8

**97155 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION**

- Administered by BCBA or qualified health care professional
- Face to face with a single member or member and line technician
- Resolves one or more problems with the protocol and may simultaneously direct a line technician in administering the modified protocol while member is present
- Direction to technician without the member present is not reported separately;
- Billing for the time of this activity is allowed only for BCBA or qualified health professional time even if other professional providers are present.
- The BACB recommends 2 hours of direct supervision per 10 hours of line therapy. Clinical rationale must be provided for requests that exceed the BACB recommendation for adaptive treatment by protocol modification.

**97156 FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE**

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardian, and caregiver with or without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors

**97157 MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE**

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardians and/or caregivers of multiple members without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors
- Maximum member per group - 8

This code is typically used during the initial treatment phase to educate and orient families in ABA behavioral nomenclature and techniques

**97158 GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION**

- Administered by BCBA or qualified health care professional
- Face to face with two or more members
- Member must have direct participation in treatment protocol/interactions in order to meet their own individual treatment goals
- Protocol adjustments are made in real time dynamically during the session
- Maximum member per group - 8

**0362T BEHAVIOR INDENTIFICATION SUPPORTING ASSESSMENT WITH FOUR REQUIRED COMPONENTS**

- On-site direction by BCBA, qualified health care professional
- With the assistance of two or more-line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional

- For member who exhibits destructive behavior (e.g., elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors
- BCBA/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors.

**0373T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION WITH FOUR REQUIRED COMPONENTS**

- On-site direction by BCBA, qualified health care professional
- With the assistance of two or more-line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional
- For member who exhibits destructive behavior (e.g., elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors
- Staged environment to teach members appropriate alternative response to severe destructive behaviors. Typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior

**Out of State claims coding:**
ABA service providers who are in network with their local Blue Cross and Blue Shield and who are contracted to utilize ABA service codes different from the approved list will be eligible for reimbursement for service codes that are equivalent to covered ABA service codes listed above. Service codes that are not equivalent to the approved service codes are not eligible for reimbursement. Approval for use of alternate service codes can be requested during the provision of ABA services.

***CPT Definition of Time Spent with Patient that is Eligible for Reimbursement:**
Face to Face time for outpatient visits is reimbursable and includes:

1. Time spent with patient
2. Time spent with family
3. Time spent with patient and family

The non-face to face time (activities which may be occur before, during or after a visit) is included in the work for each CPT code reimbursement. These non-face to face activities are therefore not eligible for claims submission, independent of face to face time. These non- reimbursable events include such activities as: review of records, arranging further services, communicating with the professionals, the patient or the

family through written reports and telephone contact, and other non-face to face activities. (REF pg. 8 of CPT Handbook 2016)

| E/M | |
|---|---|
| 99202 | Office or other outpatient visit for E/M with new patient (expanded problem focused, straight forward) |
| 99203 | Office or other outpatient visit for E/M with new patient (detailed, low complexity) |
| 99204 | Office or other outpatient visit for E/M with new patient (comprehensive, moderate complexity) |
| 99205 | Office or other outpatient visit for E/M with new patient (comprehensive, high complexity) |
| 99211 | Office or other outpatient visit for E/M with established patient (minimal) |
| 99212 | Office or other outpatient visit for E/M with established patient (problem focused, straight forward) |
| 99213 | Office or other outpatient visit for E/M with established patient (expanded problem focused, low complexity) |
| 99214 | Office or other outpatient visit for E/M with established patient (detailed, moderate complexity) |
| 99215 | Office or other outpatient visit for E/M with established patient (comprehensive, high complexity) |
| 99221 | Initial inpatient/residential evaluation – detailed or comprehensive, low complexity |
| 99222 | Initial inpatient/residential evaluation – comprehensive, moderate complexity |
| 99223 | Initial inpatient/residential evaluation – comprehensive, high complexity |
| 99231 | Subsequent inpatient/residential visit – problem focused, straight forward or low complexity |
| 99232 | Subsequent inpatient/residential visit – problem focused, moderate complexity |
| 99233 | Subsequent inpatient/residential visit – detailed, high complexity |
| 99238 | Hospital discharge day management, 30 minutes or less |
| 99251 | Initial inpatient consultation (problem focused, straight forward) |
| 99252 | Initial inpatient consultation (expanded problem focus, straight forward) |
| 99253 | Initial inpatient consultation (detailed, low complexity) |
| 99254 | Initial inpatient consultation (comprehensive, moderate complexity) |
| 99255 | Initial inpatient consultation (comprehensive, high complexity) |

| CPT and REVENUE CODES IN NUMERICAL ORDER | |
|---|---|
| 124 | Inpatient Day – Mental Health |
| 126 | Inpatient Day – Substance Use |
| 129 | Sub-Acute/ Residential Rehabilitation |
| 762 | Observation Bed |
| 901 | Electroconvulsive Therapy-Facility Code |
| 905 | Intensive Outpatient (IOP) – Psychiatric |
| 906 | Intensive Outpatient (IOP) – Chemical Dependency |
| 912 | Partial Care (PHP) - Less Intensive |
| 913 | Partial Care (PHP) - Intensive |
| 1001 | Residential Care - Psychiatric |
| 1002 | Residential Care – Chemical Dependency |

*If the time worked is more than half the time permitted by the code, than that code can be used. For example, to bill under Code 90832, you must work a minimum of 16 minutes. If you worked 16 - 37 minutes, you would use the 30-minute code (90832); for 38 - 52 minutes, you would use the 45-minute code (90834); and for 53+ minutes, you would use the 60-minute code (90837).

Reimbursement for services is subject to Plan guidelines.

## Section 11: Compliance Program

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## Overview

New Directions' Compliance Program outlines New Directions' commitment to conducting business in accordance with state and federal legal requirements and ethical standards. New Directions encourages providers and facilities to create a compliance program in order to prevent the submission of incorrect claims and to combat fraudulent conduct. To aid in the development of compliance programs and the use of internal controls to efficiently monitor adherence to applicable laws and plan requirements, The U.S. Department of Health and Human Services Office of the Inspector General has developed Compliance Program guidance for individual and small group health care practices and hospitals.

## Reporting

New Directions maintains a Compliance Reporting Line for anonymous reporting of suspected noncompliance, fraud or abuse. To report suspected noncompliance, fraud or abuse, please call 1-855-580-4871. An email or letter can also be sent to ClaimsIntegrity@ndbh.com or Ethics and Compliance, P.O. Box 6729, Leawood, KS, 66206.

New Directions will not retaliate against any person who, in good faith, reports suspected noncompliance, fraud or abuse to New Directions, the federal or state governments, or any regulatory agency.

## HIPAA Information

To help you inform members about the use and disclosure of their medical information, please refer to the Notice of Privacy Practices found at www.ndbh.com. This notice explains how personal information and protected health information are collected, used and disclosed to third parties. New Directions has implemented security measures to prevent the unauthorized release or access to personal information.

## Privacy Policy and Privacy Practices

Please refer to the Privacy Statement found at www.ndbh.com. This notice explains how personal information and protected health information are collected, used and disclosed to third parties. New Directions has implemented security measures to prevent the unauthorized release or access to personal information.

**The confidentiality of any communication transmitted to or from New Directions via unsecured email cannot be guaranteed.**

When a visitor performs a search on www.ndbh.com, New Directions may record information identifying the visitor and/or linking the visitor to the search performed. New Directions may also record limited information for every search request and use that information only to solve technical problems with the service and to calculate overall usage statistics.

## Section 12: Appendix

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## Appendix for Blue Cross and Blue Shield Plans

(Fully insured, Federal Employee Program and Self-Funded accounts)

**Note**: Information contained in the appendix is specific to each plan (i.e., not a New Directions process). For terms and definitions, refer to the member's plan or call the Customer Service number on his or her ID card. Information may be subject to change. If you have questions, please direct them to the applicable plan.

# Blue Cross Blue Shield of Alabama (including Southern Company)

## Provider Network through New Directions

| | |
|---|---|
| Outpatient Authorizations | New Directions (www.ndbh.com)<br>No authorization required. Outpatient services ma y be reviewed retrospectively. |
| Precertification | New Directions 800-248-2342 |
| Benefits & Eligibility | New Directions<br>855-339-8558 or www.provider.bcbsal.org |
| Provider Relations | New Directions<br>888-611-6285 or al_providerrelations@ndbh.com |
| Medical Necessity Appeals | For Dates of Service prior to 1/1/2021<br>EPS, EPX and EPL Claims – New Directions<br>855-339-8558 option<br>2 or al_providerrelations@ndbh.com<br>Payer ID Code: NDX99<br><br>New Directions 800-248-2342 (Expedited Appeals)<br>https://webpass.ndbh.com/ (Standard Appeals)<br>See below for additional details |
| Claims Inquiries | New Directions<br>Blue Choice, PEEHIP, All Kids, FEP, or BlueCard Claims – BCBSAL<br>205-220-6899 or Ask-EDI@bcbsal.org |
| Deaf or hearing impaired | Alabama relay phone numbers<br>800-548-2547(Voice)<br>800-548-2546 (TTY/HCO) or 711 in your service area |
| Physician Help Line | 855-339-9812 |

## Primary Requirements

- Providers/Facilities must use an NPI number in billing.

