Fourth Quarter 2024

Carelon Behavioral Health
Provider Newsletter

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AVAILITY ESSENTIALS – YOUR SECURE SELF-SERVICE PORTAL

Availity Essentials (Availity) is a secure, one-stop, self-service, multi-payer portal that supports the day-to-day needs of your patients and office. Registered Availity users can quickly check patient eligibility and benefits, submit authorizations, view previously submitted authorization requests, search and review claim details, access payer spaces and more online, without having to call Carelon Behavioral Health. **There is no cost for you to register and begin accessing the many resources available to you on Availity.**

Throughout this past year, we've introduced new functionality on Availity including:

- **Single sign-on** through Availity allowing you to access Carelon portals
- **Authorization management dashboard** to search and requests authorizations
- **Claims dashboard** to search and review claim details

Keep a lookout for new features available to you in the near future, making it easier to work with us!

New to Availity?

Providers who are not yet registered with Availity, can learn more, and sign up today, at no charge by visiting Availity.com.

You can also visit the Register and Get Started with Availity Essentials page at www.availity.com/documents/learning/LP_AP_GetStarted/index.html#/ to learn more. Here you can register for live webinars to guide you through registering an account and organization with Availity, access pre-recorded webinars, and download Availity registration guides. If you need further assistance, contact Availity Client Services at 1-800-282-4548. Assistance is available Monday through Friday 8 AM – 8 PM ET.

ONLINE APPOINTMENT REQUESTS: OPT-IN AND LET PATIENTS BOOK WITH EASE!

We're making it easier for patients to request appointments with you via our enhanced provider directory!

We are excited to announce that we recently begun gradually rolling out this new functionality, making it easier for members to access the care they need. Through our new member platform, patients will be able to request appointments with you with just a click of a button. If you opt-in, you will receive notifications about requests via email. You can then manage requests through the Availity Essentials portal, where you can review key patient information, and accept, decline, or reschedule the appointment.

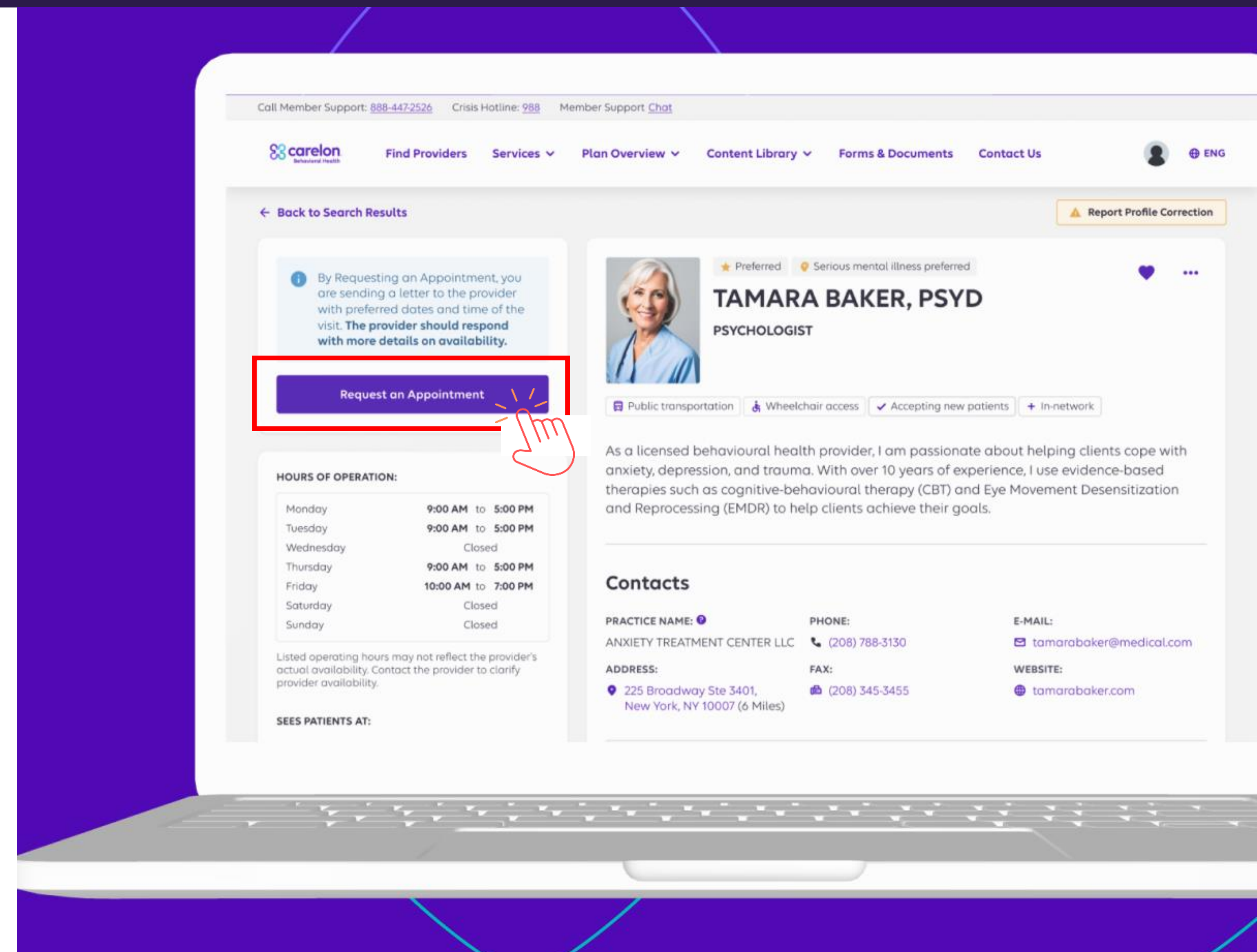
This self-service feature empowers patients to access care anytime, anywhere, from their computer or smartphone.. In turn, you will be able to filter referrals more easily by accessing key patient information such as preferred language, reason for appointment, and age. Through offering patients more options when it comes to booking their own care, we are reducing the back-and-forth calls to and from your office and improving the patient and provider experience.

