

MANAGED BEHAVIORAL HEALTH PROVIDER AND FACILITY MANUAL

July 2018



TABLE OF CONTENTS

TABLE OF CONTENTS	2
Key Changes Index for Provider and Facilities Manual.....	5
Section 1: Introduction.....	6
Preface	6
About New Directions	7
New Directions' Expectations of Providers	8
Provider Communications	11
NCQA Network Reports.....	12
Section 2: Network Operations.....	13
Policies and Procedures.....	13
Change in Provider Demographics	13
Credentialing Criteria	13
Provider Rights and Responsibilities.....	14
Checking Member Eligibility and Plan Benefits	16
Section 3: Provider Accessibility.....	17
Overview	17
Availability Standards.....	17
Coordination of Care with Primary Care Physicians and other Providers	18
Section 4: Member Safety and Quality of Care	19
Member and Client Rights and Responsibilities.....	19
Quality Improvement	20
Focus Areas	22
Adverse Event Reporting	25
Section 5: Managing Utilization.....	31
Medical Necessity Criteria	31
Utilization Management.....	31

Clinical Peers	32
UM Process Limitations	32
Treatment Record Reviews.....	33
Guidelines for Treatment Record Documentation	35
Request for Psychological/Neuropsychological Testing	40
Commercial Member and Provider Denial and Appeal Rights	41
Adverse Benefit Determination and Appeal Definitions	42
Section 6: Clinical Programs.....	43
Philosophy.....	43
Case Management Program	43
Care Transitions Program	44
Member Self-Management and Preventive Health Tools	45
Section 7: Clinical Practice Guidelines	45
About Clinical Practice Guidelines	45
Applicable Guidelines	46
Section 8: Fraud, Waste and Abuse	60
New Directions Policy.....	60
Definitions.....	60
Audits	61
Claim Recoupment and Appeals	61
Excluded Persons.....	62
Section 9: Billing Assistance.....	63
Billing and Missed Appointments	63
Medication-Assisted Treatment (MAT) Services	63
Maximum Visits per Day.....	63
Concurrent and Overlapping Services	63
Billing Submission.....	63

CPT Time Rule.....	64
Common Billable CPT and Revenue Codes.....	65
Section 10: Compliance Program	76
Overview	76
Reporting	76
HIPAA Information	76
Privacy Policy and Privacy Practices.....	76
Appendix for Blue Cross and Blue Shield Plans.....	78
Blue Cross Blue Shield of Alabama	79
Arkansas Blue Cross Blue Shield (Arkansas Blue Cross) Federal Employee Program (FEP).....	83
Walmart through Arkansas Blue Cross Blue Shield/Blue Advantage Administrators (BAA)	85
Florida Blue PPO including Medicare Advantage	87
Florida Blue HMO including Medicare Advantage	90
Florida Blue Federal Employee Program (FEP)	93
Florida Blue Medicare Preferred HMO [Florida Blue and BeHealthy].....	95
Blue Cross Blue Shield of Kansas (BCBSKS) PPO	98
Blue Cross Blue Shield of Kansas (BCBSKS) Solutions/EPO (Exclusive Provider Organization)	100
Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP)	102
Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO.....	104
Blue Cross Blue Shield of Kansas City (Blue KC) Preferred Care & Preferred Care Blue PPO	107
Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP)	110
Blue Cross and Blue Shield of Michigan (BCBSM) including United Auto Workers Retiree Medical Benefits Trust (URMBT).....	113
Blue Cross Blue Shield of Louisiana (BCBSLA)	115
Appendix for Employer groups contracted with New Directions	118
Cerner	119



Key Changes Index for Provider and Facilities Manual

July 2018 version

SECTION	PAGE	CONTENT CHANGE
2: Network Operations	WebPass: page 17	Florida providers will conduct eating disorder cases by phone rather than WebPass effective July 9, 2018
4: Member Safety and Quality of Care	Adverse Event Reporting: page 26	Sentinel Event Reporting has been added to manual
5: Managing Utilization	Treatment Record Reviews: page 31	Treatment Record Review requirements and instructions
7: Clinical Practice Guidelines	Applicable Guidelines: pages 45-57	Charts have been updated/Eating Disorder Guideline instructions for Florida providers
Appendix	Florida Blue Lines of Business: pages 84-95	Update regarding WebPass and Eating Disorder procedures

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 (Manual) as a general guide to programs, policies and processes. When updates to the Manual are made, New Directions makes every effort to communicate them 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 us about 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; case management for Members who are high risk/high cost; and specialty programs focusing on high-risk acute need populations.

All of our 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 Case 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
 - a. 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 of time.
2. Setting clear and measurable goals
 - a. 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
 - a. Make use of New Directions Care Transitions and Case Management teams (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) form before discharge because it enables New Directions to coordinate care and facilitate access to other types of clinical resources, such as in-home treatment with targeted case management. The ROI is important because

it allows these resources to work directly with the patient, as well as family members. When New Directions can include additional resources we can educate both the patient and the family, and we are able to proactively address behavioral health much sooner.

4. Discharge planning

- a. Discharge planning must begin on the day of admission. Discharge planning means the elements of IDEAL Discharge Planning as published by the Agency for Healthcare Research and Quality, available at www.ahrq.gov. Discharge Planning includes at least one (1) meeting to discuss concerns and questions with the Member, family, or support system of their choice, and the Member's attending provider.
- b. 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 in getting a comprehensive discharge plan coordinated.

5. Scheduling 7-day follow-up appointment after mental health inpatient discharge

- a. 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.

6. Community-based resources

- a. 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

- a. Coordinating care with the patient's primary care physician (PCPs) will create a holistic care plan to address comorbidity, especially as PCPs are typically the main prescribers of psychiatric medications.

8. Provider performance

- a. New Directions is committed to having 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.
- b. 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

- c. Documentation must be clear and support the claims billed and/or services that meet medical necessity criteria for ongoing treatment.
- d. The medical record must include documentation of the active participation of the Member in treatment and progress toward goals achieved.

10. Measure outcomes

- e. 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.

Contacting New Directions

To contact the New Directions Service Center for utilization management, case management, case 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 rTMS
- New Directions Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder Medical Policy
- Clinical Practice Guidelines
- Provider WebPass (username and password is needed)
- Eligibility information for many New Directions' contracts
- Outpatient Quality Review Forms
- Benefit information for many New Directions' contracts
- Notice of Privacy Practices for New Directions
- Member Rights and Responsibilities

- Information about our Quality and Case Management programs
- An Autism Resource Center for parents/caregivers of a child with an autism spectrum disorder
- An Alcohol Resource 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 Case 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 us at ProviderRelations@ndbh.com.

Change in Provider Demographics

Providers must notify New Directions of any changes to availability or demographics, including email address, with appropriate notice. Refer to the Appendix below to determine the 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.

Credentialing Criteria

New Directions credentials and re-credentials Providers and Facilities in compliance with NCQA accreditation standards 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:

- A license for independent practice
- 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 coverage

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 Form. Site visits may include a review of any or all of 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 Recredentialing 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

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 case 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 July 9, 2018, Florida contracted providers will complete utilization management reviews for Eating Disorder cases by phone, rather than via WebPass. For more information about the new Florida provider guidelines pertaining to eating disorder cases, please read [UR Florida Providers for Eating Disorder Cases](#). All other contracted providers will continue to use WebPass for all cases.*

Getting Started with WebPass

To access the New Directions WebPass system for individual Providers, you will need to obtain a user name 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 their 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

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. To facilitate Member access to care, New Directions utilizes ReferralQuick (a proprietary scheduling system) or lists of providers who have committed to seeing members within 0-7 days for an appointment.

About ReferralQuick

ReferralQuick is a proprietary, online scheduling system that allows New Directions to provide Members with real-time assistance in scheduling appointments with Network Providers. ReferralQuick is a voluntary and free service available to any Network Provider who would like to offer appointments for scheduling. If you would like more information or to begin using the ReferralQuick system, please contact Network Operations at ProviderRelations@ndbh.com

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 situation, 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 health care Providers, both behavioral and medical specialists (e.g., neurologists, pain management, etc.). New Directions will be actively participating in these collaborative efforts. You may be contacted by a New Directions staff member to assist in scheduling an appointment, verifying attendance, treatment planning, medication reconciliation, and completing the New Directions coordination of care form, as well as other efforts to coordinate care.

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.

Under HIPAA, authorization from a Member is not usually required when sharing health information with other treating health care Providers or with New Directions. Such activity falls under the treatment, payment, and health care operations exceptions under HIPAA. Heightened requirements exist for certain types of health information under 42 CFR Part 2, and state laws specific to mental health or substance use clinical information. Identifying information related to HIV/AIDS and genetics are also subject to more stringent requirements. Providers are also expected to comply with relevant state laws regarding contact with other health care Providers.