## Authorizations

- No authorization required for outpatient services, including psychological or neuropsychological testing.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- Precertification is required for all inpatient services.
- Precertification is required for partial hospitalization and intensive outpatient services when required by the Member's contract.
- Some products require a referral from the Member's primary care physician prior to treatment.
- Southern Company requires authorization for residential treatment, Transcranial Magnetic Stimulation (TMS) and Repetitive Transcranial Magnetic Stimulation (rTMS).

## Benefits

- Online eligibility and benefits information is available at https://providers.bcbsal.org/

  WebPass is New Directions' online system that allows providers to access eligibility and benefit information for products New Directions manages. The WebPass system is accessible through New Directions' website, https://webpass.ndbh.com/. To obtain a username and password to access the WebPass system, please send an encrypted email to prwebpass@ndbh.com with your Tax ID number, name and email address. A username and password will be emailed to you within 24 hours
- If you have any questions about Member benefits, please call New Directions Customer Service at 1-855-339-8558

## Medical Necessity Appeals

**(Excludes Medicare and FEP plans)***

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 2 years after denial is rendered** | 3 calendar days from receipt of request | Phone: 800-248-2342 |
| **Standard Appeal** | 2 years after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 800-248-2342<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

*Medical necessity appeal inquiries for Medicare and Federal plans should be directed towards Blue Cross Blue Shield of Alabama at 800-248-2342.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims

**Timely Filing**

Timely filing of claims is 180 days.

**Dates of Service Beginning January 1, 2021, and after**

All Blue Choice and EPS EDI Claims

Please work directly with your Practice Management System vendor or Clearinghouse to obtain information on how to enroll or set up your system to submit Blue Choice and all EPS claims to BCBSAL. Providers may work with their specific clearinghouse to set it up correctly in their practice management system. Alternatively, Providers may choose to work directly with their practice management system vendor, even if they use a clearinghouse, because the practice management system vendor will coordinate the setup for submitting Blue Choice and EPS claims to BCBSAL.

Please click the link for instructions about electronic funds transfers (EFT): **EFT Instructions.**

**For Dates of Service Prior to January 1, 2021**

All Blue Choice Claims

Blue Choice claims should be submitted to BCBSAL as stated above.

In-network EPS EDI Claims

Please work directly with your Practice Management System vendor or Clearinghouse to obtain information on how to enroll or set up your system to submit in-network EPS claims to New Directions. Providers may work with their specific clearinghouse to set it up correctly in their practice management system.

Alternatively, Providers may choose to work directly with their practice management system vendor, even if they use a clearinghouse, because the practice management system vendor will coordinate the set-up for submitting in-network EPS claims to New Directions.

- New Directions' national payer ID is NDX99.
- Please use this payer ID when submitting in-network EPS claims to New Directions.
- Submit claims to this address: NDBH Claims Department P.O. BOX 21234 Eagan, MN 55121
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

If you are an individually credentialed provider with New Directions and need to update your demographic information with us, To submit changes, please complete the electronic update form appropriate for your provider type, which are available on our website at https://www.ndbh.com/Providers. Select *Blue Cross and Blue Shield of Alabama* under the *'Choose your health plan'* drop-down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com. Accurate demographic information ensures timely referrals.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telemedicine

Telemedicine is a secure and HIPAA-compliant method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. The Member must have a covered mental health benefit that permits Telemedicine in order for Providers to receive payment for Telemedicine services.

New Directions considers telemedicine to be an aid to delivering behavioral health coverage using interactive telecommunications when the member and behavioral health provider are not in the same physical location.

Telecommunications must be synchronous (live) telemedicine service rendered via a real-time audio and video telecommunications system.

Telemedicine does not include the use of audio-only telephone, facsimile, text or email. Some exceptions may apply during public health emergencies, such as COVID-19. See, for example, Expanded Telemedicine Coverage.

Behavioral Health Providers can provide telemedicine services at a Consulting provider site (distant site), a Referring provider site (originating site), or both.

- A Consulting provider site (distant site) is one at which services are provided to a member not physically present with the behavioral health provider. Providers will use the appropriate CPT codes for Telemedicine Behavioral Health.
- A Referring provider site (originating site) is one at which services are provided to a member in an office of a provider using the originating site's equipment to receive Telemedicine Behavioral Health services with a provider in another location. The originating site can bill BCBSAL claims for providing the equipment with the appropriate Q code but not for the behavioral health services.

**Codes**
All available fee schedule codes are appropriate for use by the Behavioral Health Providers, if the service provided through Telemedicine can be done with the same quality as the service being provided in the office setting. Exceptions may apply during a Public Health Emergency.

When billing for behavioral health services delivered via Telemedicine, use the "**95**" or the "**GT**" modifier. Use Place of Service Code "**02**".

**Provider's Responsibility:**
Providers will choose a secure, HIPAA-compliant vendor and sign an attestation form agreeing to meet all necessary telemedicine requirements before conducting telemedicine services:

- Complete Telemedicine Behavioral Health Services Provider Attestation form
- Meet the requirements outlined in the Telemedicine Behavioral Health Services Provider Attestation form, including the ability to provide all telemedicine sessions through secure, HIPAA-compliant technology.
- Carry Liability and malpractice insurance that covers telemedicine services.

Questions should be directed to your provider relations representative:

- Sherry Kitchens, RN, Clinical Service Coordinator: skitchens@ndbh.com or 205-209-3743
- Krystal Burch, LPC, Clinical Network Manager, North Alabama: kburch@ndbh.com or 205-209-3757
- Nancy Thomas, LPC, Clinical Network Manager, South Alabama and Tuscaloosa: nwthomas@ndbh.com or 205-209-3742

# Arkansas Blue Cross Blue Shield (ABCBS) Commercial HMO and PPO

| | |
|---|---|
| **Precertification** | **New Directions**<br>Use Provider WebPass<br>or 877-801-1159 |
| **Eligibility & Benefits** | **New Directions**<br>Use Provider WebPass or 877-801-1159 |
| **Medical Necessity Appeals** | **See chart below** |
| **Claims Inquiries** | **ABCBS**<br>To find the ABCBS phone number, please check the back of the member's ID card or<br>visit https://www.arkansasbluecross.com/ |
| **Provider Relations** | **ABCBS**<br>To find the ABCBS phone number, please check the back of the member's ID card or<br>visit https://www.arkansasbluecross.com/ |
| **Deaf or Hearing Impaired** | Arkansas Relay Service 800-285-1131 |
| **Medical Necessity Appeals** | **New Directions**<br>800-367-0406 |

## Primary Requirements

- Providers/Facilities must use an NPI number in billing.

## Authorizations

- Authorization rules vary according to member benefits. Please call the number on the back of the member's ID card with questions.

## Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 877-345-5976.

## Medical Necessity Appeals

**(Excludes Medicare and FEP plans)***

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 3 calendar days from receipt of request | Phone: 800-367-0406 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 800-367-0406<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

*Medical necessity appeal inquiries for Medicare and Federal plans should be directed towards Arkansas Blue Cross Blue Shield. Please see the separate appendix sections on Arkansas Medicare and Federal policies.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims

- Claims must meet timely filing requirements.
- For claims inquiries, please check the back of the member's ID card or visit https://www.arkansasbluecross.com/
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – Paper claims should be mailed to:

  Arkansas Blue Cross and Blue Shield
  P.O. Box 2181
  Little Rock, AR 72203-2181

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Arkansas Blue Cross Blue Shield (ABCBS) Federal Employee Program (FEP) (including State of Arkansas Employees)

| | |
|---|---|
| Precertification | New Directions<br>Use Provider WebPass or call<br>800-367-0406 |
| Eligibility & Benefits and Claims Questions | ABCBS<br>800-482-6655 |
| Other Inquiries | New Directions 877-801-1159 |
| Provider Relations | New Directions<br>888-611-6285 or email<br>ProviderRelations@ndbh.com |
| Deaf or hearing impaired | Arkansas Relay Service 800-285-1131 |
| Medical Necessity Appeals/ Reconsideration/ Inquiries | New Directions 800-367-0406<br>State of Arkansas<br>Employee Appeals 800-482-8416<br>State of Arkansas Appeals<br>Fax 501-378-2916 |

## Primary Requirements

- Providers/Facilities must use an NPI number in billing.

## Authorizations

- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- No authorization required for outpatient services, including partial hospitalization and intensive outpatient services.
- Precertification required for all inpatient services, including residential.
- No authorization required for psychological or neuropsychological testing.
- State of Arkansas Employees: Authorization is required for ABA, inpatient, residential, partial hospitalization, intensive outpatient services, Transcranial Magnetic Stimulation (TMS).

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- ABCBS FEP department will quote benefits. If you have any questions about member benefits, please call FEP customer service at 1-800-482-6655.

