NEW DIRECTIONS
MANAGED BEHAVIORAL HEALTH PROVIDER AND FACILITY MANUAL
2016
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Preface

New Directions Behavioral Health takes pride in the collaborative relationships developed with Network Providers and Facilities. Our Members and your patients/clients gain as a result of this collaboration. 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.

New Directions offers Continuing Education (CEU) Workshops for Providers and Facilities. New information or changes may also be communicated at those events.

Providers and Facilities are encouraged to contact the Network Operations (Provider Relations) department at 888-611-6285 for explanation and clarification.
About New Directions

Since incorporation 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.

Behavioral health benefits are managed by New Directions to ensure that members have timely access to the most appropriate services in the least restrictive setting as medically necessary. We coordinate care among the member’s primary care physician, psychiatrist, behavioral health therapist, and community resources, among others.

Our close relationship with health plans has led to an unparalleled integration of behavioral health and medical service, which includes case finding, co-case management, and workflows. Workflows encompass case and disease management, joint access to technology and data, and shared planning relative to pharmacy, quality improvement and network operations.

New Directions’ unique and effective population management paradigm, based upon a philosophy of proactive Member outreach, has led to consistently high satisfaction rates from Members and Providers, based upon account surveys.

New Directions has built a national reputation for innovative services focused on patient safety. In addition to recognition and awards from URAC, NCQA, and the Blue Association, 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 Case Management, and full accreditation from NCQA (National Committee on Quality Assurance) as a Managed Behavioral Health Organization. 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.
Communication

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

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
- Clinical Practice Guidelines for Adult Depression, Attention Deficient Hyperactivity Disorder (AD/HD) for Children/Adolescents, and Adult Substance Abuse Initial Assessment
- 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
- Educational materials that include guidebooks for ADHD, Depression, Bipolar Disorder, and Substance Abuse
- 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 or specialization.
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 are reported in the Health Plan Member Section. These materials are also available in print upon request.

**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](http://www.ndbh.com). To obtain a written copy of New Directions policies and procedures, call us at 888-611-6285.

**Focus Areas – Member Safety and Quality of Care**

**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, we fax 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 has been 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 toward developing, maintaining and promoting best practices in behavioral health care. Our main focus is on defining and measuring quality.

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 Coexisting Depression and Substance Abuse Behavioral Health Screening** 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 abuse disorder. If left unidentified and untreated, the coexistence of substance abuse and depression can complicate treatment of the member and can hinder providers’ efforts to address the member’s substance abuse disorder. This comorbidity places individuals at high risk for suicide and social and personal impairment.

- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications** is a Behavioral Health Screening 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.

- **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.
  
  o **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 re-hospitalization. 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.

Plan All-Cause Readmissions - Discharge from a hospital is a critical transition point in a member’s care. New Directions monitors the number of adult acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Hospital readmissions may indicate missed opportunities to coordinate care better.
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.

Shared Information

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.

Thorough treatment record documentation forms can be downloaded from our website and may be customized to suit your specific needs.

Website (www.ndbh.com) includes information such as Medical Necessity Criteria, Clinical Practice Guidelines, and New Directions Notice of Privacy Practices. Eligibility and benefit information is available online through WebPass.

Information Changes

To avoid a delay in reimbursement for submitted claims, please notify New Directions at least 45 days prior to any changes to your availability or demographics.

- **Send an email to** ProviderRelations@ndbh.com **for the following changes:**
  - Phone/Fax/Email changes
  - Practice panel status (accepting new members or full practice)
  - Availability (office hours)
  - Populations served (age groups, specialties, languages spoken)

**Complete the Provider/Facility Update Form** for the changes listed below. Visit www.ndbh.com to download a copy of the Provider/Facility Form. In most instances, the Provider/Facility Update Form must be accompanied by a W-9.

- Primary practice location
- Billing address location
- Name changes
- Social Security Number (SSN) or Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- Provider status with group/facility
Provider/Facility Update Form

Please visit www.ndbh.com to download a copy of the Provider/Facility Update form. In most instances, the Provider/Facility Update form must be accompanied by a W-9.

Privacy Policy and Privacy Practices

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.

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.

Fraud 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 entity 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 a deception or misrepresentation made by an entity or person that results in an unauthorized benefit or payment. “Fraudulent insurance act” means any oral or written statement submitted for payment, or other benefit pursuant to an insurance policy, when the person knows the statement contains materially false information or conceals a material fact.

“Abuse” means practices that are inconsistent with sound fiscal, business, or health care practices and result in an unnecessary cost to a health care benefit program. “Abuse” may also mean reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
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

**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](http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp). Providers and Facilities are required to search this website at least monthly.

**Compliance Program**

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 OIG has developed compliance program guidance for individual and small group health care practices (Federal Register, Vol. 65, p. 59434, Oct. 5, 2000 – [http://www.gpoaccess.gov/fr/retrieve.html](http://www.gpoaccess.gov/fr/retrieve.html)). Providers may also obtain guidance from other compliance programs on the OIG website at [http://www.hhs.gov/oig](http://www.hhs.gov/oig).

**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.
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.

Some of the most common fraud, waste and abuse practices include:

- Claims for services not rendered
- Up-coding services
- Excessive use of units
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member’s age/gender
- Use of exclusion codes
- Misuse of Benefits
- Unbundling of codes

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 include:

- Be licensed for independent practice
- Practice a minimum of fifteen hours per week
- Maintain 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)
- Have an email address and access to the internet
- Have 24-hour coverage
Site Visits
As part of the credentialing or re-credentialing process, New Directions may conduct a structured site visit of offices/locations. Site visits include an evaluation using the New Directions site visit standards and New Directions clinical recordkeeping standards. Any site visit will be arranged in advance. The New Directions site visit tool is available on our website (www.ndbh.com) under the Provider section. New Directions’ clinical recordkeeping standards are found in this manual and on our website.

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 (page 15) or on www.ndbh.com. You may also contact us by email at PRWebPass@ndbh.com.

Please remember that the Internet is not secure. **Protected health information** should not be communicated by email.

Getting Started with WebPass
To access the New Directions WebPass system for individual providers, you will need to obtain an Identification number and password. Complete the “Provider WebPass Access Request Form and Agreement” located at www.webpass.ndbh.com.

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 organization’s Tax ID Number, 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.
HIPAA Information

New Directions Behavioral Health
Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please review it carefully.

Your Rights
You have the right to:

• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Respond to requests from a medical examiner
• Do research
• Comply with the law
• Address workers' compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us in writing at New Directions Behavioral Health, Privacy Officer, P.O. Box 6729, Leawood, KS 66206-0729, by calling (816) 994-1439, or by sending an email to nvergara@ndbh.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-(877)-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most uses and disclosures of psychotherapy notes
- Any other uses and disclosures not addressed in this Notice
Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
• We can use and disclose your information to run our organization and contact you.
• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your health plan to coordinate payment for your behavioral health or EAP services.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone’s health or safety
Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to requests from a medical examiner or coroner
We can share health information with a coroner or medical examiner when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:
• For workers’ compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
Other Instructions for Notice

• **Effective Date of Notice 1/1/2014**
  - If you have any questions/concerns or complaints, please contact New Directions’ Privacy Officer Noreen Vergara via telephone at (816) 994-1439, via email at nvergara@ndbh.com, or via postal mail at P.O. Box 6729, Leawood, KS 66206-0729.
  - We create and maintain psychotherapy notes, but will only release them upon written authorization by you, or as required by law and this notice.
  - Certain states place heightened restrictions upon how we are able to use and access your info, and what info we are allowed to share. New Directions will comply with all state laws and will help you understand those requirements if you ask us.
  - Although New Directions does not typically conduct fundraising activities, in the event that we do, you will be allowed to opt out.
  - New Directions may decide to contact you to provide you appointment reminders. If we do so, you will be allowed to opt out of those reminders.
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. Whenever possible, New Directions utilizes ReferralQuick, a proprietary scheduling system, to facilitate Member access to care.

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 1-888-611-6285.

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
When there is a significant risk of serious life 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.
Management of Benefits

Behavioral health benefits 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’ utilization management staff is available 24 hours a day, seven 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 prenotification or authorization for coverage specific to the Plan are included on the Plan Fact Sheets in the Appendix.

Availability of 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 utilization management 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.
Medical Necessity Criteria

Medical necessity criteria can be located and downloaded at www.ndbh.com under the Provider link.

A hard copy of the Medical Necessity Criteria can be requested by calling Network Operations toll free at 1-888-611-6285.

