

MANAGED BEHAVIORAL HEALTH PROVIDER AND FACILITY MANUAL

August 2020



NEW DIRECTIONS®

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TABLE OF CONTENTS

TABLE OF CONTENTS2

Key Changes Index for Provider and Facilities Manual.....6

Section 1: Introduction.....8

Preface8

About New Directions9

New Directions’ Expectations of Providers10

Provider Communications13

NCQA Network Reports.....14

Section 2: Network Operations15

Policies and Procedures15

Change in Provider Demographics15

Credentialing Criteria16

Provider Rights and Responsibilities18

Checking Member Eligibility and Plan Benefits20

Section 3: Provider Accessibility.....24

Overview24

Availability Standards24

Coordination of Care with Primary Care Physicians and other Providers.....25

Section 4: Member Safety and Quality of Care26

Member and Client Rights and Responsibilities26

Quality Improvement.....27

Focus Areas29

Adverse Event Reporting.....32

Section 5: Managing Utilization38



Medical Necessity Criteria	38
Utilization Management	38
Conducting Clinical Utilization Management (UM) Review.....	39
Clinical Peers	39
UM Process Limitations.....	39
Treatment Record Reviews	41
Guidelines for Treatment Record Documentation	43
Request for Psychological/Neuropsychological Testing	48
Commercial Member and Provider Denial and Appeal Rights	49
Adverse Benefit Determination and Appeal Definitions	51
Section 6: Clinical Programs	52
Philosophy.....	52
Care Management Program	52
Care Transitions Activities	53
Member Self-Management and Preventive Health Tools	54
Section 7: Clinical Practice Guidelines	55
About Clinical Practice Guidelines.....	55
Section 8: Clinical Practice Bulletins	73
Section 9: Fraud, Waste and Abuse.....	74
New Directions Policy.....	74
Definitions.....	74
Audits	75
Claim Recoupment and Appeals.....	75
Excluded Persons	76

Section 10: Billing Assistance	77
Billing and Missed Appointments.....	77
Medication-Assisted Treatment (MAT) Services	77
Maximum Visits per Day	77
Concurrent and Overlapping Services	77
Billing Submission	77
CPT Time Rule	78
Common Billable CPT and Revenue Codes	79
Section 11: Compliance Program.....	95
Overview	95
Reporting	95
HIPAA Information	95
Privacy Policy and Privacy Practices	95
Appendix for Blue Cross and Blue Shield Plans	97
Blue Cross Blue Shield of Alabama (including Southern Company).....	98
Arkansas Blue Cross Blue Shield (Arkansas Blue Cross) Federal Employee Program (FEP) (including State of Arkansas Employees)	103
Walmart through Arkansas Blue Cross Blue Shield/Blue Advantage Administrators (BAA)...	106
Florida Blue PPO including Medicare Advantage	108
Florida Blue HMO including Medicare Advantage and BlueMedicare Classic Plus HMO available in Hillsborough and Palm Beach Counties.....	111
Florida Blue Federal Employee Program (FEP)	114
Florida Blue Medicare Preferred HMO (Florida Blue and BeHealthy)	117
Blue Cross Blue Shield of Kansas (BCBSKS) PPO	120
Blue Cross Blue Shield of Kansas (BCBSKS) Solutions/EPO (Exclusive Provider Organization)	122

Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP).....	124
Blue Cross Blue Shield of Kansas (BCBSKS) Medicare Advantage.....	126
Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO	128
Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care, Preferred-Care Blue, BlueSelect & BlueSelect Plus PPO	131
Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP).....	134
Blue Cross and Blue Shield of Michigan (BCBSM) including United Auto Workers Retiree Medical Benefits Trust (URMBT), GM and State of Michigan (SOM)	137
Blue Cross Blue Shield of Louisiana (BCBSLA).....	140
Appendix A: Blue Plan Groups.....	143
Appendix A.1: Tampa General Hospital	144
Appendix A.2: Polk County Public Schools	145
Appendix B: Medicare Advantage Plans contracted with New Directions	146
Appendix B.1: BayCare Select Health Plan	147
Appendix B.2: Mutual of Omaha Medicare Advantage Company	148
Appendix B.3: Medicare Advantage Insurance Company of Omaha	149
Appendix B.4: Physicians Health Plan (PHP) Medicare.....	150
Appendix B.5: Mary Washington Health Plan	152



Key Changes Index for Provider and Facilities Manual

August 2020 version

SECTION	PAGE	CONTENT CHANGE
Section 1: Introduction Provider Communications	13	<ul style="list-style-type: none"> • Reminder that providers have 72 hours to notify New Directions of address, phone number, fax number, or email changes
Section 2: Credentialing Criteria	16-17	<ul style="list-style-type: none"> • M.D. and D.O. credentialing requirements • Inpatient on-site visit form added
Section 3: Provider Accessibility	25	<ul style="list-style-type: none"> • Coordination of Care with Primary Care Physicians and other providers
Section: 5 Managing Utilization	49	<ul style="list-style-type: none"> • Commercial Member and Provider Denial and Appeal Rights. New Directions contact information for this process added.
Section 7: Clinical Practice Guidelines	55-73	<ul style="list-style-type: none"> • Adopted Clinical Practice Guidelines updated for ADHD, Adult SUD, Adult Bipolar Disorder, Major Depression, Eating Disorders, Autism Spectrum Disorder, Schizophrenia, Opioid Use Disorder, and Suicide Risk Assessment

SECTION	PAGE	CONTENT CHANGE
Section 8: Clinical Practice Bulletins	74	<ul style="list-style-type: none">• Provider Telehealth Care Standards

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 to notify of updates to your practice locations, demographics and new areas of clinical specialization. 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.

New Directions' 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.

Our Top 10 Delivery of Care Expectations and Supportive Resources

1. Delivery of care in the least restrictive setting

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 must begin on the day of admission. New Directions expects that discharge planning is comprehensive as referenced in the 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. New Directions can support you by facilitating a comprehensive discharge plan.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

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 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.**

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

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. To submit changes, please complete the electronic [Provider/Facility Update Form](#). 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, Office Administrators and facilities. You will find membership eligibility and plan benefits at www.ndbh.com in the provider WebPass section. If you do not have a username and password to enter this area of the website, please complete the Access Request Form, which can be located in this manual or on www.ndbh.com. You may also contact us by email at PRWebPass@ndbh.com.

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 accept casre management referrals. To access our WebPass Provider sign-up form, Provider Manual, Medical Necessity Criteria, Clinical Practice Guidelines and Treatment Request Forms, visit our website.

The WebPass system provides users with a safe and secure way to send protected health information to New Directions. Please remember that much of the Internet is not secure. Protected health information should not be communicated by email.

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 about the new provider guidelines pertaining to eating disorder cases, 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) – 24 hours**
- *Post-admit Residential Treatment Center (member has been admitted to unit level of care) – 24 hours**

**Extensions of up to 72 hours 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) – 72 hours*
- *Partial Hospitalization Program (PHP)/Intensive Outpatient Program (IOP)/Outpatient services (OP): includes Electroconvulsive Therapy (ETC) 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 – 24 hours regardless of the level of care*

Getting Started with WebPass

To access the New Directions WebPass system for individual providers, you will need to obtain a username and password. To do so, email PRWebPass@ndbh.com with your name and email address.

To access the New Directions WebPass system for facilities or groups, send the names of staff needing an account to PRWebPass@ndbh.com. Please include your staff members' first and last names and email addresses.

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 and step-down reviews for urgent care on the last covered day. **Please submit continued stay and step-down reviews 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 and residential, **please submit continued stay and step-down review requests prior to 12:30 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 most 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 Webpass submission and updated with each submission of the individualized plan**, including specific providers and appointments. Members admitted to inpatient and residential levels of care require follow-up appointments within 7 days of discharge
- 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

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

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. Printed copies of the QI Program Evaluation, work plan and description are available to providers on request by emailing ProviderRelations@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.