## Claims

- Claims must meet FEP/ABCBS filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please call FEP customer service at 1-800-482-6655.
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – Paper claims should be mailed to:

- Arkansas Blue Cross Blue Shield FEP
- P.O. Box 2181
- Little Rock, AR 72203

- Arkansas Blue Cross FEP Customer Service: 1-800-482-6655
- New Directions Behavioral Health Customer Service: Please refer to the *Appendix* for the appropriate plan account name and phone number to call.
- All services must be billed in full units. Partial units will not be paid.

- Paper Claims for Arkansas State Employees – Paper claims should be mailed to:

- Arkansas Blue Cross Blue Shield – Arkansas State Employees
- PO Box 8069
- Little Rock, AR 72203

- Electronic Claims for Arkansas State Employees– Providers interested in filing electronic claims should use payer ID – 00520
- To check the status of claims for Arkansas State Employees, call 1-800-482-8416

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type, which are available on our website at https://www.ndbh.com/Providers. Select *Arkansas Blue Cross Blue Shield* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

### Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

## Arkansas Blue Cross Blue Shield (ABCBS) Medicare Advantage (MA)

| | |
|---|---|
| **Precertification** | **New Directions**<br>Use Provider WebPass<br>or call 877-913-3289 |
| **Eligibility & Benefits** | **New Directions**<br>877-913-3289 |
| **Claims Inquiries** | **ABCBS**<br>800-287-4188 |
| **Provider Relations** | 877-359-1441 |
| **Deaf or Hearing Impaired** | **Arkansas Relay Service**<br>800-285-1131 |
| **Medical Necessity Appeals** | **ABCBS**<br>501-378-2025 |

### Primary Requirements

- Providers/Facilities must use an NPI number in billing.

### Authorizations

- Precertification required for inpatient services, partial hospitalization, intensive outpatient services, and Transcranial Magnetic Stimulation (TMS).
- Residential is not a covered benefit for ABCBS MA.
- No authorization is required for outpatient care, psychological or neuropsychological testing.
- Applied Behavior Analysis (ABA) is a covered benefit for ABCBS MA. ABA does not require prior authorization for ABCBS MA.
- Out of Network authorization rules vary by group and plan.

### Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 877-345-5976.

## Claims

- Claims must meet timely filing requirements.
- For claims inquiries, call 877-345-5976
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – Paper claims should be mailed to:

  Arkansas Blue Cross and Blue Shield
  P.O. Box 2181
  Little Rock, AR 72203-2181

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Walmart through Arkansas Blue Cross Blue Shield/Blue Advantage Administrators (BAA)

| | |
|---|---|
| Precertification | **New Directions**<br>Use Provider WebPass or call 877-709-6822 |
| Other Inquiries | **New Directions**<br>800-450-8706 |
| Provider Relations | **New Directions**<br>888-611-6285 or email ProviderRelations@ndbh.com |
| Deaf or hearing impaired | **Relay Services**<br>Dial 711 for state relay service toll-free number |

## Primary Requirements

- Providers/Facilities must use an NPI number in billing.

## Authorizations

- Authorization is required for partial hospitalization and intensive outpatient services.
- No authorization is required for outpatient services.
- Precertification is required for Inpatient and residential services.
- No authorization is required for psychological or neuropsychological testing
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- Failure to obtain prior authorization may result in denial of payment.

## Timely Filing

- Timely filing of claims is 365 days.

## Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 1-877-709-6822.

## Medical Necessity Appeals

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 6 months after denial is rendered* | 3 calendar days from receipt of request | Phone: 877-709-6822 |
| **Standard Appeal** | 6 months after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 877-709-6822<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

*Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims

- Claims must meet ABCBS filing requirements.
- Clean claims will be processed within 10 to 30 days.
- Electronic Claims – providers interested in filing electronic claims should use payer ID – 00520.
- Paper Claims – paper claims should be mailed to:

  Blue Advantage Administrators
  P.O. Box 1460
  Little Rock, AR 72203

- New Directions Behavioral Health Customer Service: 1-877-709-6822
- All services must be billed in full units. Partial units will not be paid.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Florida Blue PPO including Medicare Advantage

| | |
|---|---|
| **Authorizations for ABA Therapy only** | **New Directions**<br>**Fax to 816-237-2372**<br>**Attn: FL ABA Request** |
| **Precertification Eligibility & Benefits and Claims Questions** | **New Directions**<br>**Use Provider WebPass or call 866-730-5006** |
| **Provider Relations** | **New Directions**<br>**888-611-6285 or email Florida_PR@ndbh.com** |
| **Deaf or hearing impaired** | **State relay services**<br>**Dial 711 to identify the correct toll-free number for your location** |
| **Medical Necessity Appeals** | **Florida Blue 877-842- 9118**<br>**for expedited and member appeals**<br><br>**New Directions**<br>**866-730-5006 for standard provider appeals**<br><br>**See chart below for additional details** |

## Authorizations

- ABA requires prior authorization from first visit. New Directions will assign an authorization reference number. (For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the Provider section of www.ndbh.com.) Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements. Important Note: Medicare Advantage has no benefit for Autism services.
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity. Please see complete list of CPT codes in the Florida Blue BOB Handbook.

    - If a diagnosis of ADD/ADHD is provided, then authorization of Psychological/Neuropsychological testing is required.

- For further information regarding ADD/ADHD coverage, please see Florida Blue Medical Clinical Guidelines at http://mcgs.bcbsfl.com/MCG?mcgId=01-95805-14&pv=false."
- TMS & ECT requires prior authorization from first visit. Please locate request form on www.ndbh.com. Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.

## Claims

- Please be advised: Florida Blue requires providers to utilize a type 2 NPI number. If you are billing using **a Tax ID number**, you will need to register for a type 2 NPI number. If you are billing using your **Social Security number,** you will NOT have to register for a Type 2 NPI number.
    - To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
    - **Using your new group/type 2 NPI number in the billing process**
- The group/type 2 NPI number will be used as the "billing provider" on a claim
- The individual NPI number will be used as the "rendering provider" on a claim
- Claims must be filed within 180 days from the date of service to meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity
- Claims must be submitted electronically using payer ID – 00590.
- If there is no method available for the submission of an electronic claim New Directions may waive the electronic submission requirement.
- Out-of-state claims must be submitted through Availity
- All services must be billed in full units. Partial units will not be paid.
- All higher levels of care must be billed based on the number of days authorized for proper benefit and claim adjudication. See Florida Blue billing guidelines on the floridablue.com website provider resources

## Medical Necessity Appeals

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 72 hours from receipt of request | Phone: Florida Blue @ 877-842-9118 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 866-730-5006<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

* Medical necessity appeal inquiries for federal plans should be directed towards Florida Blue. Please see the separate appendix section on Florida Blue Federal Employee Program policies. Medical necessity appeal inquiries for Medicare Advantage Plans should be directed towards Florida Blue at 877-842-9118.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Notifications/Certification

- Notification/Certification is required for all Inpatient, Residential, Partial Hospitalization and Intensive Outpatient Services. Some self-funded Plans may not have this requirement. Important Note: Medicare Advantage has no benefit for Residential Services.
- Effective February 1, 2019, Florida contracted providers will complete utilization management reviews telephonically rather than WebPass for the following cases:
    - Eating Disorder cases for all ages and levels of care
    - Children and Adolescents under the age of 18 for all diagnoses and levels of care
    - Residential cases for members with a primary substance use disorder diagnosis
    - Medicare members for all levels of care.

Please note that this change does not affect any other type of cases.

**Instructions for telephonic review process for obtaining precertification:**

1. Call the New Directions Pre-authorization phone # located on the back of Member's card.
2. Press the option # for Behavioral Health Pre-authorization.
3. You will be directed to the New Directions Clinical Support Coordinator (CSC) team.
4. Inform the CSC that you are calling for precertification for one of the diagnosis, age bands, and/or levels of care noted above.
5. You will be transferred directly to the UM staff for precertification.

For more information about the Florida Provider Telephonic Review Process, please click and read guidelines **here**

## Benefits

- Benefits vary by group and plan.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

## Florida Blue HMO including Medicare Advantage and BlueMedicare Classic Plus HMO available in Hillsborough and Palm Beach Counties

| | |
|---|---|
| **Authorizations for ABA Therapy only** | **New Directions**<br>Fax to 816-237-2372<br>Attn: FL ABA Request |
| **Precertification Eligibility & Benefits and Claims Questions** | **New Directions**<br>Use Provider WebPass or call 866-730-5006 |
| **Provider Relations** | **New Directions**<br>888-611-6285 or email Florida_PR@ndbh.com |
| **Deaf or hearing impaired** | **State relay services**<br>Dial 711 to identify the correct toll-free number for your location |
| **Medical Necessity Appeals** | **Florida Blue** 877-842-9118 for expedited and member appeals<br>**New Directions** 866-730-5006 for standard provider appeals<br>See chart below for additional details |

### Authorizations

- ABA requires prior authorization from first visit. New Directions will assign an authorization reference number. (For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the provider section of www.ndbh.com.) Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements. Note: Medicare Advantage has no benefit for Autism services.
- Authorization required for all Inpatient, Residential, Partial Hospitalization and Intensive Outpatient services (including ABA therapy). Note: some self-funded plans may not have this requirement. Note: Medicare Advantage has no benefit for Residential Services.
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity. Please see complete list of CPT codes in the Florida Blue BOB Handbook.