Quality Improvement, Utilization Management and Case Management Programs

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. Quality improvement 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 quality improvement 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
- 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 Quality Improvement Program annually. Based on the results, a new Work Plan is created for the following year. Printed copies of the Quality Improvement Program Evaluation, Work Plan, and Description are available to providers on request by calling toll free 1-888-611-6285.
Utilization Management Services
The mission of the Utilization Management (UM) program is to improve health through change and to provide support to individuals in need of behavioral health care. The UM program promotes positive health outcomes by providing the structure and processes needed to provide UM services for all managed behavioral health (MBH) Members. 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 certification of care. 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 practitioner 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. The acuity of the situation is evaluated and appropriate referrals are then provided. 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 and appeals and coordinates services with other departments.

Case Management Services
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 physician 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 telephonic service with an emphasis on:

- Supporting Members’ efforts to take an active role in developing their health care 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 and support access to high quality health care.

As a New Directions Provider, you may request Case Management services for a Member. Please see health plan or group-specific contact information in the Appendix in the back of this Manual.
Preventing Inpatient Readmissions: Care Transition Program
Fifty percent of mental health admissions readmit within one year. Readmissions occur when members:
- Lack preparedness for self-management roles
- Do not know their discharge plans
- Cannot access providers when problems arise
- Receive minimal input in the health plans
- Suffer medication errors
- Do not have adequate follow-up

New Directions’ Care Transition Program focuses on providing a better member experience, improving the health of populations, and reducing services costs. This results in avoided readmissions and improved quality of service 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 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 member understand the importance of post-hospitalization aftercare
- Increases the scheduling of and attendance at post-discharge follow-up appointments within seven 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 member special needs into account. Self-management tools are reviewed every two years and 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 health plan or group specific contact information in the Appendix in the back of this Manual.
Request for Psychological/Neuropsychological Testing

Some health 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 health plans that require authorization, please use the form found on www.ndbh.com. The form is called “Request for Psychological/Neuropsychological 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.

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 at the start of treatment.

Maximum Visits per Day
Benefits will be authorized for only ONE professional unit per day unless a Plan specifies otherwise, except for the following:

- Outpatient psychotherapy or group therapy with a non-psychiatrist Provider and medication management with a psychiatrist on the same day
- Outpatient psychotherapy or evaluation and psychological testing on the same day
- Outpatient individual psychotherapy and group therapy on the same day by different providers
**Concurrent Services**
Providers should not bill concurrent services, including two or more direct services being delivered the same time to the same Member and delivering non-group services to more than one Member at the same time. Only the provider rendering the face-to-face session with a member can bill for that service.

**Billing Submission**
Ensure that documentation supports the amount of units and/or time-based coding billed.

**CPT Time Rule**
According to the 2016 CPT manual, time is defined as the face-to-face time spent with the patient. 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**

<table>
<thead>
<tr>
<th>Actual length of session</th>
<th>Code As</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 minutes</td>
<td>Not reported</td>
<td>-</td>
</tr>
<tr>
<td>16-37 minutes</td>
<td>90832</td>
<td>30 minutes</td>
</tr>
<tr>
<td>38-52 minutes</td>
<td>90834</td>
<td>45 minutes</td>
</tr>
<tr>
<td>53-89 minutes</td>
<td>90837</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

2016 CPT Manual, Page xv
# Common Billable CPT and Revenue Codes

For full list of codes please consult the AMA CPT manual for detailed explanation and guidelines as to which CPT code to use.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Treatment Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FREQUENTLY USED CODES</strong></td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation (no medical services)</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation (with medical services)</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Psychotherapy, 30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Psychotherapy, 45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Individual Psychotherapy, 60 minutes</td>
</tr>
<tr>
<td>90833</td>
<td>30-minute psychotherapy add-on code (prescribers only)</td>
</tr>
<tr>
<td>90836</td>
<td>45-minute psychotherapy add-on code (prescribers only)</td>
</tr>
<tr>
<td>90838</td>
<td>60-minute psychotherapy add-on code (prescribers only)</td>
</tr>
<tr>
<td>90846</td>
<td>Family Session without Patient Present</td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis, first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis, each additional 30 minutes</td>
</tr>
<tr>
<td>96101, 96102,</td>
<td>Psychological Testing</td>
</tr>
<tr>
<td><strong>CPT and REVENUE CODES IN NUMERICAL ORDER</strong></td>
<td></td>
</tr>
<tr>
<td>124</td>
<td>Inpatient Day – Mental Health</td>
</tr>
<tr>
<td>126</td>
<td>Inpatient Day – Substance Abuse</td>
</tr>
<tr>
<td>129</td>
<td>Sub-Acute/ Residential Rehabilitation</td>
</tr>
<tr>
<td>762</td>
<td>Observation Bed</td>
</tr>
<tr>
<td>901</td>
<td>Electroconvulsive Therapy-Facility Code</td>
</tr>
<tr>
<td>905</td>
<td>Intensive Outpatient (IOP) – Psychiatric</td>
</tr>
<tr>
<td>906</td>
<td>Intensive Outpatient (IOP) – Chemical Dependency</td>
</tr>
<tr>
<td>912</td>
<td>Partial Care (PHP) - Less Intensive</td>
</tr>
<tr>
<td>913</td>
<td>Partial Care (PHP) - Intensive</td>
</tr>
<tr>
<td>1001</td>
<td>Residential Care - Psychiatric</td>
</tr>
<tr>
<td>1002</td>
<td>Residential Care – Chemical Dependency</td>
</tr>
</tbody>
</table>

*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).
<table>
<thead>
<tr>
<th>Service Code</th>
<th>Treatment Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0359T</td>
<td>Behavior Identification Assessment</td>
</tr>
<tr>
<td>0360T</td>
<td>Observational Behavioral Follow-up Assessment by Tech (first 30 min)</td>
</tr>
<tr>
<td>0361T</td>
<td>Observational Behavioral Follow-up Assessment by Tech (additional 30 min)</td>
</tr>
<tr>
<td>0362T</td>
<td>Exposure Behavioral Follow-up Assessment by BCBA (first 30 min)</td>
</tr>
<tr>
<td>0363T</td>
<td>Exposure Behavior Follow-up Assessment by BCBA (additional 30 min)</td>
</tr>
<tr>
<td>0364T</td>
<td>Adaptive Behavior Treatment by Tech (first 30 min)</td>
</tr>
<tr>
<td>0365T</td>
<td>Adaptive Behavior Treatment by Tech (additional 30 min)</td>
</tr>
<tr>
<td>0366T</td>
<td>Group Adaptive Behavior Treatment (first 30 min)</td>
</tr>
<tr>
<td>0367T</td>
<td>Group Adaptive Behavior Treatment (additional 30 min)</td>
</tr>
<tr>
<td>0368T</td>
<td>Adaptive Behavior Treatment by BCBA (first 30 min)</td>
</tr>
<tr>
<td>0369T</td>
<td>Adaptive Behavior Treatment by BCBA (additional 30 min)</td>
</tr>
<tr>
<td>0370T</td>
<td>Family Adaptive Behavior Treatment w/out pt present (60 min)</td>
</tr>
<tr>
<td>0371T</td>
<td>Multi-family Group Adaptive Behavior Treatment (60 min)</td>
</tr>
<tr>
<td>0372T</td>
<td>Adaptive Behavior Treatment Social Skills Group (60 min)</td>
</tr>
<tr>
<td>0373T</td>
<td>Exposure Therapy Treatment by Tech (first 60 min)</td>
</tr>
<tr>
<td>0374T</td>
<td>Exposure Therapy Treatment by Tech (additional 30 min)</td>
</tr>
<tr>
<td>0375T</td>
<td>All other treatment - BCBA</td>
</tr>
<tr>
<td>99201</td>
<td>New Patient typically 10 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99202</td>
<td>New Patient typically 20 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99203</td>
<td>New Patient typically 30 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99204</td>
<td>New Patient typically 45 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99205</td>
<td>New Patient typically 60 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99211</td>
<td>Established Patient typically 5 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99212</td>
<td>Established Patient typically 10 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99213</td>
<td>Established Patient typically 15 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99214</td>
<td>Established Patient typically 25 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99215</td>
<td>Established Patient typically 40 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99216</td>
<td>Established Patient typically 60 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99217</td>
<td>Established Patient typically 90 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99218</td>
<td>Established Patient typically 120 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99219</td>
<td>Established Patient typically 180 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99220</td>
<td>Established Patient typically 360 minutes spent face to face with patient</td>
</tr>
<tr>
<td>99221</td>
<td>Initial inpatient/residential evaluation – 30 minutes</td>
</tr>
<tr>
<td>99222</td>
<td>Initial inpatient/residential evaluation – 50 minutes</td>
</tr>
<tr>
<td>99223</td>
<td>Initial inpatient/residential evaluation – 70 minutes</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent inpatient/residential visit – 15 minutes</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent inpatient/residential visit – 25 minutes</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent inpatient/residential visit – 35 minutes</td>
</tr>
<tr>
<td>99234</td>
<td>Subsequent inpatient/residential visit – 45 minutes</td>
</tr>
<tr>
<td>99235</td>
<td>Subsequent inpatient/residential visit – 60 minutes</td>
</tr>
<tr>
<td>99238</td>
<td>Subsequent inpatient/residential visit – 90 minutes</td>
</tr>
<tr>
<td>99251</td>
<td>Initial inpatient consultation 20 minutes</td>
</tr>
<tr>
<td>99252</td>
<td>Initial inpatient consultation 40 minutes</td>
</tr>
<tr>
<td>99253</td>
<td>Initial inpatient consultation 60 minutes</td>
</tr>
<tr>
<td>99254</td>
<td>Initial inpatient consultation 80 minutes</td>
</tr>
<tr>
<td>99255</td>
<td>Initial inpatient consultation 80+ minutes</td>
</tr>
<tr>
<td>99262</td>
<td>Follow-up Consultation – 20 minutes</td>
</tr>
</tbody>
</table>
Completing the CMS (HCFA) 1500 Claim Form