CLNC-1060

Adverse Event Reporting Form

<input type="text"/>	<input type="text"/>
Facility Name	Patient Name
<input type="text"/>	<input type="text"/>
Reporter Name	Patient DOB
<input type="text"/>	<input type="text"/>
Reporter Title	Patient Policy Number
<input type="text"/>	<input type="text"/>
Reporter Phone Number	Patient Phone Number
<input type="text"/>	<input type="text"/>
Reporter Email:	Coverage (if also secondary coverage):

<input type="text"/>	<input type="text"/>
Incident Date	Date of Report
Persons Involved:	Location:
<input type="checkbox"/> Patient <input type="checkbox"/> Staff <input type="checkbox"/> Persons not associated with facility <input type="checkbox"/> Other _____	<input type="checkbox"/> In facility <input type="checkbox"/> On grounds <input type="checkbox"/> Off grounds <input type="checkbox"/> Home <input type="checkbox"/> Other _____

Incident Type:

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

1. ABUSE/ASSAULT SECTION

Alleged or suspected sexual abuse/assault:

<input type="checkbox"/> Nonconsensual contact (peer to peer) <input type="checkbox"/> Nonconsensual contact w/staff <input type="checkbox"/> Nonconsensual contact w/other perpetrator	<input type="checkbox"/> Consensual contact (peer to peer) <input type="checkbox"/> Consensual contact w/staff <input type="checkbox"/> Consensual contact w/other perpetrator
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If nonconsensual:

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

CLNC-1060

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 _____

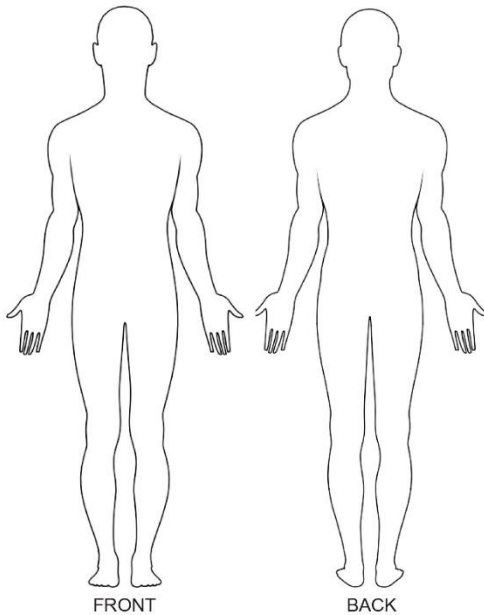
3. INJURY SECTION

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: _____



<input type="text"/>	<input type="text"/>
Family/Guardian Name	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Physician Name	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Law Enforcement	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Department of Child Services	Date/Time Contacted
<input type="text"/>	<input type="text"/>
911	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Other	Date/Time Contacted
<input type="text"/>	<input type="text"/>
Other	Date/Time Contacted

Summary of Incident

Immediate Action Taken

Exam Information

<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	Time	Provider Type
<input type="text"/>	<input type="text"/>	
Medication	Date/Time Contacted	

Medically Cleared Yes No
Date Cleared

Medical Treatment

Location/Facility Name

Medical Admission Yes No
Date and Facility Name

Medication Changes: new, change, or discontinued (name of medication, dosage, route, frequency)

Precaution or Restriction Modification

Action steps taking to prevent recurrence



Section 5: Managing Utilization

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:

- (a) The services, and Covered Services, performed under this Agreement;
- (b) The determination that services performed are Covered Services;
- (c) Reconciliation and coordination of benefit liabilities;
- (d) Determination of amounts payable;
- (e) Medical audit or review;

- f) Utilization management, quality improvement, care transitions, and other clinical program activities;
- (g) Financial transactions associated with this agreement;
- (h) Overpayment, underpayment, and documentation reviews; and
- (i) 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.

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

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.

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.

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:

- a. Date, start/stop times, and duration of the group
- b. Purpose of group
- c. Objective and subjective documentation of the member's presentation during group
(individualized to the member)
- d. Summary of the intervention utilized
- e. Member's response to the group
- f. Provider of group is documented and authenticated with professional degree and/or professional credentials
- g. 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.

Commercial Member and Provider Denial and Appeal Rights

The attending physician can request a peer-to-peer conversation upon receipt of an adverse benefit determination. A peer-to-peer conversation can be requested by calling New Directions. Please refer to the appendix for the appropriate plan account name and phone number to call. The peer-to-peer conversation will occur with the initial clinical reviewer, another clinical reviewer if the initial clinical reviewer cannot be available within one business day, or a clinical peer.

For inpatient and residential requests, peer-to-peer conversations are available only to the attending provider responsible for ordering the treatment and requesting the peer review. Attending providers may not delegate this responsibility, designate a representative or use a third billing or management company to conduct the peer-to-peer conversation.

For partial hospitalization requests, and intensive outpatient requests, the member's primary provider may request and conduct peer-to-peer conversations.

If a clinical peer makes an adverse benefit determination to deny coverage for payment of the requested service, the requesting provider, or facility, as well as the member are notified of the adverse benefit determination and appeal rights.

The right to appeal is available to the member, the member's authorized representative, and the member's provider. Appeal procedures are specific to the member's plan. New Directions has written procedures for appeal of benefit determinations for an admission, or extension of stay, including retrospective non-certification determinations. Providers, members and authorized representatives can request an appeal by calling New Directions at (800) 528-5763 or writing to us at:

NDBH
P.O. Box 6729
Leawood, KS 66206-0729

All medical necessity appeals are reviewed by a clinical peer - a physician, or other Ph.D. behavioral health professional who holds an unrestricted license or certificate to practice and in the same or similar specialty as one who typically manages the health condition, procedures or treatment under review.

Members, families and providers can access New Directions UM staff to answer general questions regarding access to services, UM issues and the UM process toll free, 24 hours a day, seven days a week. Please refer to the appendix for the appropriate plan account name and phone number to call.

The member also has the right to request an independent review when an adverse determination is based on lack of medical necessity. An independent review is a review completed by an external review organization. The external review organization will use a physician who has similar education, certification and licensure as the ordering provider.

41

New Directions' role in appeals varies by plan and group. See plan or group specific information and contact information in the appendix in the back of this manual.

Written member appeal and adverse benefit determination procedures are available upon request and can be found at www.ndbh.com.

Adverse Benefit Determination 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 rescission of coverage, including a cancellation or discontinuance of coverage that has retroactive effect.

Appeal – A verbal or written request by a member, an authorized representative on behalf of the member, or a provider, for a full review of the adverse benefit determination, including any aspect of clinical care involved. An appeal may also be referenced as a “grievance”.

Clinical Peer – A physician or Ph.D. behavioral health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under view. Generally, the individual must be in the same profession (i.e., the same licensure category) as the ordering provider.

Expedited Internal Appeal – A review of an adverse benefit determination of urgent services involving an admission, continued stay, or other health care services within a facility.

External Review – A review of an adverse benefit determination conducted pursuant to an applicable State external review process or the Federal review process.

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.