    - If a diagnosis of ADD/ADHD is provided, then authorization of Psychological/Neuropsychological testing is required.
- For further information regarding ADD/ADHD coverage, please see Florida Blue Medical Clinical Guidelines at http://mcgs.bcbsfl.com/MCG?mcgId=01-95805-14&pv=false.
- TMS and ECT require authorization from first visit. Please locate request form on www.ndbh.com. Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.

  **Instructions for obtaining precertification for eating disorder cases:**

  1. Call the New Directions Pre-authorization # on the back of member's card.
  2. Press the option # for Behavioral Health Pre-authorization.
  3. You will be directed to New Directions Clinical Support Coordinator (CSC) team.
  4. Inform the CSC that you are calling for precertification for an Eating Disorder case.
  5. You will be transferred directly to the UM staff for precertification.

  For more information about the Florida Provider Telephonic Review Process, please click and read guidelines **here**

## Medical Necessity Appeals

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 72 hours from receipt of request | Phone: Florida Blue @ 877-842-9118 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 866-730-5006<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

* Medical necessity appeal inquiries for federal plans should be directed towards Florida Blue. Please see the separate appendix section on Florida Blue Federal Employee Program policies. Medical necessity appeal inquiries for Medicare Advantage Plans should be directed towards Florida Blue at 877-842-9118.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims Filing Requirements

Please be advised: Due to a recent update to the claims payment system at Florida Blue, the requirement to utilize a type 2 NPI number is now being enforced. If you are billing using **a Tax ID number**, you will need to register for a type 2 NPI number. If you are billing using your **Social Security number,** you will NOT have to register for a Type 2 NPI number.

To avoid payment delays and or claim denials, please access the following link to register for your type 2 NPI number: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

**Using your new group/type 2 NPI number in the billing process**

- The group/type 2 NPI number will be used as the “billing provider” on a claim
- The individual NPI number will be used as the “rendering provider” on a claim

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- Varies by group
- No out-of-network benefit unless group has a POS Rider

## Claims

- Claims must meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity or call New Directions Customer Service at 1-866-730-5006.
- Claims must be submitted electronically using payer ID– 00590.
- If there is no method available for the submission of an electronic claim or the entity submitting the claim is a small provider of services, New Directions may waive the electronic submission requirement. If the electronic submission is waived, a delay in the payment may occur.
- Florida Blue Customer Service: See member’s ID card.
- New Directions Behavioral Health Customer Service: 1-866-730-5006
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type, which are available on our website at https://www.ndbh.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Florida Blue Federal Employee Program (FEP)

| | |
|---|---|
| **Precertification Eligibility & Benefits and Claims Questions** | **New Directions**<br>Use Provider **WebPass** or call 866-730-5006 |
| **Provider Relations** | **New Directions**<br>888-611-6285 or email Florida_PR@ndbh.com |
| **Deaf or hearing impaired** | **State relay services**<br>Dial 711 to identify the correct toll-free number for your location |
| **Reconsideration/ Inquiries** | **Florida Blue** 877-842-9118 |

The Federal Employee Program® (FEP) has announced the creation of the *Blue Focus* benefit plan, with an effective date of January 1, 2019. FEP Blue Focus will utilize the same provider network as the existing FEP Standard and Basic Options. To learn more about this FEP plan, click here

## Claims Filing Requirements

- Providers/Facilities must use an NPI number in billing.

## Certification

- Prior certification is required for Applied Behavior Analysis (ABA).
- No certification is required for outpatient services.
- Certification is required for all Inpatient services.
- Precertification is required for Residential Treatment. Residential has additional requirements for care management participation prior to admission, treatment plan development and agreement. Please call 866-730-5006 for additional details.
- No certification is required for psychological or neuropsychological testing. After eight (8) hours of testing are used, New Directions will review the member's chart to determine medical necessity. Providers may be requested to forward additional medical records.
- TMS and ECT require certification from first visit. Please locate request form on www.ndbh.com. Failure to obtain certification may result in denial of payment. Refer to the member's plan for specific benefits and certification requirements.

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- Contact New Directions toll free at 1-866-730-5006.

## Claims

- Claims must meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity or call New Directions Customer Service at 866-730-5006.
- Claims must be submitted electronically using payer ID – 00590.
- If there is no method available for the submission of an electronic claim or the entity submitting the claim is a small provider of services, New Directions may waive the electronic submission requirement. If the electronic submission is waived, a delay in the payment may occur.
- Florida Blue Customer Service: See member's ID card.
- New Directions Behavioral Health Customer Service: 1-866-730-5006
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Florida Blue Medicare Preferred HMO (Florida Blue and BeHealthy)

| | |
|---|---|
| Outpatient Authorizations | **New Directions**<br>No authorization required. Outpatient services may be reviewed retrospectively |
| Precertification | **New Directions**<br>Use Provider **WebPass** or call 866-730-5006 |
| Eligibility & Benefits | **New Directions** 866-730-5006 |
| Claims Inquiries | **Alignment Healthcare (AHC)**<br>Please first check Availity (800-282-4548). If further support is needed, call AHC Customer Service at 844-783-5191. |
| Other Inquiries | **New Directions** 800-450-8706 |
| Provider Relations | **New Directions**<br>888-611-6285 or email Florida_PR@ndbh.com |
| Medical Necessity Appeals | **Florida Blue** 877-842-9118 |
| Deaf or hearing impaired | **State Relay Services**<br>Call 711 to identify the correct toll-free number for your location |

## Primary Requirements

- Providers/Facilities must use an NPI number in billing.
- If you are billing using **a Tax ID number**, you will need to register for a type 2 NPI number.
- Use the following link to register for your type 2 NPI number https://nppes.cms.hhs.gov/NPPES/Welcome.do
- If you are billing using your **Social Security number,** you will NOT have to register for a Type 2 NPI number.
- If using a Type 2 NPI in the billing process:
- The group/type 2 NPI number will be used as the “billing provider” on a claim
- The individual NPI number will be used as the “rendering provider” on a claim

## Authorizations

- No authorization is required for outpatient services
- Authorization is required for all inpatient, partial hospitalization and intensive outpatient services
- Authorization is required for TMS and ECT. Please locate form on www.ndbh.com
- Psychological/Neuropsychological testing does not require authorization unless the proposed testing exceeds ten (10) hours per calendar year. Once the tenth hour is billed, any subsequent hours will require submission of medical records to determine medical necessity. Please see complete list of CPT codes in the Florida Blue BOB Handbook.
- If a diagnosis of ADD/ADHD is provided, then authorization of Psychological/Neuropsychological testing is required.
- For further information regarding ADD/ADHD coverage, please see Florida Blue Medical Clinical Guidelines at http://mcgs.bcbsfl.com/MCG?mcgId=01-95805-14&pv=false."

**Instructions for telephonic review process for obtaining precertification:**

1. Call the New Directions Pre-authorization phone # located on the back of member's card.
2. Press the option # for Behavioral Health Pre-authorization.
3. You will be directed to the New Directions Clinical Support Coordinator (CSC) team.
4. Inform the CSC that you are calling for precertification for one of the diagnosis, age bands, and/or levels of care noted above.
5. You will be transferred directly to the UM staff for precertification.

For more information about the Florida Provider Telephonic Review Process, please click and read guidelines **here**

## Timely Filing

- Timely filing of claims is 180 days

## Benefits

- Contact New Directions toll-free at 1-866-730-5006
- Benefits vary by group and plan
- Residential services are not covered

## Claims

- Claims must meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity (phone # 800-282-4548). If further support is needed, call Alignment Customer Service at 844-783-5191.
- Claims must be submitted electronically using payer ID – **CCHPC**.
- If there is no method available for the submission of an electronic claim or the entity submitting the claim is a small provider of services, New Directions may waive the electronic submission requirement. If the electronic submission is waived, a delay in the payment may occur.
- Alignment Healthcare Customer Service: 844-783-5191
- New Directions Behavioral Health Customer Service: 866-730-5006
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Florida Blue* under the *'Choose your health plan'* drop-down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

## Blue Cross Blue Shield of Kansas (BCBSKS) PPO

| | |
|---|---|
| Prior Authorizations | New Directions 800-952-5906 or electronically on WebPass |
| Precertification | New Directions 800-952-5906 |
| Benefits, Eligibility and Claims | BCBSKS 866-432-3990 |
| Other Inquiries | New Directions 800-952-5906 |
| Provider Relations | BCBSKS 800-432-3587 |
| Deaf or hearing impaired | Kansas Relay Services 800-766-3777 |
| Medical Necessity Appeals | BCBSKS 800-432-3990 |

### Authorizations

- Prior authorization required for inpatient and residential services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Precertification is requested for partial hospitalization, intensive outpatient, psychological testing, and ECT where it is a covered benefit. Medical records may be reviewed for services without a precertification to ensure medical necessity.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- New Directions Medical Necessity Criteria and the Applied Behavior Analysis for Treatment of Autism Spectrum Disorder Medical Policy may be found at www.ndbh.com in the provider section

## Benefits

- BCBSKS will quote benefits. If you have any questions about member benefits, please call BCBSKS customer service at 800-432-3990.