Providers must opt-in to participate

If you would like to allow patients to request appointments with you via our provider directory, you must opt-in to participate in this new feature. **We have started to introduce this feature gradually, beginning with select clients and eventually expanding it to our entire network.** Keep an eye on your email for opt-in details and seize the opportunity to offer seamless appointment scheduling for your patients!

Interested in learning more?

We want to ensure that you have all the information you need to take full advantage of this new feature. [Access our prerecorded training here to learn more](#).



Providers must login to Availity to manage appointment requests.
Don't have an Availity account? [Click here to register](#).

AVAILITY PAYER SPACE NOW HAS MESSAGE CENTER FUNCTIONALITY

We recently introduced the Message Center as a new functionality within the Provider Portal payer space application. The Message Center is a collection of all your web inquiry correspondence with Carelon Behavioral Health. This new feature makes it easier for providers to access their web inquiry correspondence via the Availity payer space.

This functionality delivers quick access to previously submitted web inquires. Within the Message Center, you can also review responses from our team to your inquires.

For the Message Center, login to Availity and select **Payer Spaces** > **Provider Portal** > select your **Organization** and **Provider**. The Message Center Inbox and Sent tabs will show the same messages available in ProviderConnect. Upon clicking on the message, you will be able to view the message in Availity. Upon clicking "ProviderConnect" in the message, you will be directed to the ProviderConnect application, where you can respond or take any action on the message.

Please note: The Message Center is specific to ProviderConnect users

What is a web inquiry? Today, providers can send/initiate an inquiry for any of the functionalities they are using in ProviderConnect such as authorization, claims, member information (demographics, enrollment, etc….). These inquiries get routed to our team to respond to.

Provider Portal

carelon Behavioral Health

Organization Carelon Behavioral Health Test Organization

Provider

Change Organization and Provider

Message Center

ProviderConnect

The Message Center is a collection of all your web inquiry correspondence with Carelon Behavioral Health.

Inbox Sent

Show: 30 Results

Display unread only

Showing 1 - 30 of 300 Messages

‹ Prev 1 2 3 4 … Next ›

Inquiry #	Date Received	From	Subject	Member Name	Delete
	05/23/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/23/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/23/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/23/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/22/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/22/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/22/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		
	05/22/2024	CUSTOMER SERVICE	DUP MEMBER ISSUE		