All outpatient claims submitted to New Directions must be filed on the CMS 1500 12-90 claim form. The following is a description of each section of the CMS 1500 Claim Form, 12-90 Version.

Please see the Medicare Provider Manual when completing forms for Medicare patients.

Please note that the claim form requests both a Rendering Provider and a Billing Provider. The Rendering Provider (Field 24J) is the Provider who delivered the service to the Member whose insurance is being billed. The Billing Provider (Field 33) is the Provider or Group who is to receive payment for the services that were billed.

CMS 1500 – 12-90 VERSION

<table>
<thead>
<tr>
<th>Field Number/Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of health insurance coverage.</td>
<td>Check appropriate box, usually group health Plan, Medicare, or other.</td>
</tr>
<tr>
<td>1A. Insured’s ID number.</td>
<td>Enter the certificate number shown on the Member’s ID card, including any letters.</td>
</tr>
<tr>
<td>2. Patient’s name.</td>
<td>Last, first, middle initial as shown on the patient’s insurance card.</td>
</tr>
<tr>
<td>3. Patient’s date of birth and sex.</td>
<td>Enter the patient’s 8-digit birth date (MM/DD/CCYY) and sex.</td>
</tr>
<tr>
<td>4. Insured’s name.</td>
<td>List the name printed on the identification card. If the insured and the patient are the same, enter the word “SAME.”</td>
</tr>
<tr>
<td>5. Patient’s complete address.</td>
<td>Fill in the patient’s mailing address and telephone number.</td>
</tr>
<tr>
<td>6. Patient’s relationship to insured.</td>
<td>The patient’s relationship to insured when item 4 is completed.</td>
</tr>
<tr>
<td>7. Insured’s Address.</td>
<td>Fill in the Insured’s address and telephone number. When the insured is the patient, use the word “SAME.”</td>
</tr>
<tr>
<td>8. Patient status.</td>
<td>Check appropriate boxes.</td>
</tr>
<tr>
<td>9A-D. Other insurance coverage.</td>
<td>If the patient has a Madigan policy, enter information according to Medicare guidelines. If the patient has insurance with more than one company, enter as much information as is available to you. At minimum, enter the name and address of the employer through which the other coverage was obtained.</td>
</tr>
<tr>
<td>10A. Was condition related to patient’s employment.</td>
<td>Check the appropriate box.</td>
</tr>
<tr>
<td>10B. Was condition related to an auto accident.</td>
<td>Check the appropriate box.</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>10C. Was condition related to another accident.</td>
<td>Check the appropriate box.</td>
</tr>
<tr>
<td>10D. Reserved for local use.</td>
<td>Use this item exclusively for Medicaid information. If the patient is entitled to Medicaid, this item must show the patient’s Medicaid number, preceded by “MDC.”</td>
</tr>
<tr>
<td>11A-D. Insured’s policy group number.</td>
<td>If the patient has health insurance coverage with more than one company, list as much information as possible.</td>
</tr>
<tr>
<td>12 Patient’s or authorized person’s signature.</td>
<td>The patient or authorized representative must sign and enter either a 6- or 8-digit date unless the signature is on file. If the patient’s signature is on file, “SIGNATURE ON FILE” is acceptable.</td>
</tr>
<tr>
<td>13. Authorization of payment to physician.</td>
<td>The signature in this item authorizes payment of mandated Madigan benefits. If the patient’s signature is on file, “SIGNATURE ON FILE” is acceptable.</td>
</tr>
<tr>
<td>14. Date of illness, injury, accident.</td>
<td>Enter date of the current illness, injury or pregnancy. Do not repeat date of service for patients receiving continuing services; use date of onset.</td>
</tr>
<tr>
<td>15. If patient has had same or similar illness, give first date MM/DD/YY.</td>
<td>Enter month, day and year the patient first consulted you for this condition.</td>
</tr>
<tr>
<td>17A. Name and identification number. 17B. NPI.</td>
<td>Enter the name of the referring physician or Primary Care Physician. Use the NPI of the referring Provider.</td>
</tr>
<tr>
<td>18. Hospitalization dates related to current services.</td>
<td>The 6- or 8-digit date when a medical service is furnished as a result of or subsequent to a related hospitalization.</td>
</tr>
<tr>
<td>19. Reserved for local use.</td>
<td>If this is a Medicare or Medicaid claim, the 6- or 8-digit date the patient was last seen and the UPIN of his/her attending physician should be listed.</td>
</tr>
<tr>
<td>20. Outside lab.</td>
<td>Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition price under charges if the “yes” block is checked. A “yes” check indicates that an entity other than the entity billing for the service performed the diagnostic test. A “no”</td>
</tr>
<tr>
<td>Field Number/Name</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>check indicates &quot;no anti-markup tests are included on the claim.&quot; When &quot;yes&quot; is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500.</td>
<td></td>
</tr>
<tr>
<td>21. Diagnosis or nature of illness or injury. (Through 9/30/15)</td>
<td>Enter the appropriate ICD-9-CM diagnosis code(s). Report codes to the fourth or fifth character, as defined by ICD-9. List primary diagnosis first.</td>
</tr>
<tr>
<td>21. Diagnosis or nature of illness or injury. (Effective 10/01/15)</td>
<td>Enter the appropriate ICD-10-CM diagnosis code(s). Report codes to the fourth or fifth character, as defined by ICD-10. List primary diagnosis first.</td>
</tr>
<tr>
<td>23. Prior authorization number.</td>
<td>When required, obtain from New Directions Behavioral Health.</td>
</tr>
<tr>
<td>24A. Date of service.</td>
<td>List the 6- or 8-digit date for each procedure or service. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column C.</td>
</tr>
<tr>
<td>24B. Place of service.</td>
<td>Identify the location, using place of service code for each item used or service performed.</td>
</tr>
<tr>
<td>24C. EMG.</td>
<td>Emergency Indicator. Check with carrier as to necessity of completing this area. If required, in the non shaded area, enter Y for Yes and N for No denoting whether care was provided on emergency basis or not. Medicare providers are not required to complete this item.</td>
</tr>
<tr>
<td>24D. Procedure code.</td>
<td>Enter the appropriate code that best describes the services rendered; include any necessary modifiers. If you need to describe an unlisted code or an unusual circumstance, use an attachment.</td>
</tr>
<tr>
<td>24E. Diagnosis code.</td>
<td>Reference the appropriate diagnosis code used in Box 21 for each procedure.</td>
</tr>
<tr>
<td>24F. Charges.</td>
<td>List your total charge for each service.</td>
</tr>
<tr>
<td>24G. Days or units.</td>
<td>This field is most commonly used for multiple visits or anesthesia minutes. If only one service is performed, the number “1” must be entered.</td>
</tr>
<tr>
<td>24H. EPDST.</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number/Name</td>
<td>Instructions</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>24I. ID. QUAL.</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>24J. Rendering Provider ID #</td>
<td>Use the 10-digit rendering provider number in the shaded area. Use the performing Providers 10-digit NPI in the lower unshaded portion.</td>
</tr>
<tr>
<td>25. Federal Tax ID Number.</td>
<td>List the Provider or service or supplier’s Federal Tax ID or Social Security Number. <strong>This information is required.</strong></td>
</tr>
<tr>
<td>26. Your patient’s account number.</td>
<td>Enter the patient’s account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.</td>
</tr>
<tr>
<td>27. Accept assignment.</td>
<td>The appropriate block must be checked to indicate whether the Provider of service accepts assignment of Medicare benefits.</td>
</tr>
<tr>
<td>28. Total charge.</td>
<td>Enter the total of charges listed on 24F.</td>
</tr>
<tr>
<td>29. Amount paid.</td>
<td>Enter the total amount the patient paid on the covered services only. This should include the co-payment if applicable.</td>
</tr>
<tr>
<td>30. Balance due.</td>
<td>Subtract other insurance payment from your total charge in Box 28.</td>
</tr>
<tr>
<td>31. Signature of physician.</td>
<td>Enter the physician’s name (typed, stamped, or computer-printed), signature and date.</td>
</tr>
<tr>
<td>32. Name and address of facility where services were rendered (if other than home or office).</td>
<td>Enter name and address of the facility if the services were furnished in a hospital, skilled nursing facility, nursing home, or other location if all or a portion of the services were rendered outside your office of the patient's home. Enter the NPI of the service location.</td>
</tr>
<tr>
<td>33. Physician’s name, address, zip code, and telephone number.</td>
<td>Enter the practitioner’s billing name, address, zip code, and phone number. Enter the 10-digit billing Provider NPI.</td>
</tr>
</tbody>
</table>
# New Directions – CMS Minimum Required Fields