Providers should educate their patients on the benefits of coordinated care and request ROIs, when applicable, in order to promote better outcomes and whole person treatment. 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
- Case 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 Case Management (CM) program, provide 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' case 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 abuse treatment. When New Directions' case 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 main 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 this 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 Abuse** program aims to detect depression in members admitted to a higher level of care for substance abuse 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

Facility Name	Patient Name	
Reporter Name	Patient DOB	
Reporter Title	Patient Policy Number	
Reporter Phone Number	Patient Phone Number	
Reporter Email:	Coverage (if also secondary coverage):	
<hr/>		
Incident Date	Date of Report	
Persons Involved:	Location:	
<input type="checkbox"/> Patient <input type="checkbox"/> In facility <input type="checkbox"/> Staff <input type="checkbox"/> On grounds <input type="checkbox"/> Persons not associated with facility <input type="checkbox"/> Off grounds <input type="checkbox"/> Other _____ <input type="checkbox"/> Home <input type="checkbox"/> Other _____		
<hr/>		
Incident Type:	<input type="checkbox"/> Unexpected death: <input type="checkbox"/> Expected death: <input type="checkbox"/> Altercation (if checked, please complete injury section): <input type="checkbox"/> Suicide <input type="checkbox"/> Non-suicide <input type="checkbox"/> With injury <input type="checkbox"/> Homicide <input type="checkbox"/> Natural causes <input type="checkbox"/> Without injury <input type="checkbox"/> Accidental <input type="checkbox"/> Cause unknown	
<input type="checkbox"/> Self-harming behavior <input type="checkbox"/> Fall <input type="checkbox"/> Alleged or suspected abuse (If any checked, or suicide attempt (if <input type="checkbox"/> With injury <input type="checkbox"/> please complete Abuse/Assault section): checked, please complete <input type="checkbox"/> Without injury <input type="checkbox"/> Verbal injury section): <input type="checkbox"/> With injury <input type="checkbox"/> Physical <input type="checkbox"/> With injury <input type="checkbox"/> Without injury <input type="checkbox"/> Sexual <input type="checkbox"/> Without injury <input type="checkbox"/> Other _____ <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:

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

If nonconsensual:

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

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 _____

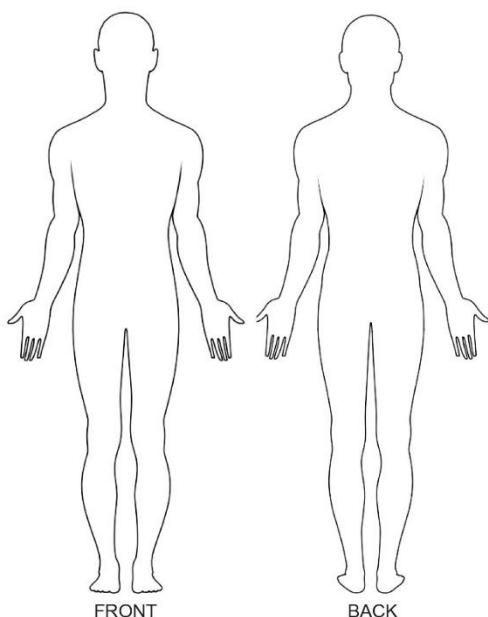
3. INJURY SECTION

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: _____



CONFIDENTIAL INFORMATION

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

Summary of Incident

Immediate Action Taken

Exam Information

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

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

CONFIDENTIAL INFORMATION

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

Utilization Management

Behavioral health benefits requiring UM, are managed by New Directions to ensure that 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 hours a day, 7 days a week. Please refer to the Appendix for 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.

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 for a referral to a Network Provider. New Directions will assist in identifying appropriate Providers in the Member's area and may provide 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 time 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 respect to the disclosure of a Member's information.

Accordingly, and 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 (i.e. Florida Blue, BCBSM, etc.), that the Member has approved such company his or her Authorized Representative. 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. Furthermore, 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 such 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 includes 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 80 percent.

1. **Confidentiality:** (a) Treatment records are securely stored; (b) only accessible by authorized personnel; and (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 work station.

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 that 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 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, 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 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 of 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: Doctor's Orders for drug screen must include: rationale and the substance tested for. Orders for drug screen 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., PhD, MD/DO, 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 time-stamp. 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 claims 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 group specific information in the Appendix at the back of this Manual.

For Plans that require authorization, 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 requested multiple CPT codes, you may use the total number of units within these code groups.

- A Reference Number or Authorization of 96101 will be interchangeable with 96102 and 96103
- A Reference Number or Authorization of 96116 will be interchangeable with 96118, 96119, 96120 and 96152

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.

CPT Codes: 96101-96103, 96118-96120

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. It 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.

New Directions appeal procedures are available to Providers and Members upon request. 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 is 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.

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.

Case Management Program

New Directions' Case 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, case managers use evidence-based practices to engage Members and partner with Providers to assist with adherence to treatment and promote recovery. Case 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

Case 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 Case Management services for a Member. Please see Plan or group-specific contact information in the Appendix in the back of this Manual.

Care Transitions Program

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 Program focuses 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 programming achieves 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 Program targets:

- Helps Providers and the Member understand the importance of post-hospitalization aftercare
- Increases the scheduling of and attendance at post-discharge follow-up appointments within 7 days
- Increases 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 2 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 providing guidance to Providers to help improve clinical effectiveness and ensure our Members receive the best care possible. New Directions' Clinical Practice Guidelines (CPG) were developed to support our UM processes, described above.

New Directions relies 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, Physician Specialty Society recommendations, and other relevant factors. In circumstances where these sources are not available, a consensus of expert opinions by licensed professionals practicing

in a particular field may also be utilized. CPGs are not intended to address individual Member variations, but reflect population-based recommendations.

Applicable Guidelines

After gaining input from New Directions clinical staff and the Provider community, the New Directions Chief Medical Officer and medical staff conduct research and analysis and develop evidence-based CPGs and Medical Policies. Our current CPGs for mental health are:

- Major Depression
- Attention Deficit Hyperactive Disorder
- Adult Bipolar Disorder - Acute and Maintenance Episodes
- Adult Substance Abuse

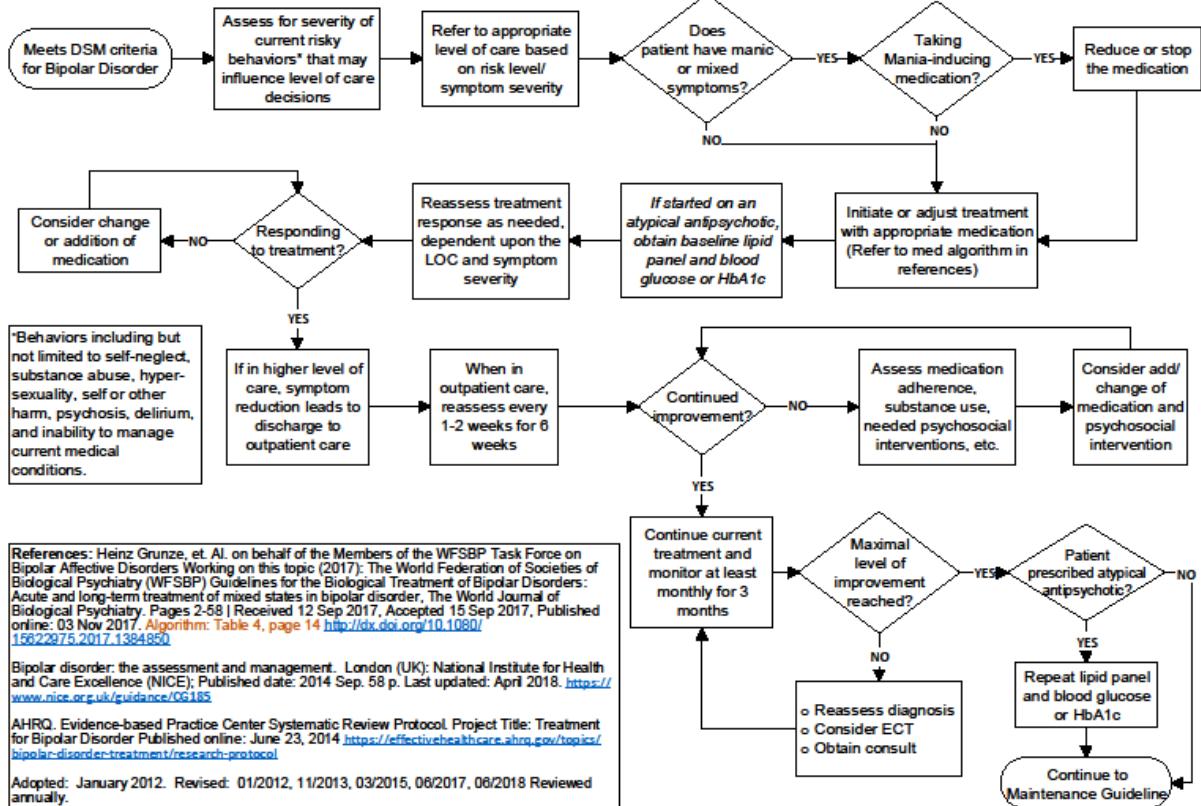
In some instances, New Directions has adopted CPGs developed by other entities. Current CPGs adopted by New Directions are: Schizophrenia