## Timely Filing

- BCBSKS manages claims. If you have any questions about timely filing, please call BCBSKS 866-432-3990 at BCBSKS.

## Claims

- BCBSKS manages claims. If you have any claims questions, please call BCBSKS at 866-432-3990
- Claims must meet BCBSKS filing requirements.
- Electronic Claims – providers interested in filing electronic claims should refer to BCBSKS.com or www.ask-edi.com.
- Paper Claims – paper claims should be mailed to:

  Blue Cross Blue Shield Kansas
  1133 SW Topeka Blvd
  Topeka, KS 66629-0001

- All services must be billed in full units. Partial units will not be paid.

## Telehealth

- Telehealth/telemedicine services are subject to plan guidelines for reimbursement. Please consult BCBSKS provider manual and BCBSKS Latest News updates for the latest guidelines and communications surrounding telehealth services.

## Blue Cross Blue Shield of Kansas (BCBSKS) Solutions/EPO (Exclusive Provider Organization)

| | |
|---|---|
| Prior Authorizations | New Directions 800-952-5906 or electronically on WebPass |
| Precertification | New Directions 800-952-5906 |
| Benefits, Eligibility and Claims | BCBSKS 800-432-3990 |
| Other Inquiries | New Directions 800-952-5906 |
| Provider Relations | BCBSKS 800-432-3587 |
| Deaf or hearing impaired | Kansas Relay Services 800-766-3777 |
| Medical Necessity Appeals | BCBSKS 800-432-3990 |

### Authorizations

- Prior authorization required for inpatient services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Precertification is requested for partial hospitalization, intensive outpatient, psychological testing, and ECT. Medical records may be reviewed for services without a precertification to ensure medical necessity.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.
- New Directions Medical Necessity Criteria and the Applied Behavior Analysis for Treatment of Autism Spectrum Disorder medical policy may be found at www.ndbh.com in the provider section.

## Benefits

- BCBSKS will quote benefits. If you have any questions about member benefits, please call customer service at 1-800-432-3990.
- EPO policies have in-network benefits for all levels of care. In-network providers are contracting providers within the 103 counties covered by the BCBSKS plan. Providers in Johnson and Wyandotte counties are not in-network providers, with the exception of the University of Kansas Hospital (and affiliated providers) and Children's Mercy. No coverage for treatment outside of BCBSKS coverage area, unless admitted through an emergency department (exceptions are Children's Mercy and University of KS Marillac)

## Timely Filing

- BCBSKS manages claims. If you have any questions about timely filing, please call BCBSKS 866-432-3990 at BCBSKS.

## Claims

- Claims must meet BCBSKS filing requirements.
- BCBSKS manages claims. If you have any claims questions, please call 866-432-3990 at BCBSKS
- Electronic Claims – providers interested in filing electronic claims should refer to BCBSKS.com or www.ask-edi.com.
- Paper Claims – paper claims should be mailed to:

  Blue Cross Blue Shield Kansas
  1133 SW Topeka Blvd
  Topeka, KS 66629-0001

- All services must be billed in full units. Partial units will not be paid.

## Telehealth

- Telehealth/telemedicine services are subject to plan guidelines for reimbursement. Please consult BCBSKS provider manual and BCBSKS Latest News updates for the latest guidelines and communications surrounding telehealth services.

# Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP)

| | |
|---|---|
| Precertification | New Directions 800-952-5906 or electronically on WebPass |
| Benefits, Eligibility and Claims | BCBSKS 800-432-0379 |
| Other Inquiries | New Directions 800-952-5906 |
| Provider Relations | BCBSKS 800-432-3587 |
| Deaf or Hearing Impaired | Kansas Relay Services 800-766-3777 |
| Reconsiderations(Medical Necessity Appeals) | BCBSKS 800-432-3990 |

## Authorizations

- Prior authorization required for inpatient
- Prior authorization is also required for residential services. Refer to the FEP service benefit plan book for additional residential prior authorization requirements (including enrollment in case management services prior to admission)
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- No authorization is required for partial hospitalization, intensive outpatient, psychological testing or OP ECT services. These services may be reviewed retrospectively to ensure medical necessity.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions.

## Benefits

- BCBSKS will quote benefits. If you have any questions about member benefits, please call FEP customer service at 800-432-0379.

## Timely Filing

- BCBSKS Federal Employee Program (FEP) contract has a claims timely filing of December 31st of the year following the date of service.

## Claims

- BCBSKS manages claims. If you have any claims questions, please call BCBSKS at 866-432-3990
- Claims must meet BCBSKS filing requirements.
- Electronic Claims – providers interested in filing electronic claims should refer to BCBSKS.com or www.ask-edi.com.
- Paper Claims – paper claims should be mailed to:

  Blue Cross Blue Shield Kansas
  1133 SW Topeka Blvd.
  Topeka, KS 66629-0001

- All services must be billed in full units. Partial units will not be paid.

## Telehealth

- Telehealth/telemedicine services are subject to plan guidelines for reimbursement. Please consult FEP provider manual for the latest guidelines and communications surrounding telehealth services.

# Blue Cross Blue Shield of Kansas (BCBSKS) Medicare Advantage

| | |
|---|---|
| Prior Authorizations | New Directions 800-589-1635<br>or electronically on WebPass |
| Precertification | New Directions 800-589-1635 |
| Benefits, Eligibility and Claims | BCBSKS 800-240-0577 |
| Other Inquiries | New Directions 800-589-1635 |
| Provider Relations | BCBSKS 800-432-3587 |
| Deaf or Hearing Impaired | Kansas Relay Services 800-766-3777 |
| Medical Necessity Appeals | BCBSKS 800-432-3990 |

## Authorizations

- Prior authorization is required for inpatient services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Precertification is not required for outpatient services.
- Medical necessity criteria may be found at www.ndbh.com

## Benefits

- BCBSKS will quote benefits. If you have any questions about member benefits, please call customer service at 800-240-0577.

## Timely Filing

- Timely filing of claims is 365 days from date of service or discharge.

## Claims

- BCBSKS manages claims. If you have any claims questions, please call BCBSKS at 866-432-3990
- Claims must meet BCBSKS filing requirements.
- Electronic Claims – providers interested in filing electronic claims should refer to BCBSKS.com or www.ask-edi.com.
- Paper Claims – paper claims should be mailed to:

  Blue Cross and Blue Shield of Kansas
  Kansas Preferred Blue Medicare Advantage
  P.O. Box 239
  Topeka, KS 66629

- All services must be billed in full units. Partial units will not be paid.

## Telehealth

- Telehealth/telemedicine services are subject to plan guidelines for reimbursement.

# Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO

| | |
|---|---|
| Prior Authorizations | New Directions 833-964-6338<br>or electronically at WebPass |
| Precertification | New Directions 833-964-6338 |
| Benefits, Eligibility and Claims | New Directions 833-964-6338 |
| Medical Necessity Appeals | New Directions 800-528-5763 (Expedited Appeals)<br>https://webpass.ndbh.com/ (Standard Appeals)<br>See below for additional details |
| Other Inquiries | New Directions 833-964-6338 |
| Provider Relations | New Directions<br>888-611-6285 option 4 or<br>KCProviderRelations@ndbh.com |
| Deaf or Hearing Impaired | Kansas Relay Services 800-766-3777 |
| Deaf or hearing impaired | Missouri Relay Services 800-735-2466 |

## Primary Requirements

- Providers must have a Blue KC Provider number. This is assigned after credentialing is complete. If you do not already have an 8-digit Blue KC Provider ID, please contact customer service at 833-964-6338.
- Providers/Facilities must use an NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered regardless of whether that is an office, home, or other location.

## Authorizations

- Prior authorization is required for all inpatient, residential, TMS, ECT, psychological/neuropsychological testing and ABA services.
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Outpatient professional services do not require authorization.
- No authorization is required for partial hospitalization and intensive outpatient services. These services may be reviewed retrospectively to ensure they meet the criteria for medical necessity.
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions. For authorizations related to autism services, please refer to the policy entitled "Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy" located under the provider section of www.ndbh.com.
- For authorizations related to testing, please refer to instructions on the psychological testing request form located under the provider section of www.ndbh.com.
    - Psychological testing requires prior authorization after five hours of testing.
    - Neuropsychological testing requires prior authorization after eight hours of testing.
- For authorizations related to TMS, please refer to instructions on the initial and continuation treatment request forms and see our medical policy for this therapy in the provider section of www.ndbh.com.