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Coverage</td>
</tr>
<tr>
<td>1A</td>
<td>Insured’s ID Number</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s complete name</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s DOB</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name or “SAME” *</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s Relationship to Insured</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>8</td>
<td>Patient Status if 4 is other than patient</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name*</td>
</tr>
<tr>
<td>9A</td>
<td>Other Insured’s Policy or Group Number*</td>
</tr>
<tr>
<td>9B</td>
<td>Other Insured’s DOB*</td>
</tr>
<tr>
<td>9C</td>
<td>Other Insured’s Employer Name or School Name*</td>
</tr>
<tr>
<td>9D</td>
<td>Other Insured’s Insurance Plan or Program Name*</td>
</tr>
<tr>
<td>10A-D</td>
<td>Check appropriate boxes</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number if patient has other coverage</td>
</tr>
<tr>
<td>11A</td>
<td>Insured’s DOB</td>
</tr>
<tr>
<td>11B</td>
<td>Insured’s Employer or School Name</td>
</tr>
<tr>
<td>11C</td>
<td>Insured’s Insurance Plan or Program Name</td>
</tr>
<tr>
<td>11D</td>
<td>Is there another Health Plan Benefit? (If yes, complete items 9, 9a, and 9d.)</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s Signature or SIGNATURE ON FILE</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s Signature or SIGNATURE ON FILE</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis using the appropriate ICD-9-CM Code (through 09/30/15)</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis using the appropriate ICD-10-CM Code (beginning 10/01/15)</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>24A-J</td>
<td>Service Information</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Provider Including Credentials</td>
</tr>
<tr>
<td>32</td>
<td>Name and Address of Facility Where Services Rendered</td>
</tr>
<tr>
<td>33</td>
<td>Physician/Supplier’s Billing Name, Address, Zip Code</td>
</tr>
</tbody>
</table>

* If applicable
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value 1</td>
<td>Value 2</td>
<td>Value 3</td>
<td>Value 4</td>
<td>Value 5</td>
</tr>
</tbody>
</table>

**PHYSICIAN OR SUPPLIER INFORMATION**

**PATIENT AND INSURED INFORMATION**

**CARRIER**
Completing the UB-04 Claim Form

All inpatient (higher levels of care) claims submitted to New Directions must be filed on the UB-04 claim form.

Please see the Medicare Provider Manual when completing forms for Medicare patients.

The authorization or pre-certification number is required in field 63 on UB-04. To ensure timely processing, please complete the UB-04 with all required information.
Statement of Rights and Responsibilities of Providers

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. Participate in activities and develop documents at New Directions, such as:
   - Clinical Practice Guidelines
   - Medical Necessity Criteria
   - Credentials Committee
   - Preventive Health Programs
5. Request a hearing (in accordance with the Policy, “Fair Hearing with the policy Plan”), if an adverse recommendation regarding participation in the New Directions Network is made
6. Be credentialed in accordance with the “Provider Appointment and Reappointment” policy, which describes the processes for credentialing and re-credentialing, including:
   - Maintaining the confidentiality of Credentials Files to the extent permitted under state or federal laws and New Directions’ Policies
   - 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 60 calendar days of 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. Maintain health information (treatment records) in accordance with the New Directions “Treatment Record Documentation” policy; submit to reasonably requested audits of health information; implement action plans as required; and participate in follow-up reviews of deficiencies
3. Participate when requested in quality improvement and professional review activities
4. Communicate with primary care physicians and other Providers about mutual Members
Statement of Rights and Responsibilities for Members and Clients

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. Receive 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

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
Commercial Member and Provider Denial and Appeal Rights

The attending physician or other ordering provider 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.

If a Clinical Peer makes an adverse benefit determination to deny coverage for payment of the requested service, the requesting Provider/Facility and the Member are notified of the adverse benefit determination and appeal rights.

The right to appeal is available to the Member, the Member’s representative, and the Member’s Provider on behalf of the Member. New Directions Behavioral Health has written procedures for appeals of determinations not to certify payment for an admission, service, or extension of stay, including retrospective non-certification determinations.

These procedures are available to Providers and Members upon request. All medical necessity appeals are reviewed by a clinical peer, a physician or other health care 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 questions regarding access to services, UM issues and the UM process toll free, 24 hours a day, seven days a week. Please refer to page 3 of 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 health plan and group. See Plan or group specific information and contact information in the Appendix in the back of this Manual.**

**Written appeal and denial procedures are available upon request and can be found at [www.ndbh.com](http://www.ndbh.com).**
Types of Appeals and Definitions

Adverse benefit determination (denial)
- 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, a representative on behalf of the Member (who may be any person), or a Provider, for a full investigation of the adverse benefit determination, including any aspect of clinical care involved. A “grievance” is an appeal.

Clinical Peer – A physician or other 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 as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

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

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.
Coordination of Care with Primary Care Physicians and other Providers

New Directions Behavioral Health 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, operations and coordination of care guidelines under HIPAA. The few exceptions may be for substance abuse, HIV/AIDS, genetic information, or because of a specific state law. Providers are also expected to comply with relevant state laws regarding contact with other health care Providers.

We encourage all providers to participate in these collaborative efforts to ensure the best possible outcomes for our members. For more information, call Network Operations toll free at 1-888-611-6285.
Guidelines for Treatment Record Documentation

As required by NCQA, the following Guidelines were developed for treatment records review, and to promote orderliness, security, confidentiality and adequate documentation. As part of the re-credentialing process, Providers seeing a high number of New Directions Members 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 treatment 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 group practice. The internal information from the Provider office is integrated with external information.

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

   Providers must establish a separate file 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.

   The electronic treatment record 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.

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. **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.

8. **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).

9. **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:
   - 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)

10. **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.
11. **Diagnostic Testing:** All diagnostic testing, reports and their interpretations are present (e.g., psychological testing reports, and neuropsychological testing reports, and laboratory reports).

12. **Treatment Plan:** Within the first three 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.

13. **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 three (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.

14. **Treatment Record Notes:** Each face-to-face encounter note contains (a) reason for the Member’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; and (e) an updated treatment plan. 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.

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

16. 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.

17. **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 patient’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

18. **Legibility:** The treatment 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.

**Author Identification, Authentication, and Date and Time of Entries:** All entries are dated, including the month and year, start and end times the member was seen; duration of service; have the rendering provider clearly identified on the entry; 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 electronic medical record signatures qualify for authentication. A typed signature on a Microsoft Word document, for example, would not qualify as authentication.

19. **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.

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

21. **Continuity and Coordination of Care:** As applicable, the treatment 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.

22. **Coordinating Care with the PCP:** Treatment records reflect contact with the patient’s primary care physician (PCP), as applicable, and follow-up contact as needed.

23. **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 an entry into a medical record, amendments and edits are made using the following steps:
   a. To remove information from the documentation, draw a single line through the words needing removed, ensuring the content is still readable. White-out is not to be used.
   b. The individual adding or editing the documentation needs to 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.
Major Depression Guideline for Initial Outpatient Treatment of Adults

Perform a diagnostic evaluation to include a full HPI (including "Why Now"?), previous psychiatric history, medical history, current and past medications, family history, substance use, etc. Clinical conforms to current DSM criteria for MDD. Assess for most appropriate LOC, accounting for safety/risk issues.