- Eating Disorders
- Autism Spectrum Disorders

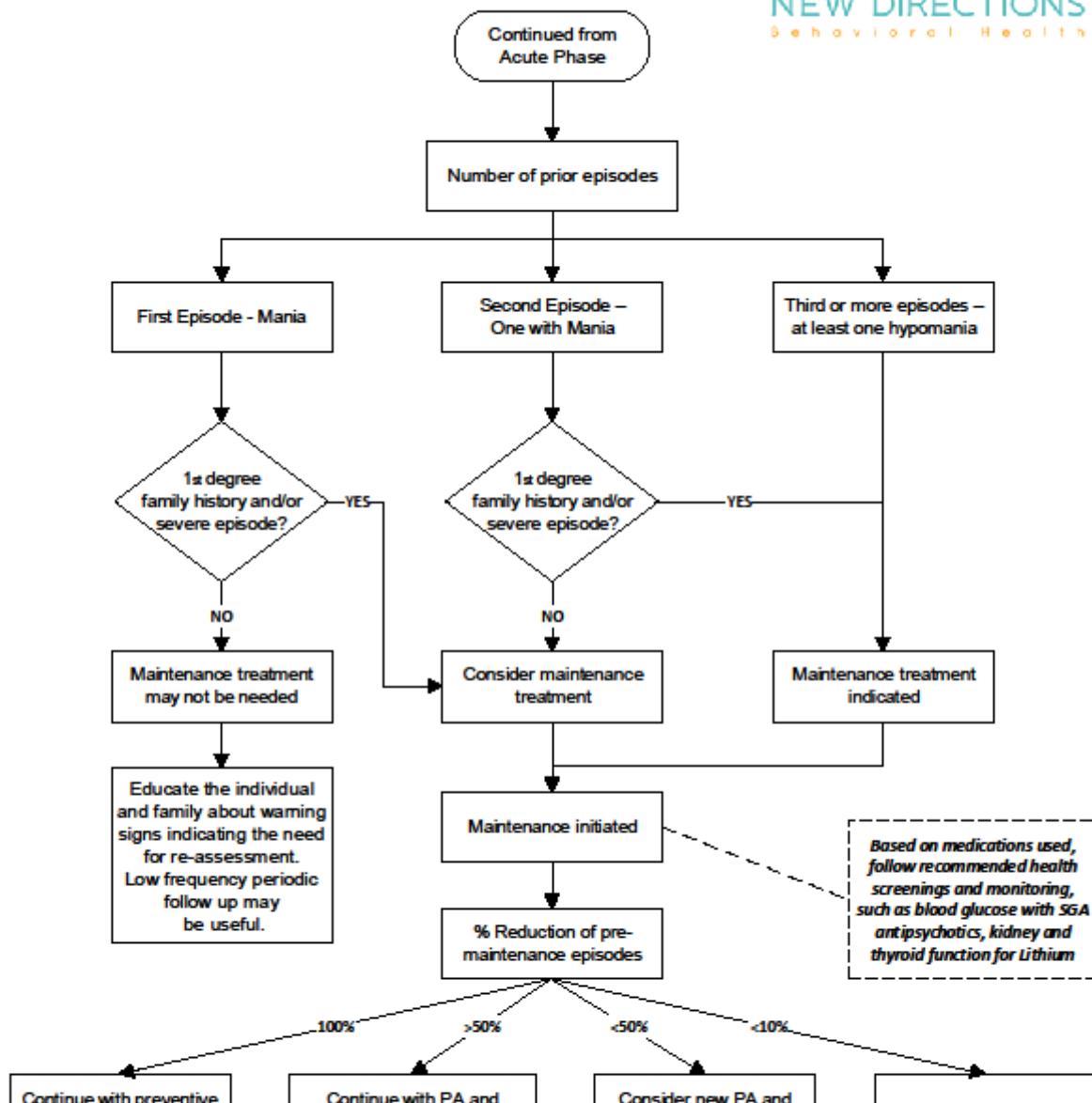
Clinical Practice Guidelines may be found at

<https://online.ndbh.com/Providers/BehavioralHealthPlanProviders.aspx>

Bipolar Disorder Treatment Guideline – Acute Episode



Bipolar Disorder Treatment Guideline – Maintenance Episodes

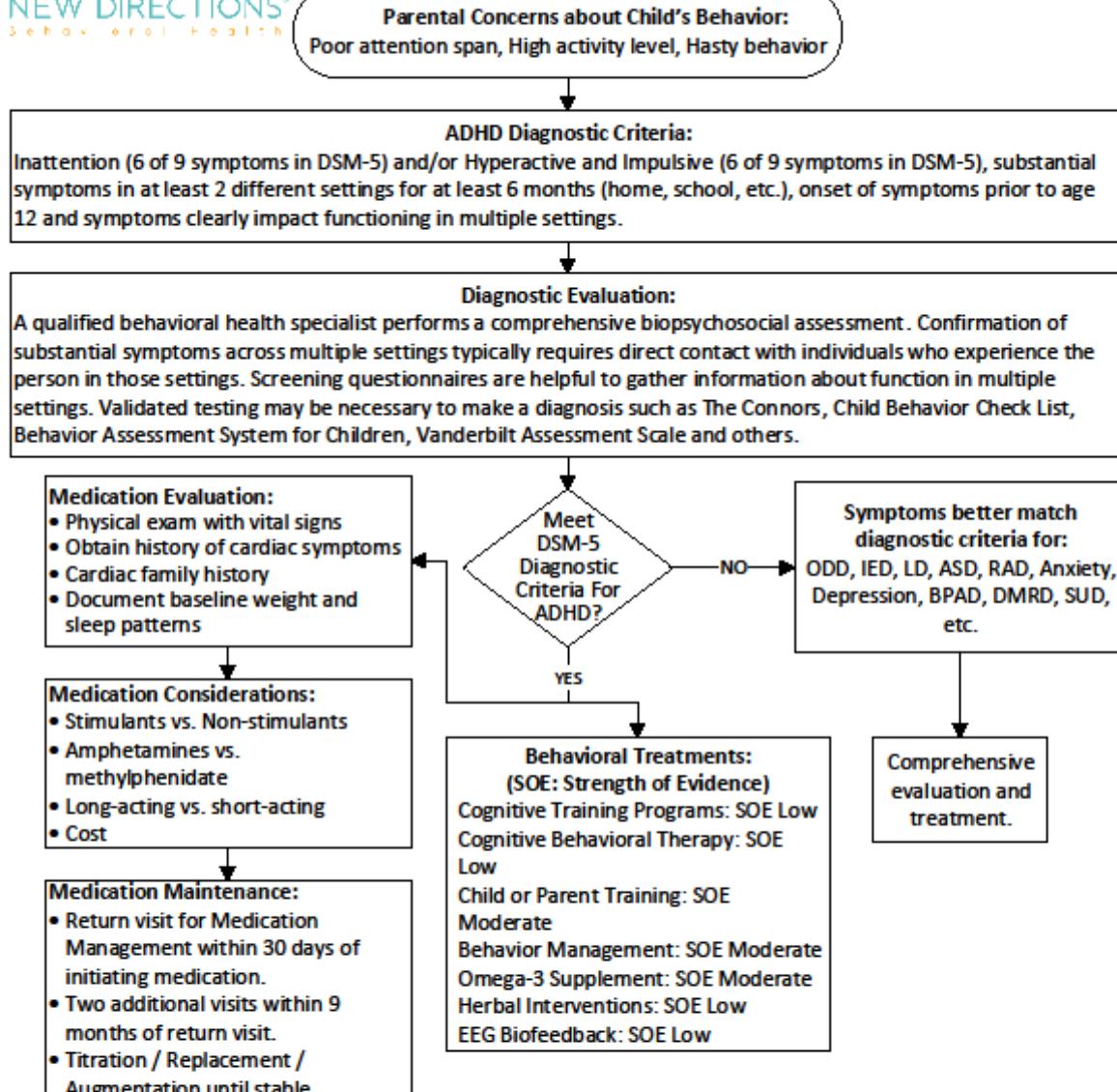


For specific maintenance medication selection and monitoring, please go to: Heinz Grunze, et. Al. on behalf of the Members of the WFSBP Task Force on Bipolar Affective Disorders Working on this topic (2017): The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Acute and long-term treatment of mixed states in bipolar disorder, The World Journal of Biological Psychiatry. Pages 2-58 | Received 12 Sep 2017, Accepted 15 Sep 2017, Published online: 03 Nov 2017.
<http://dx.doi.org/10.1080/15622975.2017.1384850>

Adopted: 10/2015 Revised: 06/2017, 06/2018. Reviewed annually.