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 833-964-6338.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member's ID number and date of birth. The phone number for Blue Touch is 816-395-3929 Online eligibility and benefits information is available at http://www.bluekc.com/. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

## Medical Necessity Appeals

**(Excludes Medicare and FEP plans)***

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 3 calendar days from receipt of request | Phone: 833-964-6338 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 833-964-6338<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

*Medical necessity appeal inquiries for Medicare and Federal plans should be directed towards Blue KC. Please see the separate appendix sections on Blue KC Medicare and Federal policies.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims

- **Important Notice:** Effective 07/01/20, Blue KC will only accept claims via electronic billing. Use payer ID - 47171
- Blue KC Customer Service: 1-800-456-3759
- New Directions Behavioral Health Customer Service: 833-964-6338
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Blue KC* under the *'Choose your health plan'* drop-down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines

## Blue Cross Blue Shield of Kansas City (Blue KC) Medicare

| | |
|---|---|
| Prior Authorizations | New Directions 833-964-6338<br>or electronically at WebPass |
| Predetermination | New Directions 833-964-6338 |
| Benefits, Eligibility and Claims | Blue KC 866-508-7140 |
| Other Inquiries | New Directions 833-964-6338 |
| Provider Relations | New Directions 888-611-6285<br>option 4 or KCProviderRelations@ndbh.com |
| Deaf or hearing impaired | Kansas Relay Services 800-766-3777 |
| Deaf or hearing impaired | Missouri Relay Services 800-735-2466 |
| Medical Necessity Appeals | Blue KC 866-508-7140 |

### Primary Requirements

- Providers must have a Blue KC Provider number. This is assigned after credentialing is complete. If you do not already have an 8-digit Blue KC Provider ID, please contact customer service at 1-866-508-7140
- Providers/Facilities must use an NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered regardless of whether that is an office, home, or other location.

## Authorizations

- Prior authorization is required for inpatient, Partial Hospital Program and Intensive Outpatient
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- Precertification is not required for outpatient professional services.
- Medical necessity criteria may be found at www.ndbh.com

## Timely Filing

- Timely filing of claims is 365 days from date of service or discharge.

## Benefits

New Directions will not quote benefits. If you have any questions about member benefits, please call Blue KC Medicare customer service at 866-508-7140

## Claims

- **Important Notice:** Effective 07/01/2020, Blue KC will only accept claims via electronic billing. Use payer ID – 47171
  - Electronic Claims – for more information on filing electronic claims, please refer to www.bluekc.com or www.ask-edi.com.
- Blue KC Provider Hotline:1-800-456-3759
- New Directions Behavioral Health Customer Service: 833-964-6338
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Blue KC* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care, Preferred-Care Blue, BlueSelect & BlueSelect Plus PPO, Affordable Care Act

| | |
|---|---|
| Prior Authorizations | New Directions 833-964-6338<br>or electronically at **WebPass** |
| Predetermination | New Directions 833-964-6338 |
| Benefits, Eligibility and Claims Questions | New Directions 833-964-6338 |
| Medical Necessity Appeals | New Directions 800-528-5763 (Expedited Appeals)<br>https://webpass.ndbh.com/ (Standard Appeals)<br>See below for additional details |
| Other Inquiries | New Directions 833-964-6338 |
| Provider Relations | New Directions<br>888-611-6285 option 4 or email<br>KCProviderRelations@ndbh.com |
| Deaf or Hearing Impaired | Kansas Relay Services 800-766-3777 |
| Deaf or hearing impaired | Missouri Relay Services 800-735-2466 |

## Primary Requirements

- Providers must have a Blue KC Provider number. This is assigned after credentialing is complete. If you do not already have an 8-digit Blue KC Provider ID, please contact customer service at 1-800-456-3759.
- Providers/Facilities must use an NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered regardless of whether that is an office, home, or other location.

## Authorizations

- Prior authorization is required for all inpatient, residential, TMS, ECT, psychological/neuropsychological testing and ABA services.
  - Failure to obtain prior authorization may result in denial of payment.

    - Refer to the member's plan for specific benefits and authorization requirements.
- Outpatient professional services do not require authorization.
- No authorization is required for partial hospitalization (PHP) and intensive outpatient services (IOP), except as indicated below. These services may be reviewed retrospectively to ensure they meet the criteria for medical necessity.
- The following plans require prior authorization for the specified services:
    - ACA: Individual members require prior authorization for PHP and IOP services.
    - You can identify ACA Individual members by their member ID, which begins with the prefix YBD, YBG, YJJ, YBS or YJT.
    - JAA groups
- Applied Behavior Analysis (ABA) therapy requires prior authorization for all sessions." For authorizations related to Autism services, please refer to the Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy located under the provider section of www.ndbh.com.
- Psychological testing requires prior authorization after five hours of testing. Prior authorization is required for neuropsychological testing after eight (8) hours of testing. For authorizations related to testing, please refer to instructions on the psychological testing request form located under the provider section of www.ndbh.com.
- Transcranial Magnetic Stimulation (TMS) requires prior authorization. For authorizations related to TMS, please refer to instructions on the initial and continuation treatment request forms and see our medical policy for this therapy.

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 833-964-6338.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member's ID number and date of birth. The phone number for Blue Touch is 816-395-3929.
- Online eligibility and benefits information is available at www.bluekc.com. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

## Medical Necessity Appeals

**(Excludes Medicare and FEP plans)***

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 3 calendar days from receipt of request | Phone: 833-964-6338 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 833-964-6338<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

*Medical necessity appeal inquiries for Medicare and Federal plans should be directed towards Blue KC. Please see the separate appendix sections on Blue KC Medicare and Federal policies.

**Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims

- **Important Notice:** Effective 07/01/20, Blue KC will only accept claims via electronic billing. Use payer ID - 47171
- Blue KC Customer Service:1-800-456-3759
- New Directions Behavioral Health Customer Service: 833-964-6338
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.
- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Blue KC* under the *'Choose your health plan'* drop down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP)

| | |
|---|---|
| Prior Authorizations | New Directions 833-964-6338<br>or electronically at WebPass |
| Predetermination | New Directions 833-964-6338 |
| Benefits, Eligibility and Claims Questions | New Directions 833-964-6338 |
| Other Inquiries | New Directions 833-964-6338 |
| Provider Relations | New Directions<br>888-611-6285: option 4 or<br>KCProviderRelations@ndbh.com |
| Deaf or hearing impaired | Kansas Relay Services 800-766-3777 |
| Deaf or hearing impaired | Missouri Relay Services 800-735-2466 |
| Medical Necessity Appeals /Reconsideration/ Inquiries | Blue KC 816-395-2500 |

## Primary Requirements

- Providers must have a Blue KC Provider ID number. Blue KC will assign a provider ID number after credentialing is complete. To obtain a Blue KC Provider ID number, please contact Blue KC customer service at 1-816-395-3678.
- Providers/Facilities must use an NPI number in billing.
- For face-to-face services, the provider must be licensed in the state where the service is delivered regardless of whether that is an office, home, or other location.

## Authorizations

- Prior authorization is required for inpatient.
- Prior authorization is required for residential services. Refer to the FEP service benefit plan book for additional residential prior authorization requirements (including enrollment in case management services prior to admission).
- Failure to obtain prior authorization may result in denial of payment. Refer to the member's plan for specific benefits and authorization requirements.
- No authorization is required for partial hospitalization, intensive outpatient, psychological/neuropsychological testing or OP ECT services. These services may be reviewed retrospectively to ensure medical necessity.
- Prior authorization is required for Applied Behavior Analysis (ABA), inpatient and residential.
- No authorization is required for psychological or neuropsychological testing. These services may be reviewed retrospectively to ensure medical necessity.

## Timely Filing

- Timely filing of claims is 180 days.

## Benefits

- If you have any questions about member benefits, please use provider WebPass or call New Directions Customer Service at 1-800-528-5763.
- Blue KC's automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member's ID number and date of birth. The phone number for Blue Touch is 816-395-3929 Online eligibility and benefits information is available at www.BlueKC.com. Click on the "Provider" icon.
- Blue KC may also be contacted at 816-395-2222.

## Claims

- **Important Notice:** Effective 07/01/20, Blue KC will only accept claims via electronic billing. Use payer ID – 47171
- Blue KC Customer Service: 1-816-395-3678
- New Directions Behavioral Health Customer Service: 1-800-528-5763
- All services must be billed in full units. Partial units will not be paid.

## Change in Demographics

- Please provide 45 days' advance notice of any planned availability or demographic changes when possible. Contractually you are required to notify us within 72 hours for changes to address, phone number, fax number, or email.

- To submit changes, please complete the electronic update form appropriate for your provider type which are available on our website at https://www.ndbh.com/Providers. Select *Blue KC* under the *'Choose your health plan'* drop-down box, and then click on the *Profile Updates* box. If you have questions, please contact Provider Relations at 888-611-6285 or ProviderRelations@ndbh.com.