Acute Phase:
The goal of tx is Recovery = absence of symptoms and a return to full function.
- 1st F/U visit within 21 days
- At least 3 F/U visits within 84 days

Screen for SUD. Rule out medical conditions.

DGM Criteria Met? Yes

Consider other diagnoses, e.g.: dysthymia, bipolar, substance use, etc.

Communicate findings and treatment plan to referring clinician.

DGM Criteria Met? No

Medication Management:
- Past or family history of response
- Side Effect Profile
- Genetic vs. Brand
- Maximizes dose, if tolerated
- Adherence education

Psychotherapy:
- Cognitive Behavioral
- Interpersonal supportive, problem solving, social skills
- Behavioral & psychodynamic therapies

Evaluate response & reassess progress with meds & psychotherapy at least monthly. If moderate improvement is not present within 8 weeks, review med adherence, need for med change, psychotherapy change.

Recovery or significant response:

Maintenance Phase:
- Continue Medication at optimal dose.
- 1st episode – 6 months
- 2nd episode – 2 to 3 years
- 3rd episode – indefinitely

Post Maintenance Phase:
- Decision is whether to resume full dose, or less.

Taper Med?

Observe carefully for sx recurrence. If taper is successful and further visits are not indicated, educate patient & family re: recurrence & treatment.

Communicate current status to PCP or referring physician.

Consider these actions:
- If after 3-12 weeks of limited response, a new medication trial is indicated
- Review diagnosis
- Evaluate for substance use co-morbidity
- Begin augmentation or combination medication strategy
- Consider ECT
- Referral for 2nd opinion

Maintain medication.
- Management visits every 2-3 months
- If stability remains, consider referral to PCP for continued medication management and communicate with PCP.

Additional Notes:
- If second generation antipsychotic is started, obtain baseline lipid and blood glucose levels, and retest in 3 months. Test yearly if long-term use is indicated.

Sources:
Nonpharmacologic Interventions for Treatment-Resistant Depression in Adults, Comparative Effectiveness Review, No. 33, prepared by the RTI International–University of North Carolina Evidence-based Practice Center, AHRQ, September 2011.
Developed and adopted 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: Reviewed annually.
ADHD Child and Adolescent Clinical Guideline

**ADHD Concern Identified**
- Inattention, Hyperactive, Impulsivity

**Evaluation**
- Severity and duration of symptoms
- Functional impairment rating scales
- Medical Hx, family Hx, and school performance
- Presence of comorbid diagnosis

**ADHD Diagnosis Only?**
- Yes
- No

**Other Dx – ODD, MDD, PTSD, Anxiety, Autism, etc.**
- Yes
- No

**Comorbid with ADHD?**
- Yes
- No

**Development of Treatment Plan**
- Medication Assessment/Mgmt.
- Family Psycho-Education
- Behavior Assessment/Mgmt.
- School-Based Behavioral Management, IEP
- Ancillary Treatments: Speech, Occupational Tx, etc.
- Modify for comorbid
- Refer to CHADD

**Ongoing care & Reevaluation**
- If symptoms improve follow up at least 2x per year for ADHD issues
- If no improvement reevaluate to confirm diagnosis and reconsider treatment plan and/or adherence issues

**Treatment plan or referral for treatment**

**Behavior Assessment/Management**
- Child Behavioral Assessment, Family Assessment and Education on Behavior Mgmt.
- Strategies

**Medication Assessment/Management**
- Physical Exam, Blood Pressure, Ht & Wt
- Review interactions with other prescribed medications

**Select Medication for ADHD**
- Stimulant
- Non-Stimulant
- Alternatives
  - See AAP process-of-care algorithm (Supplemental Table 3)

**Medication Maintenance**
- If new RX two additional visits within next 6 months

**Return visit for Medication Management within 30 days of initial visit**
- Titration/Replacement
- Augmentation until stable

Adult Substance Abuse Initial Assessment
Clinical Guideline

Health professional screens at the initial visit and periodically thereafter using a structured instrument.
Recommended instruments include:
1. Alcohol Use Disorders Identification Test (AUDIT)
2. Drug Abuse Screening Test (DAST)
3. CAGE (Substance Abuse Screening Tool; name is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

- Member has overt symptoms of withdrawal, or these are reasonably expected with abstinence
  - Evaluate for appropriate level of care for detox management. Plan for compliance with HEDIS IET for follow up after detox is complete

- If screening is positive, obtain a full history of drug and ETOH use
  - If screening is positive and results of evaluation confirm current DSM diagnosis of abuse or dependence. Plan an initial visit for SUD treatment within 14 days, and 2 follow-up visits within 35 days of the initial visit (HEDIS IET Measure)
    - If screening is positive, but a current DSM diagnosis of abuse or dependence is not met, employ Screening, Brief Intervention and Referral for Treatment (SBIRT) for problem drinking

- Currently engaged in SUD treatment
  - Assess for compliance with treatment and assess for Medication Assisted Treatment
    - Continue regular visits and if applicable, Medication Assisted Therapy compliance

- Not currently engaged in SUD treatment
  - Assess for appropriate level of rehabilitation and Medication Assisted Treatment and refer

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.

Screening tools and scoring instructions can be found at http://www.projecte.org/caretool/index.html. A site developed and maintained by Dartmouth Medical School. Information about the Audit-C can be found at http://www.oasimh.org/tools/auditc.pdf.

Definitions:
The 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 (IET) is a HEDIS measure. Members meet the measure by initiating treatment within 14 days of AOD diagnosis and have two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
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.

References:
SAMHSA: http://www.samhsa.gov/prevention/
Adopted 1/2006
Revised 6/06, 4/08, 12/09, 4/11, 1/12, 8/14 Reviewed annually
Bipolar Disorder Maintenance Episodes Guidelines

Number of prior episodes

First episode-Mania
- Yes
  - 1st degree family history and/or severe episode
    - Yes
      - Maintenance treatment may not be needed
    - No
      - Maintenance treatment may not be needed
- No

Second episode-One with Mania
- Yes
  - 1st degree family history and/or severe episode
    - Yes
      - Consider maintenance treatment
    - No
      - Maintenance initiated
- No

Third or more episode-at least one hypomania
- Yes
  - Maintenance treatment indicated
- No

% Reduction of pre maintenance episodes
- 100
- >50%
- <50%
- <10%

Continue with preventive agent (PA)
Continue with PA and consider combination therapy
Consider new PA and combination therapy
Switch to new PA

Based on medications used follow recommended health screenings and monitoring such as blood glucose with SGA antipsychotics, kidney and thyroid function for Lithium
Appendix for Blue Cross and Blue Shield Plans (Fully insured, Federal Employee Program and Self-Funded accounts)

Note: Information contained in the Appendix that is specific to each health plan (i.e., not a New Directions’ process) may be subject to change. If you have questions, please verify with the health plan.
Blue Cross Blue Shield of Alabama  
Provider Network through Managed Health Care Administration (MHCA)

MHCA Website:  www.mhcausa.com

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Primary Requirements

Authorizations
- No authorization required for outpatient services, including psychological testing.
- Applied Behavior Analysis (ABA) therapy requires authorization for all visits.
- Precertification required for all Inpatient services when provided in a facility that contracts with MHCA, and for services outside of Alabama. Precertification is required for partial hospitalization and intensive outpatient services when required by the Member’s contract.

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 1-855-339-8558.
- Online eligibility and benefits information is available at www.BCBSAL.org.
Claims
- Electronic Claims – Providers interested in filing electronic claims should email mhcaclaims@mhcausa.com.
- Paper Claims – Paper claims should be mailed to:

  Managed Health Care Administration, Inc. (MHCA)
  ATTN: Claims Processing
  956 Montclair Road, Suite 200
  Birmingham, AL 35213

Change in Demographics
- Changes in demographics should be sent or emailed to:

  Evelyn Barbee, RN, MPPM, Director of Network Development
  Managed Health Care Administration, Inc. (MHCA)
  956 Montclair Road, Suite 200
  Birmingham, AL 35213
  877-840-1971
  Evelyn.Barbee@mhcausa.com

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

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
Arkansas Blue Cross Blue Shield (ABCBS) HMO & PPO (Including Health Advantage)

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<tr>
<td>Provider Appeals</td>
<td>New Directions</td>
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</tbody>
</table>

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

**Authorizations**
- No authorization required for outpatient services.
- Prenotification required for all inpatient, Precertification for partial hospital and intensive outpatient services.
- No authorization required for psychological or neuropsychological testing.