Section 6: Clinical Programs

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

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

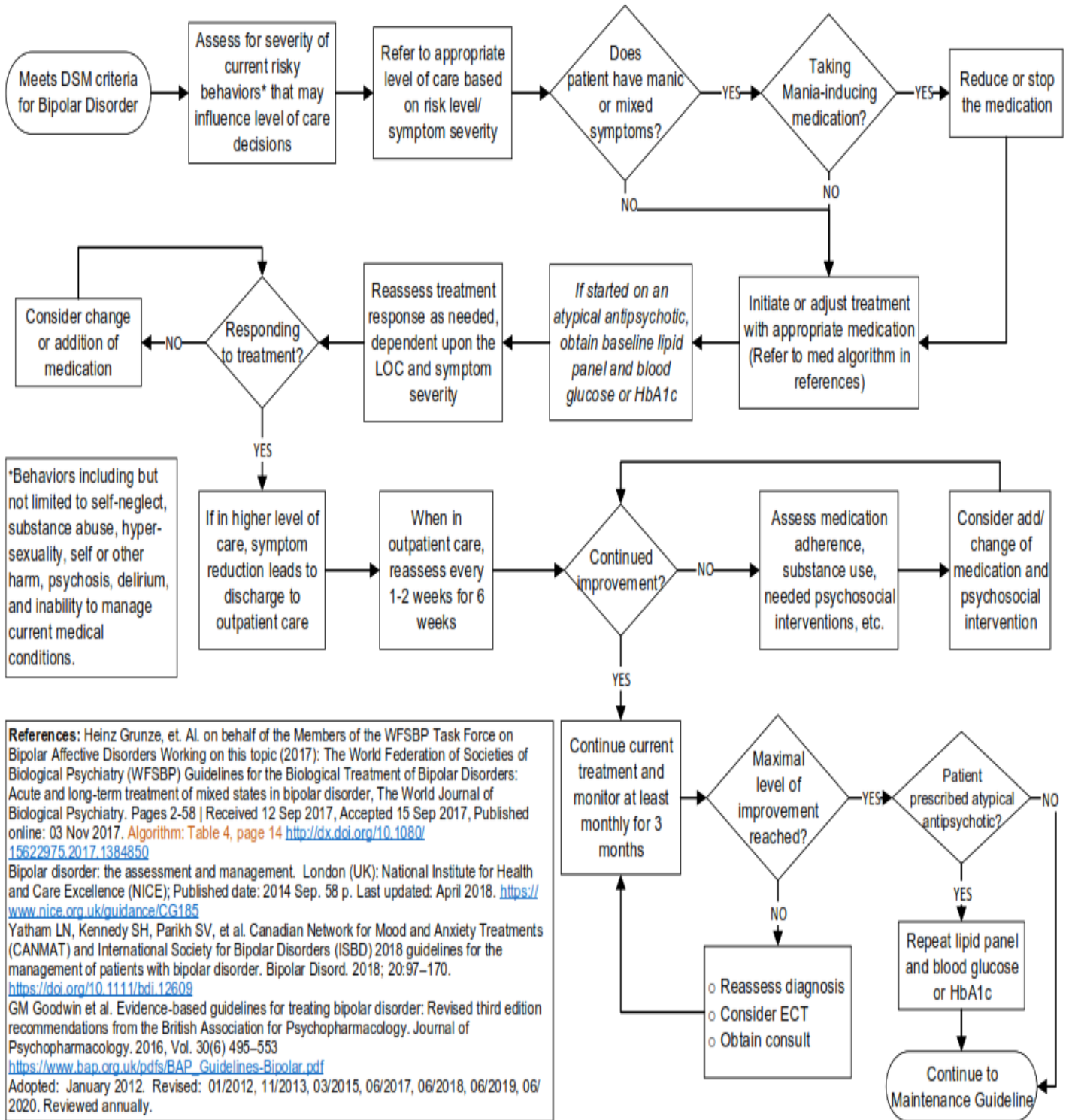
Opioid Use Disorder

- Assessment and treatment

Suicide Risk Assessment (New in 2020)

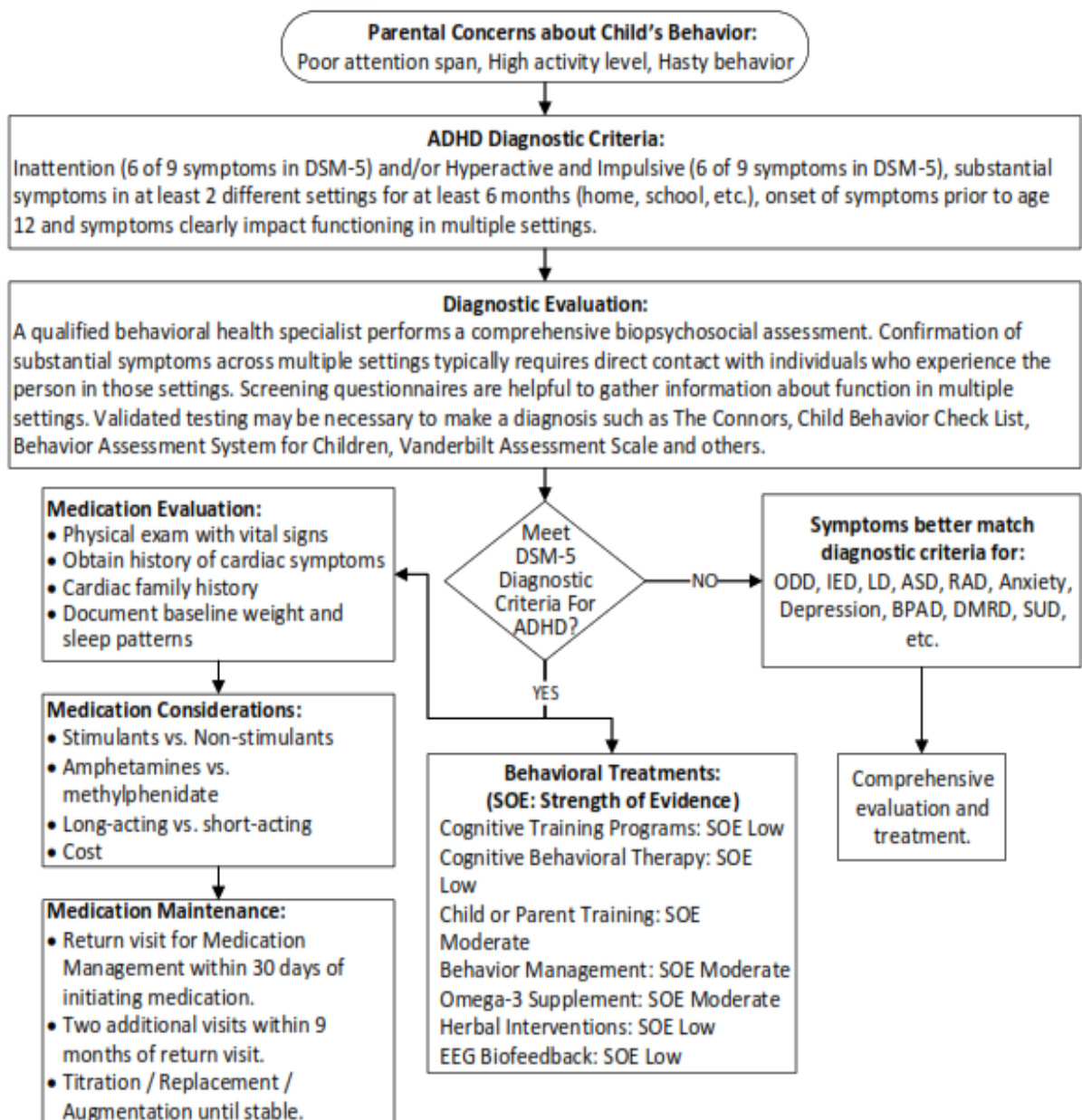
- Initial assessment

Bipolar Disorder Treatment Guideline – Acute Episode



Bipolar Disorder Treatment Guideline – Maintenance Episodes

Continued from Acute Phase



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. 290-2015-00004-1.) 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>.