## Medical Records

- Medical records are to be provided upon request without charge.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

# Blue Cross and Blue Shield of Michigan (BCBSM) including United Auto Workers Retiree Medical Benefits Trust (URMBT), General Motors (GM) and State of Michigan (SOM)

## Provider Network through Blue Cross and Blue Shield of Michigan

| | |
|---|---|
| **Outpatient Authorizations** | **New Directions**<br>No authorization required |
| **Authorization for BCBSM Contracted Facilities** | **New Directions**<br>800-762-2382 (Commercial)<br>800-342-5891 (FEP)<br>877-228-3912 (URMBT)<br>877-240-0705 (GM)<br>866-503-3158 (SOM)<br>or use WebPass |
| **Benefits & Eligibility** | **BCBSM**<br>**Commercial and FEP:**<br>See Contact Center Phone number on the Member's ID card for benefits/eligibility or go to www.bcbsm.com.<br>**URMBT:**<br>Benefits are quoted by NDBH. Call 877-228-3912 or go to www.bcbsm.com.<br>**GM:**<br>Benefits are quoted by NDBH. Call 877-240-0705 or go to www.bcbsm.com<br>**SOM:**<br>Benefits are quoted by BCBSM. Call 800-843-4876 or go to www.bcbsm.com. |
| **Claims Inquiries** | **BCBSM**<br>See Customer Service Phone number on the Member's ID card for claims or call 313-225-8100. |
| **Deaf or hearing impaired** | **MI Relay Phone Number**<br>Dial 711 for relay number |
| **Medical Necessity Appeals** | **New Directions**<br>**Expedited Appeals**<br>800-762-2382 (Commercial)<br>800-342-5891 (FEP)<br>877-228-3912 (URMBT)<br>877-240-0705 (GM)<br>866-503-3158 (SOM)<br>**Standard Appeals**<br>**WebPass**<br>See chart below for additional details |

## Authorizations

**Outpatient Services**

- BCBSM, URMBT and GM: No authorization required for outpatient services, including psychological testing and intensive outpatient program (IOP) services for mental health and substance use disorders (SUD). These services may be reviewed retrospectively.
- SOM: No authorization required for outpatient services, including psychological testing. Authorization is required for intensive outpatient services (IOP) for mental health and SUD. These services may be reviewed retrospectively.

**Intensive Outpatient**

- BCBSM, URMBT,GM, and SOM: New Directions does not manage or authorize intensive outpatient program (IOP) for mental health and substance use disorders (SUD). Requests for IOP services should be sent directly to BCBSM for processing.

- **Out-of-network or non-participating providers and facilities**
- BCBSM, URMBT, GM and SOM: For "out-of-network" or "non-participating" providers or facilities, New Directions does not authorize any level of care with the exception of MESSA.
- MESSA: Callers to New Directions are referred to MESSA 800-336-0022 for direction on authorization for admissions to non-participating facilities

**In-network services**

- BCBSM, GM: Authorization is required for the following higher level of care services for mental health and substance use disorders (SUD): inpatient hospitalization, residential, and partial hospitalization. Contact New Directions for authorization of these services.

- URMBT: Authorization is required for the following higher level of care services for mental health and substance use disorders (SUD): inpatient hospitalization, residential, and partial hospitalization. Contact New Directions for authorization of these services. Pre-certification is required for all members for inpatient hospitalization.

- SOM: New Directions only authorizes in-network services and authorization is required for inpatient hospitalization, residential treatment (SUD only), partial hospitalization and intensive outpatient services.

**Applied Behavior Analysis (ABA) Therapy**

- BCBSM: ABA Therapy requires authorization for all visits. Call 877-563-9347.
- GM: ABA Therapy requires authorization for all visits. Call 877-240-0705.
- SOM: ABA Therapy requires authorization for all visits. Call 866-503-3158.

**Transcranial Magnetic Stimulation**

- BCBSM: Authorization is required for Transcranial Magnetic Stimulation (TMS). For authorizations related to TMS, please refer to instructions on the initial and continuation treatment request forms and see BCBSM's Medical Policy for this therapy.
- URMBT, GM and SOM: Members have no TMS benefits.

## Benefits

- BCBSM Commercial: If you have questions about member benefits, please call BCBSM Customer Service at the phone number found on member's insurance ID card. Online eligibility and benefits information is available at www.BCBSM.com.
- FEP: If you have any questions about member benefits, please call 888-288-2738.
- URMBT: If you have any questions about member benefits, please call New Directions at 877-228-3912. For accumulator questions, please call BCBSM Customer Service at the phone number found on the member's insurance ID card.
- GM: If you have any questions about member benefits, please call New Directions at 877-240-0705.
- SOM: If you have any questions about member benefits, please call BCBSM Customer Service at 800-843-4876. Online eligibility and benefits information available at www.BCBSM.com.

## Medical Necessity Appeals

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered* | 3 calendar days from receipt of request | Phone:<br>Commercial 800-762-2382<br>FEP 800-342-5891<br>URMBT 877-228-3912<br>GM 877-240-0705<br>SOM 866-503-3158 |

| | | | |
|---|---|---|---|
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: See expedited appeal phone numbers above<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

* Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Telehealth

- Reimbursement for behavioral health telehealth services is subject to plan guidelines. Providers offering telehealth services should confirm with BCBSM that Member's plan includes behavioral health telehealth benefits.
- New Directions does not authorize behavioral health telehealth services.
- New Directions will refer member to BCBSM link (Ameriwell) to request telehealth services: www.bcbsmonlinevisits.com. Members can also receive telehealth services through BCBSM network providers offering telehealth services

## Other information

Please visit **http://www.bcbsm.com/providers/help/contact-us.html** for all other information.

## Blue Cross Blue Shield of Louisiana (BCBSLA)

| | |
|---|---|
| BCBSLA Authorizations | **New Directions** 800-991-5638 |
| BCBSLA Benefits & Eligibility | **BCBSLA**<br>Use www.bcbsla.com/ilinkblue for eligibility. Call the Customer Care Center at 800-922-8866 for benefits. |
| BlueCard Eligibility | **Other Blue Plans**<br>For benefits and eligibility for member of a Blue Plan other than BCBSLA<br>1-800-676-BLUE (1-800-676-2583) |
| Provider Relations | **BCBSLA**<br>provider.relations@bcbsla.com, 1-800-716-2299, option 4 |
| Provider Operations | **BCBSLA**<br>network.administration@bcbsla.com<br>1-800-716-2299<br>Option 1 for provider file questions<br>Option 2 for credentialing questions |
| Medical Necessity Appeals | **BCBSLA** 800-991-5638 (Expedited Appeals)<br>**New Directions**<br>https://webpass.ndbh.com (Standard Appeals)<br>See chart below for additional details |
| Claims Inquiries | **BCBSLA**<br>Use www.bcbsla.com/ilinkblue to check claims status. For more complex claims questions, call the Customer Care Center at 1-800-922-8866.<br><br>Refer to A Guide for Disputing Claims Tidbit to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross |
| EDI Clearinghouse | **BCBSLA**<br>EDICH@bcbsla.com<br>225-291-4334 |
| iLinkBLUE & EFT | **BCBSLA**<br>1-800-216-BLUE (1-800-216-2583) |

## Authorizations

- BCBSLA requires prior authorization for certain behavioral health services:
- Inpatient Hospital (including detox)
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Residential Treatment Center (RTC)
- Applied Behavior Analysis (ABA)

## Medical Necessity Appeals

**(Excludes Medicare and FEP plans)***

| Appeal Type | Timely Filing | NDBH Turn Around Time | How to Submit Request |
|---|---|---|---|
| **Expedited Appeal** | 180 days after denial is rendered** | 72 hours from receipt of request | Phone: 800-991-5638 |
| **Standard Appeal** | 180 days after denial is rendered | 30 calendar days from receipt of request | Online: https://webpass.ndbh.com<br><br>Phone: 800-991-5638<br><br>Fax: 816-237-2382<br><br>Mail:<br>NDBH – Attn: Appeals<br>PO Box 6729<br>Leawood, KS 66206-0729 |

* Medical necessity appeal inquiries for Medicare and Federal plans should be directed towards BCBSLA at phone number 800-991-5638.

** Member must currently be in treatment at the requested level of care, and urgency must be demonstrated

## Claims Filing Requirements

Please include the following information on all BCBSLA claims:

- Member ID Number
- Patient Name and Date of Birth
- Date of Service
- Provider NPI
- Include all applicable procedure and diagnosis codes (it is important to file “ALL” applicable diagnosis codes to the highest degree of specificity)

## Timely Claims Filing

- BCBSLA claims must be filed within 15 months of the date of service, or the length of time stated in the member's contract, if different. Claims received after 15 months, or length of time stated in the member's contract, will be denied, and the member and Blue Cross should be held harmless for these amounts.
- BCBSLA claims for FEP members must be filed by December 31 of the year after the year the service was rendered.
- Self-insured plans and plans from states other than Louisiana may have different timely filing guidelines. Please call Customer Care Center at 1-800-922-8866 to determine what the claims filing limits are for your patients.
- BCBSLA claims for OGB (Office of Group Benefits) members must be filed within 12 months of the date of service. Claims received after 12 months will be denied for timely filing and the OGB member and Blue Cross should be held harmless. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

## Claims Submission

Electronic Claims:

Electronic Claims – Providers filing electronic claims should use payer ID – 23738 (Professional/HCFA) U3738 (Institutional/UB)

Paper Claims - BCBSLA paper claims should be mailed to:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898

FEP paper claims should be mailed to:
P.O. Box 98028
Baton Rouge, LA 70898-9028

Medicare Advantage Claims

Please call the phone number on the back of member's ID card.

## Change in Demographics

- To update your address or contact information, complete BCBSLA's online interactive Provider Update Form

## Medical Records

- Medical records are to be provided upon request without charge, as agreed to in your BCBSLA provider contract.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.