**Timely Filing**
- Timely filing of claims is 180 days.

**Benefits**
- New Directions will quote benefits.
Claims

- Claims must meet ABCBS filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please call 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:

  ABCBS  
P.O. Box 2181  
Little Rock, AR 72203

- ABCBS Customer Service: 1-800-482-6655

Change in Demographics

- Please provide 45 days’ notice of any planned demographic changes, using the Provider/Facility update form.

Medical Records

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

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
Arkansas Blue Cross Blue Shield (ABCBS) Federal Employee Program (FEP)

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<td>New Directions</td>
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|                         | Use Provider WebPass or call 800-367-0406 |
|                         | ABCBS                                    |
|                         | 800-482-6655                             |
|                         | 800-450-8706                             |
|                         | 888-611-6285 or email providerrelations@ndbh.com |
|                         | 800-285-1131                             |
|                         | 800-367-0406                             |

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

**Authorizations**
- 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

- ABCBS FEP Customer Service: 1-800-482-6655
- New Directions Behavioral Health Customer Service: Please refer to the Appendix on page 3 for the appropriate plan account name and phone number to call.

Change in Demographics

- Please provide 45 days’ notice of any planned demographic changes, using the Provider/Facility update form.

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 (ABCBS)/Blue Advantage Administrators (BAA)

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<td>Use Provider WebPass or call 877-709-6822</td>
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<td>Other Inquiries</td>
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<td></td>
<td>800-450-8706</td>
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<tr>
<td>Provider Relations</td>
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<td></td>
<td>888-611-6285 or email <a href="mailto:providerrelations@ndbh.com">providerrelations@ndbh.com</a></td>
</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>Relay Services</td>
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<td></td>
<td>Dial 711 for state relay service toll free number</td>
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</table>

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

Authorizations
- No authorization required on outpatient services or intensive outpatient services.
- Prenotification recommended for all inpatient services and Partial Services.
- No authorization required for psychological or neuropsychological testing
- ABA services for Autism require prenotification. Prenotification 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 prenotification 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

Change in Demographics
- Please provide 45 days’ notice of any planned demographic changes, using the Provider/Facility update form.

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

### CONTACT INFORMATION

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<td>Use Provider WebPass or call 866-730-5006</td>
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<tr>
<td>Provider Relations</td>
<td>888-611-6285 or Email <a href="mailto:Florida_PR@ndbh.com">Florida_PR@ndbh.com</a></td>
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<tr>
<td>Deaf or hearing impaired</td>
<td>Call 711 to identify the correct toll free number for your location.</td>
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<tr>
<td>Provider Appeals</td>
<td>866-730-5006</td>
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### 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](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](http://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.
- No authorization required for psychological or neuropsychological testing. After eight (8) hours of psychological or neuropsychological testing, Florida Blue will request to see medical records from the provider of service.
- rTMS and ECT require prior authorization from first visit. Please locate request form on [www.ndbh.com](http://www.ndbh.com). Failure to obtain prior authorization may result in denial of payment. Refer to the member’s plan for specific benefits and authorization requirements.
Notifications
- Notification is required for all Inpatient, Residential, Partial Hospitalization and Intensive Outpatient Services (including ABA therapy). Note: some self-funded Plans may not have this requirement.

Timely Filing
- Timely filing of claims is 180 days.

Benefits
- Benefits vary by group and Plan.

Claims
- Claims must meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity, or call New Directions Customer Service at 1-866-730-5006.
- Electronic Claims – Providers are encouraged to file claims electronically and should use payer ID – 00590.
- Paper Claims – Paper claims are not the preferred method of claim submission and will usually delay your payment, but in certain circumstances where a paper claim is necessary they should be mailed to:

  Florida Blue
  P.O. Box 1798
  Jacksonville, FL 32231-0014

- Florida Blue PPO Customer Service: See Member’s ID card

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.

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
Florida Blue HMO including Medicare Advantage

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**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](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](http://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.
- No authorization is required for psychological or neuropsychological testing. After eight (8) hours of psychological or neuropsychological testing, Florida Blue will request to see medical records from the provider of service.
- Precertification required for all Inpatient, Residential, Partial Hospitalization and Intensive Outpatient services (including ABA therapy). Note: some self-funded Plans may not have this requirement.
• rTMS and ECT require 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.

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.
• Electronic Claims – Providers interested in filing electronic claims should use payer ID – 00590.

• Paper Claims – Paper claims should be mailed to:

  Florida Blue
  P.O. Box 1798
  Jacksonville, FL 32231-0014

• Florida Blue Customer Service: See Member’s ID card.
• New Directions Behavioral Health Customer Service: 1-866-730-5006

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.

Telehealth
• Reimbursement for telehealth services is subject to plan guidelines.

Florida Blue Federal Employee Program (FEP)

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

Authorizations
- No authorization is required for outpatient services.
- Precertification is required for all Inpatient services, including Residential Treatment. Residential has additional requirements for case management services and treatment plan development and agreement. Please call 866-730-5006 for additional details.
- No authorization required for psychological or neuropsychological testing. After eight (8) hours, medical records need to be sent to Florida Blue.
- rTMS and ECT require 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.

Timely Filing
- Timely filing of claims is 180 days.

Benefits
- Contact New Directions toll free at 1-866-730-5006.
**Claims**
- Claims must meet timely filing requirements.
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity or call New Directions Customer Service at 866-730-5006.
- Electronic Claims – Providers interested in filing electronic claims should use payer ID – 00590.

- Paper Claims – Paper claims should be mailed to:
  
  Florida Blue  
  P.O. Box 1798  
  Jacksonville, FL 32231-0014

- Florida Blue Customer Service: See Member’s ID card  

**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](http://www.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

**CONTACT INFORMATION**

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**Network**

- BCBSKS provides the network

**Authorizations**

- No authorization required on outpatient services effective 1/1/16, except for Autism services.
- Authorization is required for psychological or neuropsychological testing on the first date of service.
- Precertification is required for all higher levels of care, including inpatient, residential, partial hospitalization, intensive outpatient and ECT.
- ABA requires prior authorization from first visit. A reference number will then be assigned. (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.

**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 18 months.
Claims
- Claims must meet BCBSKS filing requirements.
- Electronic Claims – Providers interested in filing electronic claims should refer to BCBSKS.com.
- Paper Claims – Paper claims should be mailed to:
  
  Blue Cross Blue Shield Kansas
  1133 SW Topeka Blvd
  Topeka, KS 66629-0001

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
Blue Cross Blue Shield of Kansas (BCBSKS) HMO

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Network
- BCBSKS provides the network.

Authorizations
- No authorization required on outpatient services effective 1/1/16, except for Autism services.
- Authorization is required for psychological or neuropsychological testing on the first date of service.
- Precertification is required for all higher levels of care, including inpatient, residential, partial hospitalization, intensive outpatient and ECT.
- ABA requires prior authorization from first visit. A reference number will then be assigned. (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.

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 18 months.
Claims

- Claims must meet BCBSKS filing requirements.
- Electronic Claims – Providers interested in filing electronic claims should refer to BCBSKS.com.
- Paper Claims – Paper claims should be mailed to:

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

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
Blue Cross Blue Shield of Kansas (BCBSKS) Federal Employee Program (FEP)

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<td>Provider Relations</td>
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</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>Kansas relay services</td>
</tr>
<tr>
<td>Reconsiderations</td>
<td>New Directions</td>
</tr>
</tbody>
</table>

**Network**
- BCBSKS provides the network.

**Authorizations**
- Advanced benefit determination is no longer required effective 1/1/16 for Professional outpatient services, with the exception of Autism Services
- Precertification is required for all inpatient services, including residential.
- Pre-authorization is not required by contract for PHP, IOP, ECT or Psychological testing, however these services will be reviewed for medical necessity beginning with the first date of service or unit of service. You may request prior-approval for services to be reviewed by submitting the ITR/OTR/Psych testing forms in the same manner they were submitted prior to January 1, 2016.

**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 does not follow a strict filing requirement and performs retrospective reviews on claims if they are filed.
Claims

- Claims must meet BCBSKS filing requirements.
- Electronic Claims – Providers interested in filing electronic claims should refer to BCBSKS.com.