ADHD Child and Adolescent Clinical Guideline



American Academy of Child and Adolescent Psychiatry (AACAP) Charach A, et.al, Attention Deficit Hyperactivity Disorder: Effectiveness of Treatment in At-Risk Preschoolers; Long-Term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment. Comparative Effectiveness Review No. 44. (Prepared by the AHRQ Publication No. 12-EHC003-ER. Rockville, MD: Agency for Healthcare Research and Quality. October 2011. Surveillance Report: August, 2014 (<https://effectivehealthcare.ahrq.gov/topics/adhd/surveillance>). Available at: <https://effectivehealthcare.ahrq.gov/topics/adhd/surveillance>).

Kemper AR, Maslow GR, Hill S, Namdani B, Allen LaPointe NM, Goode AP, Coeytaux RR, Befus D, Kosinski AS, Bowen SE, McBroom AJ, Lallinger KR, Sanders GD. Attention Deficit Hyperactivity Disorder: Diagnosis and Treatment in Children and Adolescents. Comparative Effectiveness Review No. 203. (Prepared by the Duke University Evidence-based Practice Center under Contract No. 290-2015-00004-I.) AHRQ Publication No. 18-EHC005-ER. 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/AHROEPCCR203>.

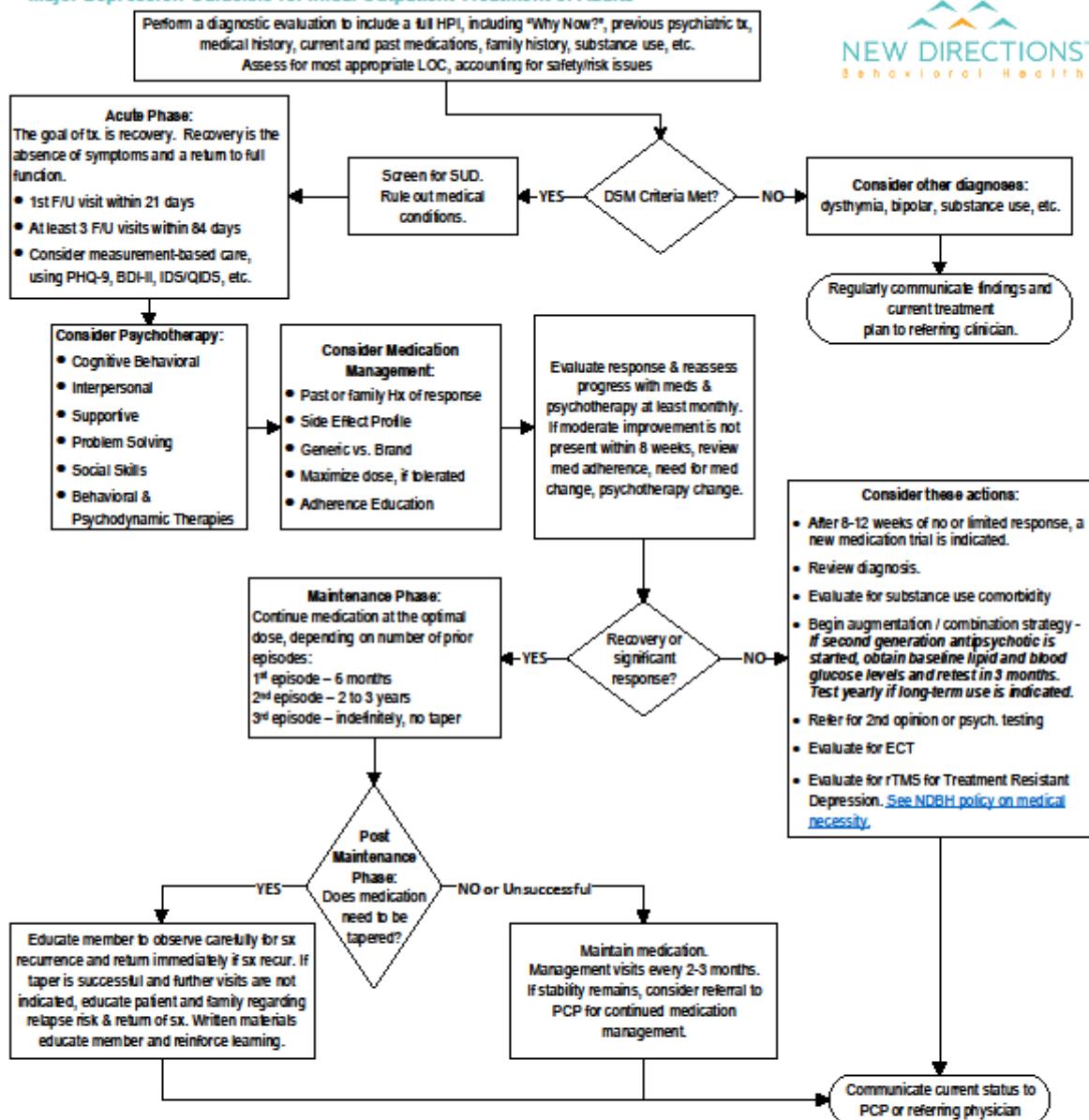
Attention deficit hyperactivity disorder: diagnosis and management. National Institute for Health and Care Excellence (NICE) Clinical guideline [CG72]. Published date: September 2008 Last updated: February 2016. <https://www.nice.org.uk/guidance/cg72>

Attention-Deficit / Hyperactivity Disorder (ADHD). (2017, April 11). Retrieved May 19, 2017, from <https://www.cdc.gov/ncbddd/adhd/treatment.html>

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. Pediatrics 2011;128:1007; originally published online October 16, 2011; DOI: 10.1542/peds.2011-2654

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

Major Depression Guideline for Initial Outpatient Treatment of Adults



Sources:
2017-2018 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (2018). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration. http://www.medicalmentalhealth.org/_assets/file/Guidelines/2018_Psychotherapeutic%20Medication%20Guidelines%20for%20Adults%20with%20References.pdf

Gin S Mahl, Darryl Bassett, Philip Boyce, Richard Bryant, Paul B Fitzgerald, Kristina Fritz, Malcolm Hopwood, Bill Lyndon, Roger Mulder, Greg Murray, Richard Porter, and Ajay B Singh. Royal Australian and New Zealand College of Psychiatrists, Clinical Practice Guidelines for Mood Disorders: Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185. <https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinical/Mood-Disorders-CPG.aspx>