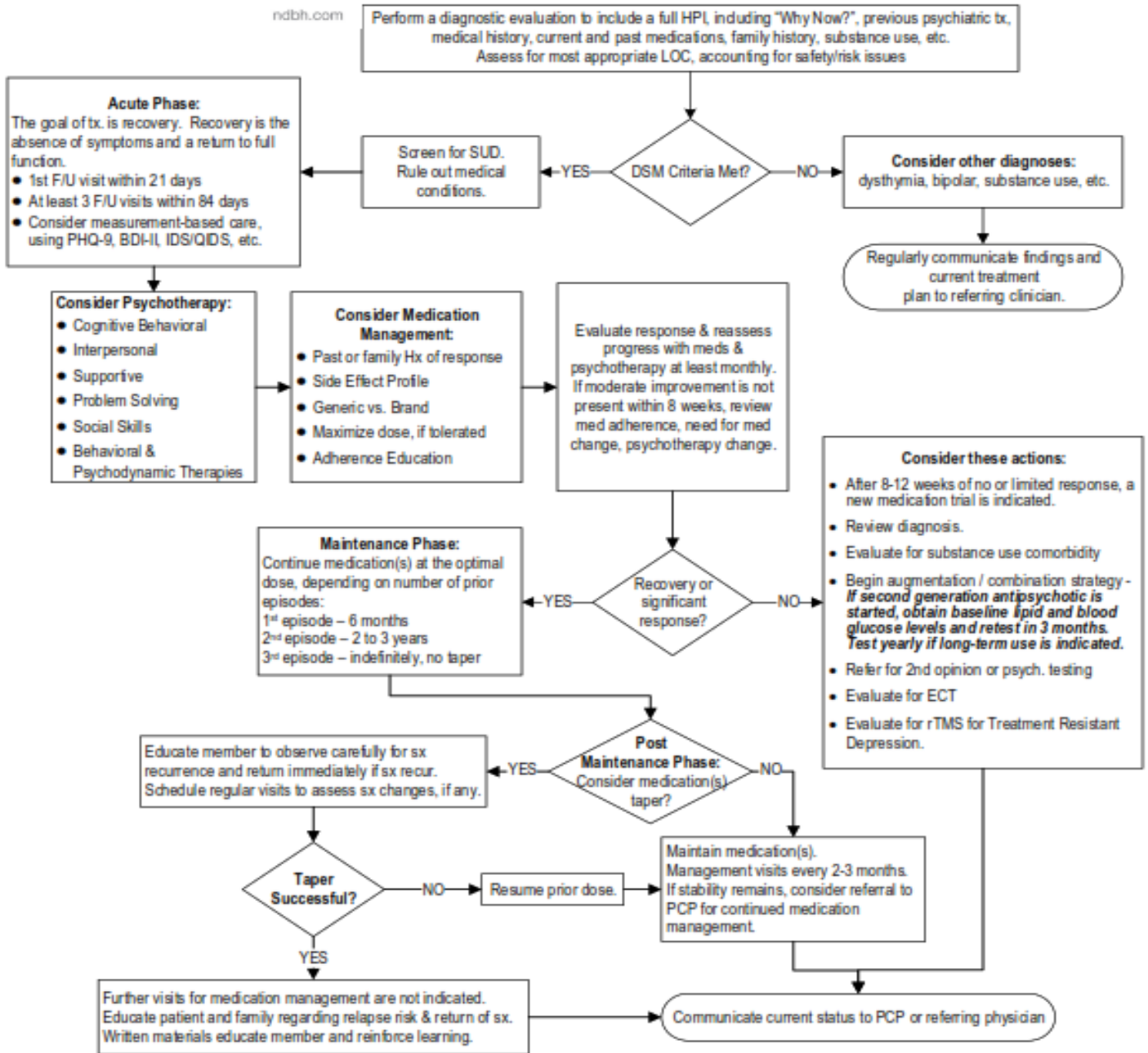
Attention deficit hyperactivity disorder: diagnosis and management. National Institute for Health and Care Excellence (NICE) Clinical guideline [NG87] Published Date: March 2018. Last Updated: September, 2019. <https://www.nice.org.uk/guidance/ng87>

Treatment of ADHD. (Last Reviewed: October 8, 2019). Retrieved: January 28, 2020, from <https://www.cdc.gov/ncbddd/adhd/treatment.html>

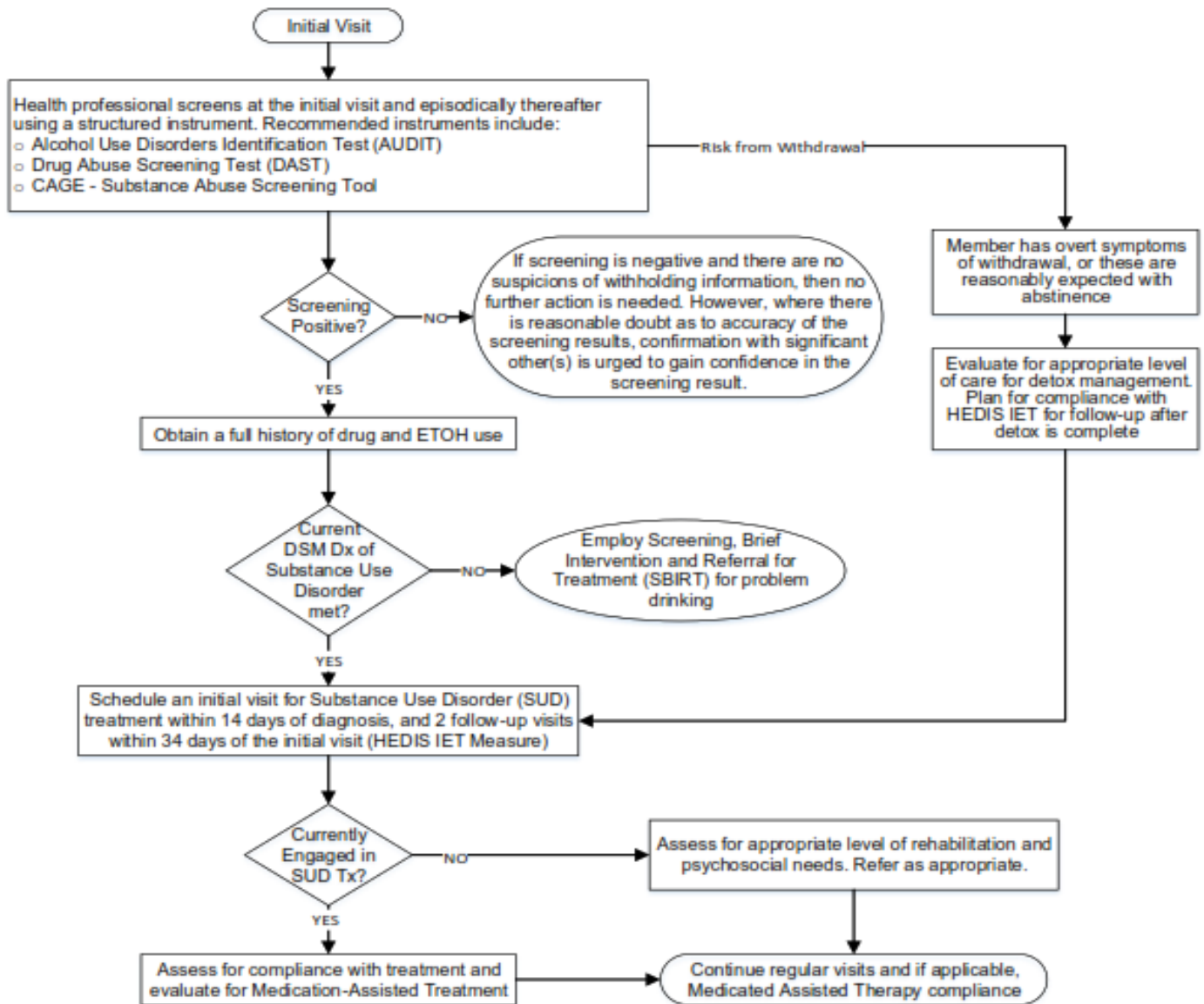
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

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.