- Paper Claims – Paper claims should be mailed to:
  Blue Cross Blue Shield Kansas
  1133 SW Topeka Blvd.
  Topeka, KS 66629-0001

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
Blue Cross Blue Shield of Kansas City (Blue KC) Blue Care HMO

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>Toll Free Number</th>
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<tbody>
<tr>
<td>Precertification</td>
<td>800-528-5763</td>
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<tr>
<td>Eligibility &amp;</td>
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<td>Benefits and</td>
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<tr>
<td>Claims Questions</td>
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<tr>
<td>Other Inquiries</td>
<td>800-528-5763</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>888-611-6285 or</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:providerrelationsteam@ndbh.com">providerrelationsteam@ndbh.com</a></td>
</tr>
<tr>
<td>Deaf or hearing</td>
<td>800-766-3777</td>
</tr>
<tr>
<td>impaired</td>
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<tr>
<td>Deaf or hearing</td>
<td>800-736-2966</td>
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<tr>
<td>impaired</td>
<td></td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>800-528-5763</td>
</tr>
</tbody>
</table>

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
- No authorization required for outpatient services.
- Precertification is required for all Inpatient, residential, partial hospitalization and intensive outpatient services.
- ABA requires prior authorization from first visit. A reference number will then be assigned. (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.
- Authorization is required for psychological testing after three (3) hours of testing.
- Authorization required for neuropsychological testing after eight (8) hours of testing.

Timely Filing
- Timely filing of claims is 180 days.
Benefits
- If you have any questions about Member benefits, please use Provider WebPass or call New Directions Customer Service at 1-800-528-5763.
- Blue KC’s automated system, “Blue Touch,” will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member’s ID number and date of birth. The phone numbers for Blue Touch are 816-395-3829 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

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

**CONTACT INFORMATION**

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<td>New Directions 888-611-6285 or email <a href="mailto:providerrelationsteam@ndbh.com">providerrelationsteam@ndbh.com</a></td>
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<td>Deaf or hearing impaired</td>
<td>Kansas relay phone number 800-766-3777</td>
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<tr>
<td>Deaf or hearing impaired</td>
<td>Missouri relay Phone number 800-736-2966</td>
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<tr>
<td>Provider Appeals</td>
<td>New Directions 800-528-5763</td>
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**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**

- No authorization is required for outpatient services.
- Precertification is required for all Inpatient, residential, partial hospitalization and intensive outpatient services.
- ABA requires prior authorization from first visit. A reference number will then be assigned. (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.
- Authorization is required for psychological testing after five (5) hours of testing.
- Authorization is required for neuropsychological testing after five (5) hours of testing.

**Timely Filing**

- Timely filing of claims is 180 days.
Benefits

- If you have any questions about Member benefits, please use Provider WebPass or call New Directions Customer Service at 1-800-528-5763.
- Blue KC’s automated system, “Blue Touch,” will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member’s ID number and date of birth. The phone numbers for Blue Touch are 816-395-3829 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

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.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
Blue Cross Blue Shield of Kansas City (Blue KC) Federal Employee Program (FEP)

**CONTACT INFORMATION** | **Toll Free Number**
--- | ---
Precertification Eligibility, Benefits and Claim 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 phone number | 800-766-3777
Deaf or hearing impaired | Missouri relay Phone number | 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**
- No authorization is required for outpatient services, including partial hospitalization and intensive outpatient services.
- Precertification is required for all inpatient services, including residential.
- No authorization is required for psychological or neuropsychological testing.

**Timely Filing**
- Timely filing of claims is 180 days.
Benefits
- If you have any questions about Member benefits, please use Provider WebPass or call New Directions Customer Service at 1-800-528-5763.
- Blue KC’s automated system, "Blue Touch," will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member’s ID number and date of birth. The phone numbers for Blue Touch are 816-395-3829 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 419071
  Kansas City, MO 64141-6163

- Blue KC Customer Service: 1-816-395-3678
- New Directions Behavioral Health Customer Service: 1-800-528-5763

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.
# CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Toll Free Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Authorizations</td>
<td>New Directions</td>
<td>No authorization required. Outpatient services may be reviewed retrospectively.</td>
</tr>
<tr>
<td>Precertification for BCBSM Contracted Facilities</td>
<td>New Directions</td>
<td>800-762-2382 (Commercial) 800-342-5891 (FEP) or use WebPass</td>
</tr>
<tr>
<td>Benefits &amp; Eligibility</td>
<td>BCBSM</td>
<td>See Customer Service Phone number on the Member’s ID card for benefits/eligibility or go to <a href="http://www.bcbsm.org">www.bcbsm.org</a>.</td>
</tr>
<tr>
<td>Claims Inquiries</td>
<td>BCBSM</td>
<td>See Customer Service phone number on the Member’s ID card for claims</td>
</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>MI relay phone numbers</td>
<td>Dial 711 for relay number</td>
</tr>
<tr>
<td>Medical Necessity Appeals</td>
<td>New Directions</td>
<td>800-762-2382 (Commercial) 800-342-5891 (FEP)</td>
</tr>
</tbody>
</table>

## Authorizations

- No authorization required for outpatient services, including Psychological testing.
- ABA Therapy requires authorization for all visits. Call 877-563-9347
- Prenotification required for all higher level of care services

## Benefits

- If you have any questions about Member benefits, please call BCBSM Customer Service. Phone Number is found on the Member’s Insurance ID card.
- Online eligibility and benefits information is available at BCBSM.org.
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.
Appendix for Employer groups contracted with New Directions

Note: Information contained in the Appendix that is specific to each health plan (i.e., not a New Directions’ process) may be subject to change. If you have questions, please verify with the health plan.
Archer Daniels Midland (ADM)
Blue Cross Blue Shield of Illinois provides the network

<table>
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<tr>
<th>CONTACT INFORMATION</th>
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<td>New Directions</td>
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<tr>
<td>Other Inquiries</td>
<td>New Directions</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>New Directions</td>
</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>Contact your state relay services for the toll free number</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>New Directions</td>
</tr>
</tbody>
</table>

Network: BCBSIL PPO

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

Authorizations
- No authorization is required for outpatient services.
- Precertification is required for all inpatient services.
- No authorization is required for psychological or neuropsychological testing.

Timely Filing
- Timely filing of claims is 180 days.

Claims
- Paper Claims – Paper claims should be mailed to:

  BCBS of Illinois
  1400 North 30 Street
  Quincy, IL 62301

  - BCBSIL Customer Service: 1-866-219-8511

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.

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
### Ball’s Food
**Price Chopper & Hen House Market Employees**

#### CONTACT INFORMATION

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<thead>
<tr>
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<tbody>
<tr>
<td>Outpatient Authorizations</td>
<td>New Directions</td>
<td>Use Provider WebPass or fax to: 866-645-0653</td>
</tr>
<tr>
<td>Precertification Eligibility &amp; Benefits and Claims Questions</td>
<td>New Directions</td>
<td>800-528-5763</td>
</tr>
<tr>
<td>Other Inquiries</td>
<td>New Directions</td>
<td></td>
</tr>
<tr>
<td>Provider Relations</td>
<td>New Directions</td>
<td>888-611-6285 or email <a href="mailto:providerrelationsteam@ndbh.com">providerrelationsteam@ndbh.com</a></td>
</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>Kansas relay phone number</td>
<td>800-766-3777</td>
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<tr>
<td>Deaf or hearing impaired</td>
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<tr>
<td>Provider Appeals</td>
<td>New Directions</td>
<td>800-528-5763</td>
</tr>
</tbody>
</table>

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

#### Authorizations
- Authorizations for outpatient services are required after the eighth visit.
- MD/DO’s and ARNP’s do not require an authorization.
- Precertification is required for all inpatient services, including Partial and Intensive Outpatient services.
- No authorization is required for neuropsychological testing.

#### Timely Filing
- Timely filing of claims is 365 days.

#### Benefits
- Psychological testing is not a covered benefit.
- Neuropsychological testing is covered under the medical benefit.
- If you have any questions about Member benefits, please call Ball’s Food customer service at 1-866-360-9070.
Claims

- Clean claims will be processed within 10 to 30 days.
- Paper Claims – Paper claims should be mailed to:

  Freedom Network Select  
  C/O Preferred Health Professionals  
  P.O. Box 25938  
  Shawnee Mission, KS 66225-5938

- Ball’s Food Customer Service: 1-866-360-9070

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.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
Cerner
(The following information will be effective 1/1/16 through 2/29/16)

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<tr>
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<tr>
<td>Outpatient Notification</td>
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<td></td>
<td>Use Provider WebPass or fax to: 866-645-0653</td>
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<td>Prenotification Eligibility, Benefits and Claim Questions</td>
<td>New Directions</td>
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<td></td>
<td>Use Provider WebPass or call: 877-500-8335</td>
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<td>Other Inquiries</td>
<td>New Directions</td>
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<td>Provider Relations</td>
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<td>888-611-6285 or email <a href="mailto:providerrelationsteam@ndbh.com">providerrelationsteam@ndbh.com</a></td>
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<td>877-500-8335</td>
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</table>

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

**Authorizations**
- Prenotification is required after eight (8) outpatient visits – will result in a reference number.
- ABA requires prior authorization from first visit. A reference number will then be assigned. (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.
- Prenotification is required for inpatient services.
- No authorization is required for psychological or neuropsychological testing.