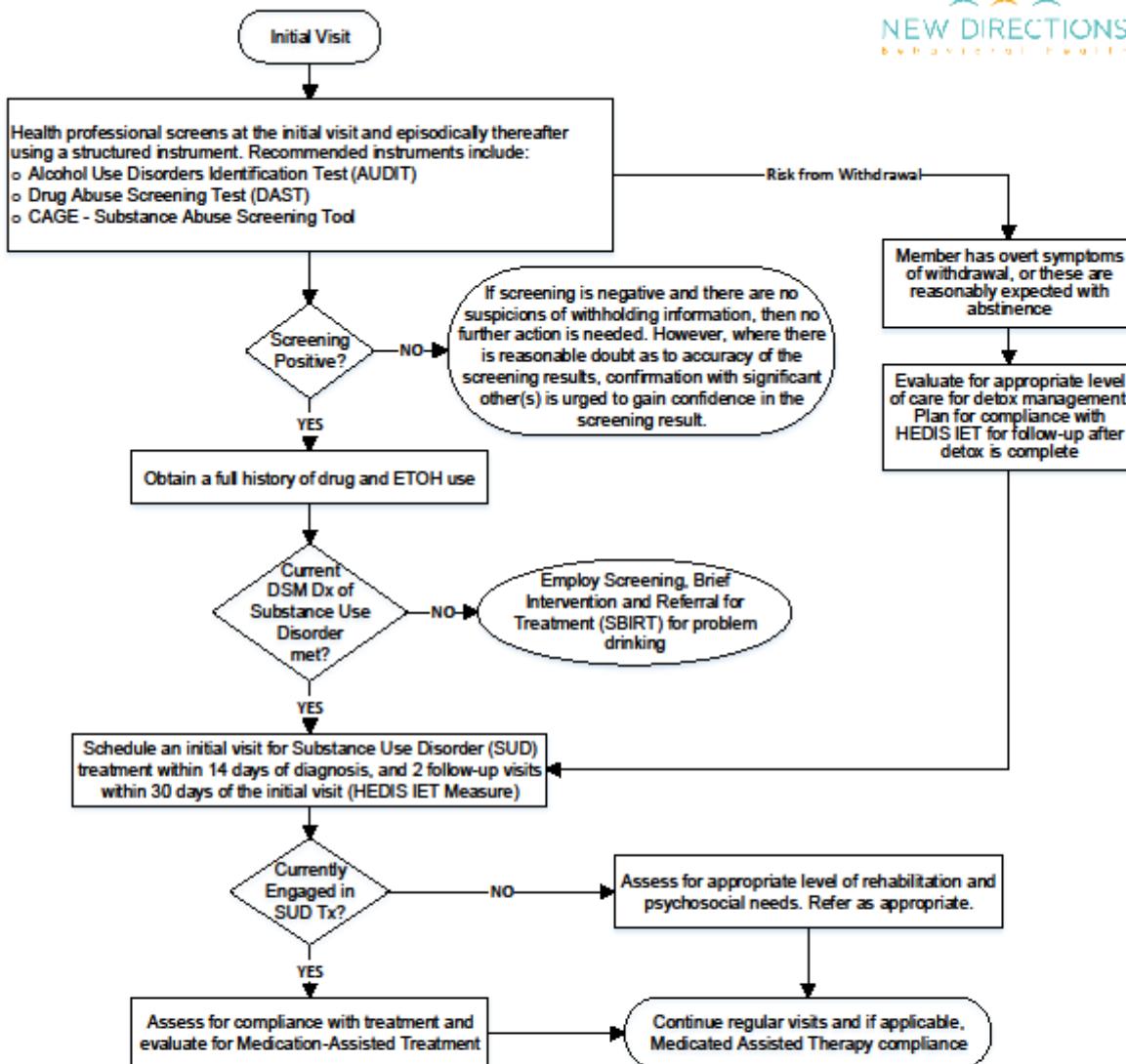
VA/DoD clinical practice guideline for the management of major depressive disorder 2016 Apr 11. [cited 2018 June 2018]. Available: <https://www.healthquality.va.gov/guidelines/MH/mdd/>

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. Reviewed annually.



Adult Substance Abuse Initial Assessment Clinical Guideline



Screen: Periodically and routinely screen patients for substance use as well as for substance use dependence. Screening requires only two to four minutes. Use the DAST to screen for drug use. This tool profiles the frequency of substance use behavior. Use the AUDIT-C alone or in combination with the CAGE to screen for alcohol use. AUDIT-C is designed to identify hazardous drinking and focuses on recent drinking behaviors. The CAGE is better at detecting alcohol dependence. These screening tools and scoring instructions can be found at: <https://www.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 30 days of the initiation visit. <http://www.ncqa.org/hedis-quality-measurement/hedis-measures>

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

References:

- Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). The ASAM (American Society of Addiction Medicine) Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Carson City, NV: The Change Companies. <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria>
- SAMHSA: <https://www.samhsa.gov/prevention>.
- 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, 08/14, 06/17. 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). With over 9,000 members who have a psychotic disorder as a diagnosis, 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.

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:

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

Table 1: Members who have Schizophrenia/Psychosis as a primary diagnosis Last Updated: 2018

Age Band	Schizophrenia Diagnosis	Population	Percent
0-9	19	601,610	0.003%
10-20	793	956,885	0.08%
21-29	2,449	998,840	0.25%
30+	6,812	4,928,928	0.14%
Total	10,073	7,486,263	0.13%

Data Source: New Directions Claims Data, 1/2017 to 12/2017 (includes Membership from five major Health Plans)

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://orygen.org.au/Campus/Expert-Network/Resources/Free/Clinical-Practice/Australian-Clinical-Guidelines-for-Early-Psychosis/Australian-Clinical-Guidelines-for-Early-Psychosis.aspx?ext>
- 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: 6/2018

Reviewed annually.



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

**Effective July 9, 2018, there is a change to how Florida providers will incorporate these guidelines. For all contracted providers other than Florida, you will continue to use WebPass.*

Contracted Florida providers will no longer be using WebPass for any part of the UM review process for Eating Disorder cases. Beginning July 9, 2018, these reviews will be completed by phone. Please note that this change does not affect any other type of cases.

Due to the complex nature of Eating Disorder cases, we believe telephonic reviews will facilitate a more in-depth discussion and provide New Directions with a clearer understanding of clinical presentations. By collaborating together, we aim to improve decision-making, goal setting and discharge planning.

Instructions for the telephonic UM review process are included below. Please review them carefully. If you have questions or concerns, do not hesitate to contact Florida_PR@ndbh.com.

Instructions

- 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.**



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. With over 3,600 members who have been diagnosed with an eating disorder, New Directions is committed to providing guidance to providers to align with evidence-based practice guidelines. See Table 1 for prevalence. 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 2014 by the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Eating disorders are characterized by disturbances of eating behaviors and a core psychopathology centered on food, eating and body image concerns. 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.

Anorexia Nervosa (AN) is a serious disturbance in eating that typically starts in early adolescence. Anorexia Nervosa affects females disproportionately and carries a long-term risk for mortality. Starvation due to severe calorie restriction is the hallmark, and often accompanied by significant medical comorbidity. The etiology is uncertain, and outcomes are better with early, intensive treatment. Severe and longstanding AN requires a different treatment approach than the more acute disorder. Nutritional rehabilitation with an expected weight gain of 2 pounds each week is critical to weight restoration. Moderate evidence-based treatments for affected adolescents are family therapy and possibly the Maudsley method.

Bulimia Nervosa (BN) is a disorder generally characterized by bingeing and purging behaviors, more normal weight and frequent comorbidity with other mental health and substance abuse diagnoses.

Table 1: New Directions Eating Disorder Prevalence Rate for Members by Age, Primary Diagnosis

AGE	Eating Disorder Diagnosis	Population	Percent
0-9	85	601,610	0.01%
10-20	879	956,885	0.09%
21-29	921	998,840	0.09%
30+	2,347	4,928,928	0.05%
Total	4,232	7,486,263	0.06%

Data Source: New Directions Claims Data, 1/2017 to 12/2017 (Includes Membership from 5 Major Health Plans)

There are three caveats concerning the CPG:

1. This CPG uses joules rather than calories. One calorie equals 4.184 joules;
2. The following oral medication is not available in the US: amisulpride; and
3. In addition, parts of this document addresses specific populations, including Aboriginal, Torres Strait Islander, Māori and Pacific Islander peoples.

Links and References:

1. Phillipa Hay, David Chinn, David Forbes, Sloane Madden, Richard Newton, Lois Sugenor, Stephen Touyz, and Warren Ward. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian & New Zealand Journal of Psychiatry. 2014, Vol. 48(11) 1–62
<https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx>
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

Adopted: 6/2017

Last Updated: 6/2018

Reviewed annually



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

New Directions Behavioral Health® (New Directions) offers a full range of behavioral health solutions. The members we serve have a wide range of mental health diagnoses, including Autism Spectrum Disorder (ASD). With over 7,000 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. Benefit coverage for behavioral therapies to treat symptoms of ASD is driven by individual state mandates.

New Directions manages Applied Behavior Analysis (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 Therapies for Children With Autism Spectrum Disorder: Behavioral Interventions Update/ Executive Summary, published in August 2014 by the Agency for

Healthcare Research and Quality, as a Clinical Practice Guideline (CPG) for ASD. A link is included below.

The prevalence of ASD among children is thought to be around 1.5 percent, but varies widely by region of the country, sex and race/ethnicity. The rate is historically higher among males (2.3 percent) than females (0.5 percent). It is estimated that the total lifetime societal cost of caring for and treating a person with ASD in the United States is \$3.2 million.