Major Depression Guideline for Initial Outpatient Treatment of Adults



Sources:
2017-2016 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (2016). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration. <http://www.medicallmentalhealth.org/assets/file/Guidelines/2016-Psychotherapeutic%20Medication%20Guidelines%20for%20Adults%20with%20References.pdf>
Qaseem A, Barry MJ, Kansagara D, for the Clinical Guidelines Committee of the American College of Physicians. Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients With Major Depressive Disorder: A Clinical Practice Guideline From the American College of Physicians. Ann Intern Med. 2016; 164:350–359. [Epub ahead of print 9 February 2016]. doi: <https://doi.org/10.7326/M15-2570>
VA/DoD Clinical Practice Guideline for The Management Of Major Depressive Disorder, Version 3.0 – 2016, Department of Veterans Affairs and Department of Defense. Prepared by: The Management of Major Depressive Disorder Working Group. <https://www.healthquality.va.gov/guidelines/MH/mdd/>
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. 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.



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.integration.samhsa.gov/clinical-practice/screening-tools#drugs>.

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.ncoa.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-1937573761733>
 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>
 SAMHSA Substance Abuse and Mental Illness Prevention (Last Updated: 02/04/2020): <https://www.samhsa.gov/prevention> (Retrieved: 03-02-2020)
 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Adopted: 12/05. Revised: 06/06, 04/08, 12/09, 04/11, 01/12, 05/14, 06/17, 06/19. 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 adopted the Clinical Practice Guidelines (CPG) developed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) for the management of schizophrenia and related disorders.

New Directions has three caveats concerning this CPG:

- The following oral/injectable medications are not available in the U.S.: amisulpride, pericyazine, zuclopenthixol
- The following long-acting injectable medications are not available in the U.S.: flupenthixol, zuclopenthixol
- In addition, section 5 of the RANZCP document¹ deals with specific populations, including Aboriginal, Torres Strait Islanders, Māori, and Pacific Islander peoples.

Links and References:

1. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Cherrie Galletly, David Castle, Frances Dark, Verity Humberstone, Assen Jablensky, Eóin Killackey, Jayashri Kulkarni, Patrick McGorry, Olav Nielssen and Nga Tran. Australian & New Zealand Journal of Psychiatry 2016, Vol. 50(5) 1-117.
https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Schizophrenia-pdf.aspx
2. Early Psychosis Guidelines Writing Group and EPPIC National Support Program, Australian Clinical Guidelines for Early Psychosis, 2nd edition update, 2016, Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne.
https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/clinical-guidelines-for-early-psychosis_a-summary.aspx
3. 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>.
4. 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 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

The members New Directions serve have a wide range of mental health diagnoses, including Autism Spectrum Disorder (ASD). With over 8,600 members who have been diagnosed with ASD, we are committed to offer guidance to providers so they can align with evidence-based practice guidelines. See Table 1 for prevalence. 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 communication, and restricted, repetitive patterns of behavior. Behavioral therapies are the main form of treatment for ASD. The primary form of behavioral therapy 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 driven by individual state mandates.

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 care 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 Care 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. Care 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' Care 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, Fonnesebeck 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/AHRQEPCER189>.
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. Available from URL: <https://www.sign.ac.uk/assets/sign145.pdf>

Adopted: 06-2017

Last Revised: 06-2020

Reviewed annually.

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

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 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, in which treatment intensity is continually adjusted to accommodate individual patient 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).

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](#).

<p>Assessment & Diagnosis:</p> <ul style="list-style-type: none"> ◆ Identify & refer urgent or emergent medical or psychiatric problems ◆ Medical history & physical exam <ul style="list-style-type: none"> ● Focus on withdrawal signs & symptoms ● Use scales to measure OUD withdrawal symptoms (i.e., COWS and others) ● Screen for concomitant medical conditions (infectious diseases, acute trauma, and pregnancy) ● Physical exam (comprehensive assessment) ● Laboratory testing (including urine drug screen, TB, HIV, Hep B&C, pregnancy testing, and others as indicated) ● Contraception query ● Mental Health Assessment ● Assessment for other substance use disorders ● Initial and regular checking of PDMP ● Social & environmental factors assessment ◆ Provider with prescribing authority confirms OUD diagnosis 	<p>Treatment of Opioid Withdrawal:</p> <ul style="list-style-type: none"> ◆ Clinician & patient share treatment option decisions ◆ Medication approaches (agonist/partial agonist/symptomatic relief) are preferred for withdrawal management vs. abrupt cessation ◆ Consider patient preferences, treatment history & treatment setting to determine medications selection. Treatment setting as important as medications selected. <ul style="list-style-type: none"> ● Office-based opioid treatment (OBOT) with buprenorphine preparations may not be suitable for patients with certain other drug addiction issues ● Opioid Treatment Programs (OTPs) offer daily dosing and supervision of methadone, although some now offer buprenorphine approaches ● OTP or inpatient setting if Methadone selected ◆ Advise patients that medications alone for opioid withdrawal is not a complete treatment method. Psychosocial treatment in conjunction with opioid withdrawal management is recommended and at a minimum should include: <ul style="list-style-type: none"> ● Psychosocial needs assessment ● Supportive counseling ● Links to existing family support ● Referrals to community services ● Tobacco cessation counseling ◆ Determine frequency of urine drug testing ◆ Concomitant use of benzodiazepines is not recommended ◆ Provider with prescribing authority should collaborate with behavioral provider
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<p>Opioid Withdrawal Management Medication Options:</p> <ul style="list-style-type: none"> ◆ Methadone ◆ Buprenorphine ◆ Lofexidine ◆ Naltrexone, as an oral standalone treatment, has poor adherence ◆ Combination buprenorphine & low dose oral naltrexone to manage withdrawal & facilitate induction to MAT during rehabilitation. Accelerated use of extended-release injectable naltrexone after withdrawal shows promise, but more work is needed. ◆ Clonidine to support opioid withdrawal management ◆ Naloxone for the treatment of opioid overdose. Advise patients of increased risk of overdose or death with stopping agonist therapy & resuming opioid use. Patient & family given prescription and trained on use. ◆ Anesthesia ultra-rapid opioid detoxification (UROD) is NOT recommended - too high risk 	<p>Populations that Require Special Management:</p> <ul style="list-style-type: none"> ◆ Pregnant women ◆ Adolescents ◆ Individuals with pain ◆ Co-occurring psychiatric disorders ◆ In criminal justice system
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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, 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
3. 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: 06/2020

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 American Psychiatric Association's Practice Guidelines for The Psychiatric Evaluation Of Adults, Third Edition (2016), 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), the Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm (2016), and the Suicide Prevention Resource Center's Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments (2015) as the CPG 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 significant 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.).

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. The American Psychiatric Association Practice Guidelines for The Psychiatric Evaluation of Adults, Third Edition (2016); American Psychiatric Association (APA) 2016.
<http://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>.
2. 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/>.
3. Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. Australian and New Zealand Journal of Psychiatry 2016, Vol. 50(10) 939-1000.

https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/deliberate-self-harm-cpg.aspx

4. Suicide Prevention Resource Center. Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments. 2015.
<https://www.sprc.org/edguide>

Adopted: 06-2020

Section 8: Clinical Practice Bulletins

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 judgement but are intended to enhance compliance with current best practice treatment with a focus on positive member outcomes.

Clicking on a link below will take you to a New Directions Clinical Best Practice Resource:

[Guiding principles in the treatment of SUBSTANCE USE DISORDERS
Provider Telehealth Care Standards](#)

Section 9: Fraud, Waste and Abuse

New Directions Policy

New Directions is committed to preventing, identifying, investigating and reporting fraud and abuse. The Compliance Program provides education on what types of activities constitute fraud and abuse. 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 “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse,” which is an excellent resource on fraud and abuse (<http://oig.hhs.gov/compliance/physicianeducation/index.asp>).