**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 1-800-500-8335.
Claims
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please call Health Exchange customer service at 1-800-231-4015.
- Electronic Claims – Providers interested in filing electronic claims should use payer ID – 20356.
- Paper Claims – Paper claims should be mailed to:

  Health Exchange
  P.O. Box 165750
  Kansas City, MO 64116

- Health Exchange Customer Service: 1-800-231-4015
- New Directions Behavioral Health Customer Service: 1-800-500-8335

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.

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
**HCA**

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<td>Precertification</td>
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<tr>
<td>Benefits, Eligibility and Claim Inquiries</td>
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**Primary Requirements**
- Providers/Facilities must use an NPI number in billing.

**Authorizations**
- Authorization is required for all outpatient services after the thirtieth (30th) visit.
- Precertification is required for all inpatient, residential, partial hospitalization and intensive outpatient services.
- Authorization is required for psychological testing after three (3) hours of testing.
- Authorization is required for neuropsychological testing after eight (8) hours of 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. Please refer to the Appendix on page 3 for the appropriate plan account name and phone number.

Claims
- To check the status of a claim, please call New Directions Customer Service. Refer to the Appendix on page 3 for the appropriate plan account name and phone number.
- Electronic Claim: Use payer ID – 31478
- Paper Claim: – Paper claims should be mailed to:
  PHP/New Directions
  P.O. Box 25938
  Shawnee Mission, KS 66225-5938
- HCA Customer Service: 1-800-566-4114
- New Directions Behavioral Health Customer Service: Please refer to the Appendix on page 3 for the appropriate plan account name and phone number to call.

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.

Telehealth
- Reimbursement for telehealth services is subject to plan guidelines.
Blue Cross Blue Shield of Kansas City (Blue KC)
Medicare Advantage

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**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**

- No authorization required for outpatient services.
- Authorization is required for psychological testing after three (3) hours of testing.
- Authorization required for neuropsychological testing after eight (8) hours of 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. Please refer to the Appendix on page 3 for the appropriate plan account name and phone number to call.
- Blue KC’s automated system, “Blue Touch,” will walk you through the process to obtain eligibility and benefits information. You will need your Blue KC Provider number and the member’s ID number and date of birth. The phone numbers for Blue Touch are 816-395-3829 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: Please refer to the Appendix on page 3 for the appropriate plan account name and phone number to call.

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.

Telehealth

- Reimbursement for telehealth services is subject to plan guidelines.
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th></th>
<th>Plan or New Directions</th>
<th>Toll Free Number</th>
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</thead>
<tbody>
<tr>
<td>BCBSLA Authorizations</td>
<td>New Directions</td>
<td>1-800-991-5638</td>
</tr>
<tr>
<td>Blue Advantage</td>
<td>New Directions</td>
<td>1-800-991-5638</td>
</tr>
<tr>
<td>Authorizations</td>
<td></td>
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<tr>
<td>BCBSLA Benefits &amp;</td>
<td>BCBSLA</td>
<td><a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a></td>
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<tr>
<td>Eligibility</td>
<td></td>
<td>or call Provider Services at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-922-8866</td>
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<tr>
<td>Blue Advantage</td>
<td>BCBSLA</td>
<td>Use the Blue Advantage Provider Portal in</td>
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<tr>
<td>Eligibility</td>
<td></td>
<td>iLinkBLUE (<a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a>),</td>
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<tr>
<td></td>
<td></td>
<td>then click the Blue Advantage menu option</td>
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<tr>
<td>BlueCard Eligibility</td>
<td>Other Blue Plans</td>
<td>For benefits and eligibility for member of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a Blue Plan other than BCBSLA</td>
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<tr>
<td></td>
<td></td>
<td>1-800-676-BLUE (1-800-676-2583)</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>BCBSLA</td>
<td><a href="mailto:provider.relations@bcbsla.com">provider.relations@bcbsla.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-716-2299, option 4</td>
</tr>
<tr>
<td>Provider Operations</td>
<td>BCBSLA</td>
<td><a href="mailto:network.administration@bcbsla.com">network.administration@bcbsla.com</a></td>
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<tr>
<td></td>
<td></td>
<td>1-800-716-2299</td>
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<td>• Option 1 for provider file questions</td>
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<tr>
<td></td>
<td></td>
<td>• Option 2 for credentialing questions</td>
</tr>
<tr>
<td>Claims Inquiries</td>
<td>BCBSLA</td>
<td><a href="http://www.bcbsla.com/ilinkblue">www.bcbsla.com/ilinkblue</a></td>
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<td></td>
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<td>or call Provider Services at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-922-8866</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>BCBSLA</td>
<td>BCBSLA recognizes that disputes may</td>
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<tr>
<td></td>
<td></td>
<td>arise between members and Blue Cross</td>
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<td></td>
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<td>regarding covered services</td>
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<td>Refer to A Guide for Disputing Claims</td>
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<td>Tidbit to properly route claim reviews,</td>
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<tr>
<td></td>
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<td>disputes and appeals to the appropriate</td>
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<td></td>
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<td>departments within Blue Cross</td>
</tr>
<tr>
<td>EDI Clearinghouse</td>
<td>BCBSLA</td>
<td><a href="mailto:EDICH@bcbsla.com">EDICH@bcbsla.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>225-291-4334</td>
</tr>
<tr>
<td>iLinkBLUE &amp; EFT</td>
<td>BCBSLA</td>
<td>1-800-216-BLUE (1-800-216-2583)</td>
</tr>
</tbody>
</table>
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 Provider Services 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 interested in 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 – Hardcopy:
HMO Louisiana, Inc.
P.O. Box 32406
St. Louis, MO 63132

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.
## Florida’s BlueMedicare Preferred HMO [Florida Blue, Florida Health Care Plans (FHCP), and BeHealthy]

<table>
<thead>
<tr>
<th>CONTACT INFORMATION</th>
<th>Organization Owner</th>
<th>Toll Free Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Authorizations</td>
<td>New Directions</td>
<td>No authorization required. Outpatient services may be reviewed retrospectively.</td>
</tr>
<tr>
<td>Precertification</td>
<td>New Directions</td>
<td>Use Provider WebPass or call: 866-730-5006</td>
</tr>
<tr>
<td>Eligibility &amp; Benefits Questions</td>
<td>New Directions</td>
<td>866-730-5006</td>
</tr>
<tr>
<td>Claims Inquiries</td>
<td>Alignment Healthcare (AHC)</td>
<td>Please first check Availity (phone # 800-282-4548). If further support is needed, call AHC Customer Service at 844-783-5191</td>
</tr>
<tr>
<td>Other Inquiries</td>
<td>New Directions</td>
<td>800-450-8706</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>New Directions</td>
<td>888-611-6285 or email <a href="mailto:Florida_PR@ndbh.com">Florida_PR@ndbh.com</a></td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>New Directions</td>
<td>866-730-5006</td>
</tr>
<tr>
<td>Deaf or hearing impaired</td>
<td>State Relay Services</td>
<td>Call 711 to identify the correct toll-free number for you location</td>
</tr>
</tbody>
</table>

### 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
- Precertification is required for all inpatient services

Notifications
- Notification is required for all inpatient, partial hospitalization and intensive outpatient services. Note: some self-funded Plans may not have this requirement.
- Residential services are not covered.

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

Claims
- Claims must meet timely filing requirements
- Clean claims will be processed within 10 to 30 days. To check the status of a claim, please check Availity (phone # 800-282-4548). If further support is needed, call Alignment Customer Service at 844-783-5191.
- Electronic Claims – Providers interested in filing electronic claims should use payer ID – CCHPC.
- Paper Claims – Paper claims should be mailed to:
  Claims Dept.
  BlueMedicare Preferred HMO
  P.O. Box 14010
  Orange, CA 92869-9936
- Alignment Healthcare Customer Service: 844-783-5191

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.

**Telehealth**
- Reimbursement for telehealth services is subject to plan guidelines.