Table 1: New Directions prevalence rate for members by age

Age Bands	Autism Primary Diagnosis	Population	Percent
0-4	851	241,968	0.35%
5-9	2,130	323,911	0.66%
10-21	3,453	994,102	0.35%
22+	1,036	5,394,949	0.02%
Total	7,470	6,954,930	0.11%

Data Source: Claims Data, 7/2015 to 6/2016, Includes Membership from 5 Major Health Plans

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

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

Literature Citations:

1. Weitlauf AS, McPheeters ML, Peters B, Sathe N, Travis R, Aiello R, Williamson E, VeenstraVanderWeele J, Krishnaswami S, Jerome R, Warren Z. Therapies for Children With Autism Spectrum Disorder: Behavioral Interventions Update. Comparative Effectiveness Review No. 137. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2012-00009-I.) AHRQ Publication No. 14-EHC036-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2014. www.effectivehealthcare.ahrq.gov/reports/final.cfm. (Updates 2011 study below) There is the full report, and a shorter executive summary:
 - a. <https://effectivehealthcare.ahrq.gov/ehc/products/544/1945/autism-update-report-140929.pdf> (AHRQ Publication No. 14-EHC036-EF)
 - b. <https://effectivehealthcare.ahrq.gov/ehc/products/544/1946/autism-update-executive-140806.pdf> (AHRQ Pub. No. 14-EHC036-1-EF)
2. Warren Z, Veenstra-VanderWeele J, Stone W, Bruzek JL, Nahmias AS, Foss-Feig JH, Jerome RN, Krishnaswami S, Sathe NA, Glasser AM, Surawicz T, McPheeters ML. Therapies for Children With Autism Spectrum Disorders. Comparative Effectiveness Review No. 26. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-200710065-I.) AHRQ Publication No. 11-EHC029-EF. Rockville, MD: Agency for Healthcare Research and Quality. April 2011. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Links For Families/Caregivers:

1. Therapies for Children With Autism Spectrum Disorder: A Review of the Research for Parents and Caregivers: AHRQ Pub. No. 14-EHC036-A, September 2014 (Replaces AHRQ Pub. No. 11EHC029-A). <https://effectivehealthcare.ahrq.gov/ehc/products/544/1974/autism-update-160516.pdf>
2. Comparative Effectiveness of Therapies for Children With Autism Spectrum Disorders, Clinical Research Summary: AHRQ Pub No.14-EHC036-3, September 2014 (Replaces AHRQ Pub. No. 11-EHC029-3). <https://effectivehealthcare.ahrq.gov/ehc/products/544/1975/Autism-update-clinician-141002.pdf>

Adopted: 06-2017

Section 8: 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/physician-education/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 9: 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 amount 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 on pages 57-63.

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 and Psych Testing	
90791	Psychiatric diagnostic evaluation (no medical services)
90792	Psychiatric diagnostic evaluation (with medical services)
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with E/M Service
99354	Prolonged E/M or Psychotherapy Service, first hour
99355	Prolonged E/M or Psychotherapy Service, each additional 30 minutes
90836	Psychotherapy, 45 minutes with patient when performed with E/M Service
90838	Psychotherapy, 60 minutes with patient when performed with E/M Service
90846	Family Psychotherapy without Patient Present, 50 minutes
90847	Family Psychotherapy with Patient Present, 50 minutes
90853	Group Psychotherapy
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes
96101, 96102, 96103	Psychological Testing
96118, 96119, 96120	Neuropsychological Testing

Applied Behavior Analysis

0359T	Behavior Identification Assessment
0360T	Observational Behavioral Follow-up Assessment by Tech (first 30 min)
0361T	Observational Behavioral Follow-up Assessment by Tech (additional 30 min)
0362T	Exposure Behavioral Follow-up Assessment by BCBA (first 30 min)
0363T	Exposure Behavior Follow-up Assessment by BCBA (additional 30 min)
0364T	Adaptive Behavior Treatment by Tech (first 30 min)
0365T	Adaptive Behavior Treatment by Tech (additional 30 min)
0366T	Group Adaptive Behavior Treatment (first 30 min)
0367T	Group Adaptive Behavior Treatment (additional 30 min)
0368T	Adaptive Behavior Treatment by BCBA (first 30 min)
0369T	Adaptive Behavior Treatment by BCBA (additional 30 min)
0370T	Family Adaptive Behavior Treatment w/out pt present by BCBA (60 min)
0371T	Multi-family Group Adaptive Behavior Treatment by BCBA (60 min)
0372T	Adaptive Behavior Treatment Social Skills Group (60 min)
0373T	Exposure Therapy Treatment by Tech (first 60 min)
0374T	Exposure Therapy Treatment by Tech (additional 30 min)
99201	Office or other outpatient visit for E/M with new patient (problem focused, straight forward)

ABA DOCUMENTATION REQUIREMENTS

REQUEST FOR AUTHORIZATION AND TREATMENT PLAN	<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.
GENERAL GUIDELINES FOR TREATMENT NOTES	<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> <ul style="list-style-type: none"> (a) Time spent with patient (b) Time spent with family (c) Time spent with patient and family <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>
CPT CODES DESCRIPTIONS	
0360T, 0361T OBSERVATIONAL BEHAVIORAL FOLLOW-UP ASSESSMENT	<p>This code is utilized for observation and data collection either for failure to show progress on treatment plan and/or for Functional Behavioral Assessments. Service administered by a single line therapist and includes physician's or other qualified health care professional's work. Administered single calendar day with follow-up time on other days. One unit equals 30 minutes of face-to-face time with member. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Assessment administered by line therapist (e) Physician's or other qualified health care professional's work, which includes: <ul style="list-style-type: none"> 1) technician direction; 2) analysis of results of testing and data collection; 3) preparation of report and plan of care; 4) discussion of findings and recommendations with the primary guardian(s)/ caregiver(s) (f) Authentication of documentation

0364T, 0365T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL	<p>Service administered by a single line therapist to member. One unit equals 30 minutes of face-to-face time with member. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Member's presentation, symptoms, and behaviors (e) Treatment goals addressed during session (f) Summary of intervention provided by rendering provider during session (g) Member's response to intervention provided in the session (h) Authentication of documentation
0366T, 0367T GROUP ADAPTIVE BEHAVIOR TREATMENT	<p>Service administered by a single line therapist to group. One unit equals 30 minutes of face-to-face group. Do not report these codes if the group is larger than eight (8) patients. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with two or more members (b) Rendering provider and member identified (c) Date of service with start/stop time and/or duration of service (d) Member's presentation, symptoms, and behaviors (e) Treatment goals addressed during session (f) Summary of intervention provided by rendering provider during session (g) Member's response to intervention provided in the session (h) Authentication of documentation

<p>0368T, 0369T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION</p>	<p>Service administered by a BCBA or qualified health professional to member or to member and line therapist.</p> <p>Service includes a direct intervention with member and/or supervision of a line therapist with member present.</p> <p>Service also includes parent/caregiver training with member present. One unit equals 30 minutes of face-to-face time with member present.</p> <p>Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Member's presentation, symptoms, and behaviors (e) Treatment goals addressed during session (f) If service is a direction intervention with the member, include; <ul style="list-style-type: none"> 1) Summary of intervention provided by rendering provider during session 2) Member's response to intervention provided in the session (g) If service is supervision of a line therapist with member present, summary of supervision provided by rendering provider during session, including: <ul style="list-style-type: none"> 1) Directly observe treatment implementation for potential program revision; 2) Monitor treatment integrity to ensure satisfactory implementation of treatment protocols; 3) Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client present); (h) Member's and/or line therapist's response to intervention provided in the session (i) Authentication of documentation <p>Billing for the time of this activity is allowed only for BCBA or qualified health professional time even if other professional providers are present. Indirect supervision activities including instructing technicians about the treatment protocol without the patient present are considered bundled into the direct reimbursement and cannot be billed separately.</p>
---	--

0370T FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE	<p>Service administered by BCBA or qualified health care professional for parent training without member present. One unit equals one hour of face-to-face time. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with parents, guardian, and caregiver w/o member present (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Treatment goals addressed during session (e) Summary of intervention provided by rendering provider during session (f) Parents/guardian/caregiver's response to intervention provided in the session (g) Authentication of documentation
0371T MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE	<p>Service administered by a BCBA or qualified health care professional for parent training without member present for multiple families (group). One unit equals one hour of face-to-face time. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with parents, guardians, and caregivers w/o members present (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Treatment goals addressed during session (e) Summary of intervention provided by rendering provider during session (f) Parents/guardian/caregiver's response to intervention provided in the session (g) Authentication of documentation
0372T ADAPTIVE BEHAVIOR TREATMENT SOCIAL SKILLS GROUP-	<p>Service administered by a BCBA or qualified health professional to group of patients. One unit equals one hour of face-to-face time. Do not report these codes if the group is larger than eight (8) patients. Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with two or more members (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Member's presentation, symptoms, and behaviors (e) Treatment goals addressed during session (f) Summary of intervention provided by rendering provider during session (g) Member's response to intervention provided in the session (h) Authentication of documentation