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 Federal or State 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 Federal- or State-funded 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 at http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp. Providers and Facilities are required to search this website at least monthly.

Section 10: Billing Assistance

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, to pay out of pocket for any missed appointments prior to beginning treatment with the provider.

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
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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)
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Automated Testing and Result

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

<p>REQUEST FOR AUTHORIZATION AND TREATMENT PLAN</p>	<p>A comprehensive medical record is submitted by the Board-Certified Behavior Analyst (BCBA) to request authorization that includes:</p> <ul style="list-style-type: none"> (a) All initial assessments performed by the BCBA. Preferred assessments include the ABLLS, VB-MAPP, and any other developmental measurements employed; (b) Individualized treatment plan with measurable goals that clearly address the active symptoms and signs of the member’s core deficits of ASD; (c) Goals should be written with measurable criteria such that they can be reasonably achieved within six months; (d) 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; (e) 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.
<p>GENERAL GUIDELINES FOR TREATMENT NOTES</p>	<p>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.</p> <p>Each service billed must have face-to-face encounter note that contains:</p> <ul style="list-style-type: none"> (a) reason for the member’s visit; (b) objective and subjective documentation of the patient’s presentation; (c) goal of the service rendered on the date billed and how it is connected to the treatment plan; (d) procedure code and specific service rendered; (e) date of service with start/stop time and/or duration of service that matches units and time-based CPT code billed; (f) summary of the intervention/service provided with the member response; (g) documentation of coordination of care (when applicable); (h) identified rendering provider including BCBA, line therapists, and behavioral technicians; (i) signature of rendering provider with professional degree and/or professional credentials; (j) no repetitive, rote, or cloned charting; (k) 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	<p>Face-to-face time is for direct services with interventions and includes:</p> <p>(a) Time spent with patient (b) Time spent with family (c) Time spent with patient and family</p> <p>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.</p>

ASSESSMENT CODES

Essential Elements of Applied Behavior Analysis Services:

Development of individualized treatment plan by supervising behavior analyst/QHP*

*Refers to qualified Healthcare Professional: Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, Board Certified Behavior Analyst-Doctoral, Board Certified Behavior Analyst, Board Certified Assistant Behavior Analyst, or other credentialed professional whose scope of practice, training, and competence includes applied behavior analysis.

- 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	<p>General Description: Assessment for treatment plan development</p> <p>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.</p> <p>Time/Units=per 15 minutes Attended By=client, QHP*</p>
97152 BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT	<p>General Description: Assessment for treatment plan development</p> <p>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.</p> <p>Time/Units=per 15 minutes Attended By=client, technician (QHP* may substitute for the technician)</p>
0362T BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT	<p>General Description: Functional analysis of severe maladaptive behaviors in specialized settings</p> <p>Descriptor: each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:</p> <ul style="list-style-type: none"> • 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.); • With the assistance of two or more technicians; • For a patient who exhibits destructive behavior; • Completed in an environment that is customized to the patient's behavior. <p>Time/Units=per 15 minutes Attended By=client and 2 or more technicians; QHP*</p>

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 supervision of technician and caregiver implementation.
- 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.

<p>97153 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL</p>	<p>General Description: Direct Treatment.</p> <p>Descriptor: Service administered by Technician under the direction of a physician or other QHP*, face-to-face with one patient, each 15 minutes.</p> <p>Time/Units=per 15 minutes Attended By=client, technician (QHP* may substitute for the technician)</p>
<p>0373T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION</p>	<p>General Description: Direct treatment of sever maladaptive behavior in specialized settings.</p> <p>Descriptor: each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:</p> <ul style="list-style-type: none"> • 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.); • With the assistance of two or more technicians; • For a patient who exhibits destructive behavior; • Completed in an environment that is customized to the patient's behavior <p>Time/Units=per 15 minutes Attended By=client and 2 or more technicians; QHP* on site</p>

<p>97154 GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL</p>	<p>General Description: Group Treatment</p> <p>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.</p> <p>Time/Units=per 15 minutes Attended By=two or more clients, technician (QHP* may substitute for the technician)</p>
<p>97158 GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION</p>	<p>General Description: Group Treatment</p> <p>Descriptor: Service administered by a physician or other QHP*, face-to-face with multiple patients, each 15 minutes.</p> <p>Time/Units=per 15 minutes Attended By=two or more clients and QHP*</p>
<p>97155 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION</p>	<p>General Description: Direct Treatment by QHP*</p> <p>Descriptor: Service administered by physician or other QHP* which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.</p> <p>Time/Units=per 15 minutes Attended By=client, QHP*, may include technician and/or caregiver</p>
<p>97156 FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE</p>	<p>General Description: Family Training</p> <p>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.</p> <p>Time/Units=per 15 minutes Attended By=caregiver and QHP*</p>



<p>97157 MULTIPLE- FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE</p>	<p>General Description: Family Training</p> <p>Descriptor: Service administered by physician or other QHP* (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.</p> <p>Time/Units=per 15 minutes Attended By=caregivers of two or more clients and QHP*</p>
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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 technicians 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 test such as VB-MAPP, ABLLS, EFL
 - 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)
- May be reported only once within a six-month interval

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 IDENTIFICATION 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, then 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

Overview

New Directions encourages providers and facilities to create a compliance program in order to proactively prevent the submission of incorrect claims and combat fraudulent conduct. Internal controls efficiently monitor adherence to applicable laws and plan requirements. The Office of Inspector General has developed compliance program guidance for individual and small group health care practices (Federal Register, Vol. 65, p. 59434, Oct. 5, 2000 – <https://www.hhs.gov>, search “OIG compliance for individual and small group physician practices”).

Reporting

New Directions maintains a Compliance Reporting Line for anonymous reporting of suspected fraud or abuse. To report suspected 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 fraud or abuse to New Directions, the federal or state governments, or any other 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.

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) No authorization required. Outpatient services may be reviewed retrospectively.
Precertification	New Directions (www.ndbh.com) 800-248-2342
Benefits & Eligibility	New Directions (www.ndbh.com) 800-528-5763 or www.provider.bcbsal.org
Provider Relations	New Directions 888-611-6285 or providerrelations@ndbh.com
Claims Inquiries	EPS, EPX and EPL Claims – New Directions 855-339-8558 or providerrelations@ndbh.com Payer ID Code: NDX99
	Blue Choice, Peehip, All Kids, FEP, or BlueCard Claims – BCBSAL 205-220-6899 or Ask-EDI@bcbsal.org
Deaf or hearing impaired	Alabama relay phone numbers 800-548-2547(Voice) 800-548-2546 (TTY/HCO) or 711 in your service area
Medical Necessity Appeals	New Directions (www.ndbh.com) 800-248-2342
Physician Help Line	866-201-2642

Primary Requirements

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

Authorizations

- No authorization required for outpatient services, including psychological testing.
- Applied Behavior Analysis (ABA) therapy requires authorization for all visits.
- 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).

Timely Filing

- Timely filing of claims is 180 days.

Benefits

- If you have any questions about member benefits, please call New Directions Customer Service at 1-800-528-5763.
- Online eligibility and benefits information is available at <https://providers.bcbsal.org/>

Claims

Blue Choice and Out-of-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 Blue Choice and out-of-network EPS claims to BCBSAL. Some providers will know how to work with their specific clearinghouse and set it up correctly in their practice management system. Other 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 out-of-network EPS claims to BCBSAL.

In-network EPS EDI Claims Submission for Dates of Service Effective October 1, 2017, and after

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. Some providers will know how to work with their specific clearinghouse and set it up correctly in their practice management system. Other 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, please complete the [Provider Update Form](#). Accurate demographic information assures timely referrals.