## Appendix A: Blue Plan Groups

**Note**: Information contained in the appendix is specific to each plan (i.e., not a New Directions process). It may be subject to change. If you have questions, please direct them to the applicable plan.

# Appendix A.1: Tampa General Hospital

| | |
|---|---|
| Customer Service | 1-844-594-6012 |
| PPO Provider Locator | 1-800-810-2583 |
| Preadmission Certification | 1-855-288-8357 |
| rovider Benefits/Eligibility | 1-855-630-6825 |
| Pharmacist Help Line | 1-800-545-8349 |
| EAP | 1-800-624-5544 |

## Timely Filing

- Timely filing of claims is 180 days.

## Claims

- Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.
- Claims submitted electronically use payer ID– 00590.
- Members file claims to:

  Birmingham Service Center
  PO Box 10527
  Birmingham, AL 35202-0500

# Appendix A.2: Polk County Public Schools

| | |
|---|---|
| **Customer Service** | **1-855-630-6824** |
| **PPO Provider Locator** | **1-800-810-2583** |
| **Preadmission Certification** | **1-855-288-8357** |
| **rovider Benefits/Eligibility** | **1-855-630-6825** |
| **Pharmacist Help Line** | **1-800-545-8349** |
| **EAP** | **1-800-272-7252** |
| **PCSB Employee Clinic*** | **1-863-419-3322** |
| **Contracts separately with group* | |

## Timely Filing

- Timely filing of claims is 180 days.

## Claims

- Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.
- Claims submitted electronically use payer ID– 00590.
- Members file claims to:

  Birmingham Service Center
  PO Box 10527
  Birmingham, AL 35202-0500

## Appendix B: Medicare Advantage Plans contracted with New Directions

**Note**: Information contained in the appendix is specific to each plan (i.e., not a New Directions process). It may be subject to change. If you have questions, please direct them to the applicable plan.

# Appendix B.1: BayCare Select Health Plan

| | | |
|---|---|---|
| **Benefits & Eligibility** | **BayCare Select Health Plan** | **See Customer Service Phone number on the Member's ID card for benefits/eligibility or call 866-509-5396** |
| **Provider Relations/ Operations** | **BayCare Select Health Plan** | **866-509-5396** |
| **Claims Inquiries** | **BayCare Select Health Plan** | **866-509-5396** |
| **Deaf or Hearing Impaired** | **State Relay Phone Number** | **Relay services Dial 711 for state relay service toll-free number** |
| **Provider Appeals** | **BayCare Select Health Plan** | **www.baycareplus.org appeals@baycarehealthplans.org 866-509-5396 DNIS 3827** |

## Timely Filing

- BayCare Select Health Plan claims must be filed according to your contract:
    - 12 months from the date of service or date of discharge; or
    - 6 months from the date of service; or
    - 90 days from the date of discharge
- Non-contracted providers must file within 12 months from the date of service or date of discharge.
- Claims received after 12 months from the date of service or date of discharge, or after the length of time stated in the member's contract, will be denied. In such an event, the member and BayCare Health Plan will be held harmless for these amounts.

## Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 81079.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services is not a covered benefit for BayCare Select Health Plan

# Appendix B.2: Mutual of Omaha Medicare Advantage Company

| | | |
|---|---|---|
| Benefits & Eligibility | Mutual of Omaha Medicare Advantage Company | See Customer Service Phone number on the Member's ID card for benefits/eligibility or call<br>Cincinnati, OH (KY) – 1-877-603-0785<br>San Antonio, TX – 1-866-488-0249 |
| Provider Relations/ Operations | Mutual of Omaha Medicare Advantage Company | Cincinnati, OH (KY) – 1-877-603-0785<br>San Antonio, TX – 1-866-488-0249 |
| Claims Inquiries | Mutual of Omaha Medicare Advantage Company | Cincinnati, OH (KY) – 1-877-603-0785<br>San Antonio, TX – 1-866-488-0249 |
| Deaf or Hearing Impaired | State Relay Phone Number | Relay services<br>Dial 711 for state relay service toll-free number |
| Provider Appeals | Mutual of Omaha Medicare Advantage Company | www.mutualofomahacareadvantage.com<br>appeals@mutualmedicareadvantage.com<br>Cincinnati, OH (KY) - 877-603-0785<br>DNIS 3802<br>San Antonio, TX - 866-488-0249<br>DNIS 4859 |

## Timely Filing

- Mutual of Omaha Medicare Advantage Company claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or length of time stated in the member's contract, will be denied. In such event, the member and Mutual of Omaha Medicare Advantage Company will be held harmless for these amounts.

## Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 82275.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services is not a covered benefit for Mutual of Omaha Medicare Advantage Company.

# Appendix B.3: Medicare Advantage Insurance Company of Omaha

| | | |
|---|---|---|
| **Benefits & Eligibility** | **Medicare Advantage Insurance Company of Omaha** | **See Customer Service Phone number on the Member's ID card for benefits/eligibility or call<br>Dallas, TX – 1-844-335-3776<br>El Paso, TX – 1-844-335-2918<br>Denver, CO – 1-844-335-4178** |
| **Provider Relations / Operations** | **Medicare Advantage Insurance Company of Omaha** | **Dallas, TX – 1-844-335-3776<br>El Paso, TX – 1-844-335-2918<br>Denver, CO – 1-844-335-4178** |
| **Claims Inquiries** | **Medicare Advantage Insurance Company of Omaha** | **Dallas, TX – 1-844-335-3776<br>El Paso, TX – 1-844-335-2918<br>Denver, CO – 1-844-335-4178** |
| **Deaf or Hearing Impaired** | **State Relay Phone Number** | **Relay services<br>Dial 711 for state relay service toll-free number** |
| **Provider Appeals** | **Medicare Advantage Insurance Company of Omaha** | **Dallas, TX – 1-844-335-3776<br>El Paso, TX – 1-844-335-2918<br>Denver, CO – 1-844-335-4178** |

## Timely Filing

- Medicare Advantage Insurance Company of Omaha claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or length of time stated in the member's contract, will be denied. In such event, the member and Medicare Advantage Insurance Company of Omaha will be held harmless for these amounts.

## Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 82275.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services is not a covered benefit for Medicare Advantage Insurance Company of Omaha.

# Appendix B.4: Physicians Health Plan (PHP) Medicare

| | | |
|---|---|---|
| **Benefits & Eligibility** | **Physicians Health Plan (PHP) Medicare** | **See Customer Service Phone number on the Member's ID card for benefits/eligibility or call**<br>**PHP Sparrow & Sparrow Advantage: 1-844-529-3757**<br>**PHP Covenant & Covenant Advantage: 1-844-329-9247**<br>**PHP Advantage: 1-855-229-2172** |
| **Provider Relations / Operations** | **Physicians Health Plan (PHP) Medicare** | **PHP Sparrow & Sparrow Advantage: 1-844-529-3757**<br>**PHP Covenant & Covenant Advantage: 1-844-329-9247**<br>**PHP Advantage: 1-855-229-2172** |
| **Claims Inquiries** | **Physicians Health Plan (PHP) Medicare** | **PHP Sparrow & Sparrow Advantage: 1-844-529-3757**<br>**PHP Covenant & Covenant Advantage: 1-844-329-9247**<br>**PHP Advantage: 1-855-229-2172** |
| **Deaf or Hearing Impaired** | **State Relay Phone Number** | **Relay services**<br>**Dial 711 for state relay service toll-free number** |
| **Provider Appeals** | **Physicians Health Plan (PHP) Medicare** | **PHP Sparrow & Sparrow Advantage: 1-844-529-3757**<br>**PHP Covenant & Covenant Advantage: 1-844-329-9247**<br>**PHP Advantage: 1-855-229-2172** |

## Timely Filing

- Physician Health Plan (PHP) Medicare claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or length of time stated in the member's contract, will be denied. In such event, the member and Physician Health Plan (PHP) Medicare will be held harmless for these amounts.

## Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 83276.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services is not a covered benefit for Physician Health Plan (PHP) Medicare.

# Appendix B.5: Mary Washington Health Plan

| | | |
|---|---|---|
| **Benefits & Eligibility** | **Mary Washington Health Plan** | **See Customer Service Phone number on the Member's ID card for benefits/eligibility or call Mary Washington: 1-844-529-3760** |
| **Provider Relations / Operations** | **Mary Washington Health Plan** | **Mary Washington: 1-844-529-3760** |
| **Claims Inquiries** | **Mary Washington Health Plan** | **Mary Washington: 1-844-529-3760** |
| **Deaf or Hearing Impaired** | **State Relay Phone Number** | **Relay services Dial 711 for state relay service toll-free number** |
| **Provider Appeals** | **Mary Washington Health Plan** | **Mary Washington: 1-844-529-3760** |

## Timely Filing

- Mary Washington Health Plan claims must be filed within 180 days from the date of service or date of discharge.
- Claims received after 180 days, or length of time stated in the member's contract, will be denied. In such event, the member and Mary Washington Health Plan will be held harmless for these amounts.

## Claims Submission

Electronic Claims:

- Providers filing electronic claims should use payer ID – 83269.

## Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
- Important notice: Telehealth services is not a covered benefit Mary Washington Health Plan