0362T, 0363T EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT	<p>One or more line therapists assist in treatment protocol with supervision of BCBA, qualified health care professional.</p> <p>One unit equals 30 minutes of line therapist(s) face-to-face time with member present. Only one technician's time can be billed.</p> <p>Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Summary of assessment methods
	<ul style="list-style-type: none"> (e) Interpretation of results by BCBA or qualified health care professional (f) Discussion of findings and recommendations with primary parent/caregiver (g) Authentication of documentation
0373T, 0374T EXPOSURE ADAPTIVE BEHAVIOR TREATMENT	<p>Service administered by BCBA or qualified health care professional provides onsite supervision and direction of two or more line therapists. Service (0373T) is a one-hour unit, with 30-minute units (0374T) utilized after first hour. Only one technician's time can be billed.</p> <p>These services are, "typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior," per AMA CPT Assistant. Requires safe, structured environment with possible use of protective gear and padded room.</p> <p>Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Summary of line therapist exposing member to specific environmental conditions and treatment (e) Interpretation of results by BCBA or qualified health care professional and summary of redefined therapy (f) Authentication of documentation

0359T BEHAVIOR IDENTIFICATION ASSESSMENT	<p>Service administered by a BCBA or qualified health professional with member. This code is used both for the initial ABA treatment assessment as well as for ongoing 6 month updated ABA treatment assessments. Untimed single unit of service.</p> <p>Documentation needs to reflect:</p> <ul style="list-style-type: none"> (a) Face to face with one member (Does not require member to present the entire duration of service). (b) All participants who were present (c) Date of service with start/stop time and/or duration of service (d) Obtain history of current and past behavioral functioning (e) Review previous assessments and health records (f) Interview parent/caregiver to further identify and define deficient adaptive or maladaptive behaviors (g) Administer standardized and non-standardized test such as VB-MAPP, ABLLS, EFL (h) Interpret test results (i) Recommendations to parent/caregiver (j) Authentication of documentation
---	---

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 new patient (detailed, moderate complexity)
99215	Office or other outpatient visit for E/M with new 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 Abuse
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 10: 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 Claims_Integrity@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). It may be subject to change. If you have questions, please direct them to the applicable Plan.

Blue Cross Blue Shield of Alabama

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) 800-248-2342 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

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.

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 1-800-248-2342.
- Online eligibility and benefits information is available at <https://providers.bcbsal.org/>

Claims

Blue Choice and Out-of-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 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.

- 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/Facility Update Form](#).

Medical Records

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

Telehealth

Telehealth Services Guide and Attestation for BCBSAL BH Providers

Telehealth services by prescribing and non-prescribing licensed Behavioral Health clinicians is adopted to increase access to care. Telehealth is a secured and HIPAA compliant method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. The New Directions Behavioral Health member must have a covered mental health benefit that permits telehealth in order for providers to receive payment for telehealth services.

The following office visit codes are appropriate for use by the Behavioral Health Provider:

Prescribers: (Psychiatrists and ARNP)

Consultations 99241-99245

New patient office visit 99201-99205

Established patient office visit 99211-99215

Psychiatric consultation 90832-90838, 90863, 90785

Non-Prescribers: (Psychologists or Licensed Masters Level Therapists)

90791 – Assessment of patient's psychosocial history, current mental status, review and ordering of diagnostic studies followed by appropriate treatment recommendations

90832 – Psychotherapy, 30 minutes

90834 – Psychotherapy, 45 minutes

90837 – Psychotherapy, 60 minutes

90847 – Family psychotherapy (with the patient present), 50 minutes

When billing for Telehealth services the following modifier must be used: use the "95" or the "GT" modifier to identify services as delivered through telehealth.

Provider's Responsibility:

Providers will choose a secure and HIPAA compliant vendor and sign an attestation form agreeing to meet all necessary telehealth requirements.

- Before conducting telehealth services, providers must complete and return the [telehealth services attestation form](#) to New Directions.
- Meet the specific requirements outlined in the telehealth services attestation form including the ability to provide all telehealth sessions through secure and HIPAA compliant technology.
- Liability and malpractice insurance carrier to provide telehealth services.

Questions should be directed to your provider relations representative.



Telehealth Services Provider Attestation

Provider Name: _____

Group/Practice Name: _____

Office Address: _____

State(s) where telehealth services will be provided: _____

NPI number(s): _____

Provider TIN Number(s): _____

New Directions defines telehealth as an aid to delivering behavioral health gaps-in-care coverage using long-distance interactive telecommunications when the member and behavioral health provider are not in the same physical location.

Telecommunications must be synchronous (live) telemedicine service rendered via a real-time audio and video telecommunications system. Telehealth does not include the use of audio-only telephone, facsimile, text or email pursuant to the Provider and/or member contact.

By checking the following, you are attesting that you meet the criteria listed.

- I meet all state licensure and/or certification requirements to provide behavioral telehealth services within the state(s) where I will be providing telehealth services.
- I will provide behavioral telehealth services only in the state(s) where I hold a license.
- If I am a prescriber, I will follow all state and federal statutes and regulations regarding prescribing practices.
- I have written policies and procedures documenting how my telehealth services meet federal and state laws and regulations including all HIPAA & HITECH privacy and security regulations.
- I use secure, HIPAA compliant synchronous technology while providing all telehealth services.
- My professional liability insurance includes services performed via telehealth in the states where the provision of services occurs.
- I have written policies, procedures, and standards of care for my telehealth services including managing urgent/emergent situations.

Note: You may be required to complete an additional survey and/or attestation to receive payment for telehealth services.

I hereby certify and attest, by my signature, that all of 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 Manual and other supplemental telehealth materials and understand the requirements for delivery of telehealth services. I understand it is my responsibility to comply with all New Directions requirements and state, and federal telehealth statutes, regulations, and guidelines. I will cooperate with New Directions during any audit to verify that I meet the above.

Name (print): _____

Signature: _____ Date: _____

Arkansas Blue Cross Blue Shield (Arkansas Blue Cross) Federal Employee Program (FEP)

Precertification	New Directions Use Provider WebPass or call 800-367-0406
Eligibility & Benefits and Claims Questions	ABCBS 800-482-6655
Other Inquiries	New Directions 800-450-8706
Provider Relations	New Directions 888-611-6285 or email ProviderRelations@ndbh.com
Deaf or hearing impaired	Arkansas Relay Service 800-285-1131
Reconsideration/ Inquiries	New Directions 800-367-0406

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.

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.

Change in Demographics

- Please provide 45 days' notice of any planned demographic changes.
- 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

- No authorization required for partial day, intensive outpatient, or regular outpatient services.
- Precertification is required for Inpatient and residential services beginning 1/1/17.
- No authorization 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' notice of any planned demographic changes.
- 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.
- rTMS & 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.
- Requests for authorizations sent via facsimile will no longer be accepted, except for ABA therapy.

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.
- Contracted Florida providers will no longer be using WebPass for any part of the UM review process for Eating Disorder cases. Beginning July 9, 2018, these reviews will be completed by phone. Please note that this change does not affect any other type of cases. If you have any questions or concerns, contact Florida_PR@ndbh.com

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.

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 Availability 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 notify New Directions of any changes to your availability or demographics with 45 days' notice. 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

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: 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.
- rTMS 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.
- Requests for authorizations sent via facsimile will no longer be accepted, except for ABA therapy.
- Contracted Florida providers will no longer be using WebPass for any part of the UM review process for Eating Disorder cases. Beginning July 9, 2018, these reviews will be completed by phone. Please note that this change does not affect any other type of cases. If you have any questions or concerns, contact Florida_PR@ndbh.com

Instructions for obtaining precertification for eating disorder cases:

1. 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.

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 notify New Directions of any changes to your availability or demographics with 45 days' notice. 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

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 case management participation prior to admission, treatment plan development and agreement. Please call 866-730-5006 for additional details.
- No certification required for psychological or neuropsychological testing. After eight (8) hours, medical records need to be sent to Florida Blue.
- rTMS 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.
- Requests for certification sent via facsimile will no longer be accepted, except for ABA therapy.
- Contracted Florida providers will no longer be using WebPass for any part of the UM review process for Eating Disorder cases. Beginning July 9, 2018, these reviews will be completed by phone. Please note that this change does not affect any other type of cases. If you have any questions or concerns, contact Florida_PR@ndbh.com

Instructions for obtaining precertification for eating disorder cases:

1. 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.