Medical Records

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

Telemedicine

1. All available fee schedule codes are appropriate for use by the Behavioral Health Providers though telemedicine, if the service provided can be done with the same quality as the service being provided in the office setting.
2. When billing for Telemedicine services, use Place of Service Code -“02”- Telehealth.
3. Choose one of the following two modifiers:

Modifiers	
95	Synchronous Telemedicine Service Rendered via a Real time Audio and Video Telecommunications System
GT	Via interactive audio and video telecommunications systems

Provider’s Responsibilities

- Submit a Telemedicine Behavioral Health Services Provider Attestation to New Directions before delivering Telemedicine services.
- Meet the specific requirements outlined in the Telemedicine services attestation form including following all state and federal laws governing telemedicine services and their delivery.
- Confirm that your liability and malpractice insurance policy includes coverage to provide telemedicine services.
- Bill services following the billing information provided above.

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



NEW DIRECTIONS[®] Telemedicine Behavioral Health Services Provider Attestation

Provider Name: _____

Group/Practice Name: _____

Office Address: _____

State(s) where Telemedicine services will be provided _____

NPI number(s): _____

Provider TIN Number(s) _____

New Directions defines Telemedicine as the use of interactive telecommunications to deliver behavioral health services when the member and behavioral health provider are not in the same physical location. Telecommunications must be synchronous (live) services rendered via a real-time audio and video telecommunications system. Telemedicine does not include the use of audio-only telephone, facsimile, text or email for the delivery of services.

Please indicate what type of telemedicine services you provide by placing a check mark in the appropriate box.

- Distant provider** (*patient not at this location, provider delivering service from this location*) **OR**
- Originating site** (*patient(s) at this location connected to distant provider who is delivering the service*) **OR**
- Both**

Please indicate that you meet and agree to the following criteria by placing a check mark in each box.

- I meet all state licensure and/or certification requirements to provide Telemedicine services within the state(s) where I will be providing Telemedicine services.
- I will deliver Telemedicine services only in the state(s) where I hold a license or certification.
- If I am a prescriber, I will follow all state and federal laws and regulations regarding prescribing practices.
- I have adopted written policies and procedures documenting how my Telemedicine services meet applicable federal and state laws and regulations, including all HIPAA & HITECH privacy and security regulations.
- I always use secure, HIPAA-compliant synchronous technology while delivering Telemedicine services.
- My professional liability and malpractice insurance policy covers telemedicine services in the states I provide telemedicine.
- I obtain written consent from the member specific to Telemedicine services participation.
- I have adopted written policies, procedures, and standards of care for my Telemedicine services that include managing urgent/emergent situations.
- I will regularly review and adhere to published New Directions telemedicine materials and any subsequent updates.

I hereby certify and attest, by my signature, that all the information above is true and accurate. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the New Directions' behavioral health network.

Furthermore, I have read the New Directions Provider and Facility Manual and supplemental Telemedicine materials on the New Directions Behavioral Health website and understand the requirements for delivery of Telemedicine services. I understand it is my responsibility to comply with all New Directions requirements and state and federal Telemedicine statutes, regulations, and guidelines. I will cooperate with New Directions during any audit to verify that I meet the criteria above.

Name (print): _____

Signature: _____ Date: _____

Please return by email to Sherry Kitchens at SKitchens@ndbh.com or fax to: Attn: Sherry Kitchens at 816-237-2397.



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

<p>Precertification</p>	<p>New Directions Use Provider WebPass or call 800-367-0406</p>
<p>Eligibility & Benefits and Claims Questions</p>	<p>ABCBS 800-482-8416</p>
<p>Other Inquiries</p>	<p>New Directions 800-450-8706</p>
<p>Provider Relations</p>	<p>New Directions 888-611-6285 or email ProviderRelations@ndbh.com</p>
<p>Deaf or hearing impaired</p>	<p>Arkansas Relay Service 800-285-1131</p>
<p>Reconsideration/Inquiries</p>	<p>New Directions 800-367-0406 State of Arkansas Employee Appeals 800-482-8416 State of Arkansas Appeals Fax 501-378-2916</p>

Primary Requirements

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

Authorizations

- Applied Behavior Analysis (ABA) therapy requires authorization for all visits.
- 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 [Provider Update Form](#).

For facility demographic updates, please email: 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.

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

Precertification	New Directions Use Provider WebPass or call 877-709-6822
Other Inquiries	New Directions 800-450-8706
Provider Relations	New Directions 888-611-6285 or email Provider Relations@ndbh.com
Deaf or hearing impaired	Relay Services 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
- ABA services for Autism require pre-notification. Pre-notification includes submitting a treatment request form to be reviewed for coverage under the BlueAdvantage Walmart Coverage Policy Manual (NDBH.com/providers/Walmart). After the treatment request form is reviewed and approved, New Directions will assign an authorization reference number. Should a provider fail to obtain pre-notification prior to rendering services, New Directions may review the member's full medical record.
- 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.

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.

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 [Provider Update Form](#).

For facility demographic updates, please email: 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 PPO including Medicare Advantage

Authorizations for ABA Therapy only	New Directions Fax to 816-237-2372 Attn: FL ABA Request
Precertification Eligibility & Benefits and Claims Questions	New Directions Use Provider WebPass or call 866-730-5006
Provider Relations	New Directions 888-611-6285 or email Florida_PR@ndbh.com
Deaf or hearing impaired	State relay services Dial 711 to identify the correct toll-free number for your location
Provider Appeals	New Directions 866-730-5006

Claims Filing Requirements

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

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.

- No authorization required for psychological testing. After eight (8) hours of psychological or neuropsychological testing, Florida Blue will request to see medical records from the provider of service.
- 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.

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](#)

Timely Filing

- Timely filing of claims is 180 days.

Benefits

- Benefits vary by group and plan.

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 PPO 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 [Provider Update Form](#). Instructions on how to complete the form are available in the providers section of the New Directions website: www.ndbh.com.

For facility demographic updates, please email: 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	<p>New Directions Fax to 816-237-2372 Attn: FL ABA Request</p>
Precertification Eligibility & Benefits and Claims Questions	<p>New Directions Use Provider WebPass or call 866-730-5006</p>
Provider Relations	<p>New Directions 888-611-6285 or email Florida_PR@ndbh.com</p>
Deaf or hearing impaired	<p>State relay services Dial 711 to identify the correct toll-free number for your location</p>
Provider Appeals	<p>New Directions 866-730-5006</p>

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

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.

- 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. Important Note: Medicare Advantage has no benefit for Residential Services.
- 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.
- Effective February 1, 2019, Florida contracted providers will complete utilization management reviews telephonically rather than WebPass for the following cases:
 - o Eating Disorder cases for all ages and levels of care
 - o Children and Adolescents under the age of 18 for all diagnoses and levels of care
 - o Residential cases for members and primary substance use disorder diagnosis
 - o Medicare members for all levels of care.

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

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](#)

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 [Provider Update Form](#). Instructions on how to complete the form are available in the Providers section of the New Directions website: www.ndbh.com.

For facility demographic updates, please email: 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 Use Provider WebPass or call 866-730-5006
Provider Relations	New Directions 888-611-6285 or email Florida_PR@ndbh.com
Deaf or hearing impaired	State relay services Dial 711 to identify the correct toll-free number for your location
Reconsideration/ Inquiries	New Directions 866-730-5006

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.
- 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 and primary substance use disorder diagnosis
-

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](#)

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 [Provider Update Form](#). Instructions on how to complete the form are available in the providers section of the New Directions website: www.ndbh.com.

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

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 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.
- 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
- 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 and 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](#)

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 [Provider Update Form](#). Instructions on how to complete the form are [available in the Providers section of New Direction's website: \[www.ndbh.com\]\(http://www.ndbh.com\)](#).