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 Availability 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 notify New Directions of any changes to your availability or demographics with 45 days' notice. 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	New Directions No authorization required. Outpatient services may be reviewed retrospectively.
Precertification	New Directions Use Provider WebPass or call 866-730-5006
Eligibility & Benefits	New Directions 866-730-5006
Claims Inquiries	Alignment Healthcare (AHC) Please first check Availity (800-282-4548). If further support is needed, call AHC Customer Service at 844-783-5191.
Other Inquiries	New Directions 800-450-8706
Provider Relations	New Directions 888-611-6285 or email Florida_PR@ndbh.com
Provider Appeals	New Directions 866-730-5006
Deaf or hearing impaired	State Relay Services Call 711 to identify the correct toll-free number for your location

Primary Requirements

- Providers/Facilities must use an NPI number in billing.
- If you are billing using a **Tax ID number**, you will need to register for a type 2 NPI number.
 - Use the following link to register for your type 2 NPI number
<https://nppes.cms.hhs.gov/NPPES/Welcome.do>
- If you are billing using your **Social Security number**, you will NOT have to register for a Type 2 NPI number.
- If using a Type 2 NPI in the billing process:

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

Authorizations

- No authorization required for psychological or neuropsychological testing. Claims for hours beyond eight (8) will be pended and medical records will be requested.
- No authorization is required for outpatient services
- Authorization is required for all inpatient, partial hospitalization and intensive outpatient services
- Authorization is required for rTMS and ECT. Please locate form on www.ndbh.com
- Requests for authorizations sent via facsimile will no longer be accepted.
- Contracted Florida providers will no longer be using WebPass for any part of the UM review process for Eating Disorder cases. Beginning July 9, 2018, these reviews will be completed by phone. Please note that this change does not affect any other type of cases. If you have any questions or concerns, contact Florida_PR@ndbh.com

Instructions for obtaining precertification for eating disorder cases:

1. 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.

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 Availability (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 notify New Directions of any changes to your availability or demographics with 45 days' notice. 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](#).
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

Network

- BCBSKS provides the network

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

Network

- BCBSKS provides the network.
- All services must be provided by in-network providers.
 - Exceptions may be made when services are provided for a medical/behavioral health emergency or when a medically necessary service is not available from a network provider.

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

Network

- BCBSKS provides the network.
- Prior authorization required for inpatient and residential services. Residential services require the member to have been previously enrolled in case 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 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 a 5-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, rTMS, 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.
- Precertification is encouraged for all 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 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 rTMS, 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 816395-3829 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

- Electronic Claims – Providers interested in filing electronic claims should use payer ID – 47171.
- Paper Claims – Paper claims should be mailed to:

Blue Cross Blue Shield Kansas City
P.O. Box 419169
Kansas City, MO 64141-6163

- 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' notice of any planned demographic changes, using the Provider/Facility update form. This form is found in the New Directions Provider and Facility Manual at www.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 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 a 5-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, rTMS, 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.
- Precertification is encouraged for all 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.
- Repetitive Transcranial Magnetic Stimulation (rTMS) requires prior authorization. For authorizations related to rTMS, 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 816395-3829 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

- Electronic Claims – Providers interested in filing electronic claims should use payer ID – 47171.
- Paper Claims – Paper claims should be mailed to:

Blue Cross Blue Shield Kansas City
P.O. Box 419169
Kansas City, MO 64141-6163

- 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' notice of any planned demographic changes.
- 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 outpatient services, including partial hospitalization and intensive outpatient services.
- 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 816395-3829 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

- Electronic Claims – Providers filing electronic claims should use payer ID – 47171.
- Paper Claims – Paper claims should be mailed to:

Blue Cross Blue Shield Kansas City
P.O. Box 419071
Kansas City, MO 64141-6163

- 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' notice of any planned demographic changes.
- 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) Provider Network through Blue Cross and Blue Shield of Michigan

Outpatient Authorizations	New Directions No authorization required
Precertification for BCBSM Contracted Facilities	New Directions 800-762-2382 (Commercial) 800-342-5891 (FEP) 877-228-3912 (URMBT) or use WebPass
Benefits & Eligibility	BCBSM Commercial and FEP: See Customer Service 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.bsbsm.com .
Claims Inquiries	BCBSM See Customer Service Phone number on the Member's ID card for claims or call 313-225-8100.
Deaf or hearing impaired	MI Relay Phone Number Dial 711 for relay number
Medical Necessity Appeals	New Directions 800-762-2382 (Commercial) 800-342-5891 (FEP) 877-228-3912 (URMBT)

Authorizations

- No authorization required for outpatient services, including psychological testing and intensive outpatient program (IOP) services for mental health and substance abuse issues. These services may be reviewed retrospectively.
- New Directions does not manage or authorize IOP services. Claims for IOP services should be sent directly to BCBSM for processing.
- Important notice for URMBT members: New Directions only authorizes in network services for inpatient, residential treatment and partial hospitalization. URMBT members have no out-of-network inpatient benefit except for true

emergencies, such as an involuntary admission. Geo-Access issues go through Single Case Agreement/Alternative Benefit Options processes.

- Applied Behavior Analysis (ABA) Therapy requires authorization for all visits. Call 877563-9347. Important notice for URMBT members: URMBT has no ABA benefits.
- For Commercial and FEP members: Precertification required for the following higher level of care services: partial hospitalization, residential treatment and inpatient hospitalization. Contact New Directions for authorization of these services.
- Authorization is required for rTMS. For authorizations related to rTMS, please refer to instructions on the initial and continuation treatment request forms and see BCBSM's Medical Policy for this therapy. Important notice: URMBT has no rTMS benefits.
- For "out-of-network" or "non-participating" providers or facilities, New Directions does not authorize any level of care. Important notice for URMBT members: New Directions only authorizes in-network services for inpatient, residential treatment and partial hospitalization. URMBT members have no out-of-network inpatient benefit except for true emergencies, such as an involuntary admission. Geo-Access issues go through Single Case Agreement/Alternative Benefit Options processes.

Benefits

- Commercial and FEP:
 - If you have any 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.
- URMBT:
 - If you have any questions about Member benefits, please call New Directions' Customer Service at 877-228-3912.
 - For accumulator questions, please call BCBSM Customer Service at the phone number found on Member's insurance ID card.

Other information

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

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines. Important notice: This is not a covered benefit for URMBT.

Blue Cross Blue Shield of Louisiana (BCBSLA)

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

	<p>Refer to A Guide for Disputing Claims Tidbit to properly route claim reviews, disputes and appeals to the appropriate departments within Blue Cross</p>
EDI Clearinghouse	BCBSLA EDICH@bcbsla.com 225-291-4334
iLinkBLUE & EFT	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, or length of time stated in the member's contract, of the date of service. 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 other states 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 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/HCFA) U3738 (Institutional/UB)

Hardcopy Claims:

- BCBSLA Hardcopy Claims should be mailed to:
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898

FEP Hardcopy 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 payor identification of 84555. In addition, 84555 is the new payor 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 payor identification BCLAM.

Blue Advantage Claims – Hard copy:

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 for Employer groups 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.

Cerner

Outpatient Notification and Precertification	American Health Facilities can be transferred to 866-648-5548
Eligibility, Benefits and Claim Questions	Cerner Callers can be warm transferred to 877-765-1033
Referrals for all levels of care	New Directions 877-500-8335
Provider Relations	New Directions 888-611-6285 or email providerrelationsteam@ndbh.com
Deaf or hearing impaired	Kansas Relay Phone 800-766-3777
Deaf or hearing impaired	Missouri Relay Phone 800-736-2966
Provider Appeals	Cerner 877-765-1033

Timely Filing

- Timely filing of claims is 365 days.

Benefits

- If you have any questions about Member benefits, please call Cerner Health at 1-877-765-1033.

Claims

- To check the status of a claim, please call Cerner Health customer service at 1-866-765-1033.
- Electronic Claims – Providers interested in filing electronic claims should use payer ID – 20356.

- Paper Claims – Paper claims should be mailed to:
Cerner Health
P.O. Box 165750
Kansas City, MO 64116
- Cerner Health Customer Service: 1-877-765-1033
- New Directions Behavioral Health Customer Service: 1-800-500-8335

Change in Demographics

- Please provide 45 days' notice of any planned demographic changes.
- 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.