For facility demographic updates, please email: 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
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
Provider 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, ECT and residential where it is a covered benefit. Medical records may be reviewed for services without a precertification to ensure medical necessity.
- ABA requires prior authorization from first visit. New Directions will assign an authorization reference number.

- Medical necessity criteria may be found at www.ndbh.com
- For 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.

Benefits

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

Timely Filing

- Timely filing of claims is 15 months from date of service.

Claims

- 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.

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

Prior Authorizations	New Directions 800-952-5906
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
Provider 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.

- ABA requires prior authorization from first visit. New Directions will assign an authorization reference number.
- Medical necessity criteria may be found at www.ndbh.com
- For 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.

Benefits

- BCBSKS will quote benefits. If you have any questions about member benefits, please call customer service at 1-800-432-3990.

Timely Filing

- Timely filing of claims is 15 months from date of service.

Claims

- 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.

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

Precertification of Inpatient	New Directions 800-952-5906
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 (Appeals)	BCBSKS 800-432-0379

Authorizations

- Prior authorization required for inpatient and residential services. Residential services require the member to have been previously enrolled in care management 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, ECT and residential where it is a covered benefit. Medical records may be reviewed for services without a precertification to ensure medical necessity.
- ABA requires prior authorization from first visit. New Directions will assign an authorization reference number.
- Medical necessity criteria may be found at www.ndbh.com
- For 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.

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

- 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.

Blue Cross Blue Shield of Kansas (BCBSKS) Medicare Advantage

Prior Authorizations	New Directions 800-589-1635
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
Provider Appeals	BCBSKS 800-240-0577

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

- 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 800-528-5763
Precertification	New Directions 800-528-5763
Benefits, Eligibility and Claims	New Directions 800-528-5763
Other Inquiries	New Directions 800-528-5763
Provider Relations	New Directions 888-611-6285 or providerrelationsteam@ndbh.com
Deaf or hearing impaired	Kansas Relay Services 800-766-3777
Deaf or hearing impaired	Missouri Relay Services 800-736-2966
Provider Appeals	New Directions 800-528-5763

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.

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) requires prior authorization from first visit. New Directions will assign an authorization reference number. 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.

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 numbers for Blue Touch are 816-395-3929 or 1-800-451-2348.
- 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.

Claims

- **Important Notice:** Effective 02/01/20, 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: 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. Please use the [Provider Update Form](#).

For facility demographic updates, please email ProviderRelations@ndbh.com.

Medical Records

- Medical records are to be provided upon request without charge.
- Reimbursement for telehealth services is subject to plan guidelines.

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

Prior Authorizations	New Directions 800-528-5763
Predetermination	New Directions 800-528-5763
Benefits, Eligibility and Claims Questions	New Directions 800-528-5763
Other Inquiries	New Directions 800-528-5763
Provider Relations	New Directions 888-611-6285 or providerrelationsteam@ndbh.com
Deaf or hearing impaired	Kansas Relay Services 800-766-3777
Deaf or hearing impaired	Missouri Relay Services 800-736-2966
Provider Appeals	New Directions 800-528-5763

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.

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.
- 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.
- 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 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 numbers for Blue Touch are 816-395-3929 or 1-800-451-2348.
- 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 02/01/20, 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: 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 [Provider Update Form](#).

For facility demographic updates, please email 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 800-528-5763
Predetermination	New Directions 800-528-5763
Benefits, Eligibility and Claims Questions	New Directions 800-528-5763
Other Inquiries	New Directions 800-528-5763
Provider Relations	New Directions 888-611-6285 or providerrelationsteam@ndbh.com
Deaf or hearing impaired	Kansas Relay Services 800-766-3777
Deaf or hearing impaired	Missouri Relay Services 800-736-2966
Reconsideration/ Inquiries	New Directions 800-528-5763

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.

Authorizations

- Prior authorization is required for Applied Behavior Analysis (ABA), inpatient and residential.
 - For residential, please refer to service benefit plan book for additional prior authorization requirements
- No authorization is required for partial hospitalization and intensive outpatient services. These services may be reviewed retrospectively to ensure medical necessity.
- No authorization is required for psychological or neuropsychological testing.

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 numbers for Blue Touch are 816-395-3929 or 1-800-451-2348.
- 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 02/01/20, 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 [Provider Update Form](#).

For facility demographic updates, please email ProviderRelations@ndbh.com.

Medical Records

- Medical records are to be provided upon request without charge.
- Reimbursement for telehealth services is subject to plan guidelines.

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), GM and State of Michigan (SOM)

Provider Network through Blue Cross and Blue Shield of Michigan

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



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

SOM: New Directions does manage, and authorization is required for, intensive outpatient program (IOP) for mental health and substance use disorders (SUD).

- **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.

- **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.
- UMBRT: 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.

Telehealth

- Reimbursement for behavioral health telehealth services is subject to plan guidelines.
- New Directions does not authorize behavioral health telehealth services. New Directions with refer member to BCBSM link (Ameriwell) for member to request telehealth services: www.bcbsmonlinevisits.com.
- Telehealth is not a covered service for URMBT members.

Other information

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

Blue Cross Blue Shield of Louisiana (BCBSLA)

<p>BCBSLA Authorizations</p>	<p>New Directions 800-991-5638</p>
<p>Blue Advantage Authorizations</p>	<p>New Directions 800-991-5638</p>
<p>BCBSLA Benefits & Eligibility</p>	<p>BCBSLA Use www.bcbsla.com/ilinkblue for eligibility. Call the Customer Care Center at 800-922-8866 for benefits.</p>
<p>Blue Advantage Eligibility</p>	<p>BCBSLA Use the Blue Advantage Provider Portal in iLinkBLUE (www.bcbsla.com/ilinkblue), then click the Blue Advantage menu option.</p>
<p>BlueCard Eligibility</p>	<p>Other Blue Plans For benefits and eligibility for member of a Blue Plan other than BCBSLA 1-800-676-BLUE (1-800-676-2583)</p>
<p>Provider Relations</p>	<p>BCBSLA provider.relations@bcbsla.com, 1-800-716-2299, option 4</p>
<p>Provider Operations</p>	<p>BCBSLA network.administration@bcbsla.com 1-800-716-2299 -Option 1 for provider file questions -Option 2 for credentialing questions</p>
<p>Claims Inquiries</p>	<p>BCBSLA Use www.bcbsla.com/ilinkblue to check claims status. For more complex claim questions, call the Customer Care Center at 1-800-922-8866.</p>
<p>Provider Appeals</p>	<p>BCBSLA BCBSLA recognizes that disputes may arise between members and Blue Cross regarding covered services</p>

EDI Clearinghouse

iLinkBLUE & EFT

Refer to A Guide for Disputing Claims Tidbit to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross

BCBSLA

EDICH@bcbsla.com
225-291-4334

BCBSLA

1-800-216-BLUE (1-800-216-2583)

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)

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)

Timely 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.

- Blue Advantage claims must be filed within 12 months from the date of service.

Claims Submission

Electronic Claims:

Electronic Claims – Providers filing electronic claims should use payer ID – 23738 (Professional/HCF) 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

Blue Advantage Claims – Electronic:

Blue Advantage claims should be submitted electronically through Change Healthcare using the Blue Advantage payer identification of 84555. In addition, 84555 is the new payer identification that Change Healthcare has assigned for claims submission and receipt of the 835 ERA. All 27X transactions must be submitted to Change Healthcare using the payer identification BCLAM.

Blue Advantage Claims – Blue Advantage paper claims should be mailed to:

HMO Louisiana, Inc.
P.O. Box 32406
St. Louis, MO 63132

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

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
Provider 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
Provider 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
<i>*Contracts separately with group</i>	

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

Topic	Organization Owner	Other Information
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

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

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

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

Topic	Organization Owner	Other Information
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