KEEP YOUR CARELON DIRECTORY DATA ACCURATE

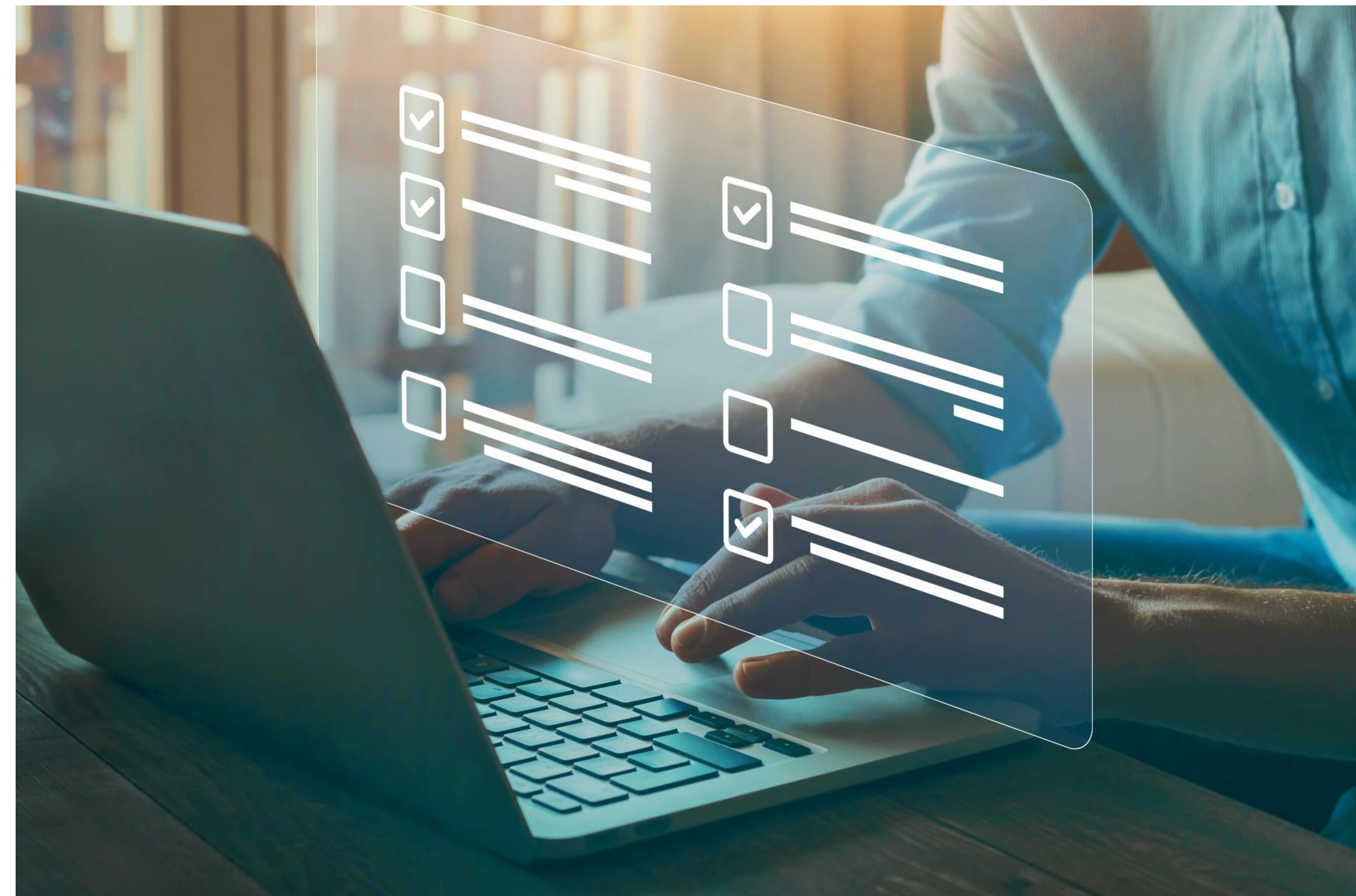
To best serve our members together, the most up-to-date provider data is essential.

Accurate provider data is members' primary gateway to access care - align with your current availability, your areas of practice and services, and optimize matching members to the right providers – you!

Carelon is committed to helping members find you. In addition to maintaining your provider data with CAQH and Carelon Behavioral Health's (CBH) ProviderConnect, you may receive a CBH Provider Data Validation Audit via email or text. Please keep an eye out for these digital audits. By participating in these provider data validations, you will help keep your data up-to-date by validating select directory fields and your current availability to see members. Together we are making a difference!

*CAQH Providers should attest, confirm, or update their data through the CAQH portal. Non-CAQH Providers and Facilities should attest, confirm, or update their data directly with Carelon Behavioral Health.

NEW: Federal regulations now require an annual submission of providers offering telehealth services. Please indicate whether you offer telehealth services when validating your information.



SUBMIT AUTHORIZATIONS ELECTRONICALLY USING THE AVAILITY ESSENTIALS PROVIDER PORTAL

Availity's Authorizations & Referrals tool allows providers to electronically submit prior authorization requests and check status on previously submitted requests and/or update applicable existing requests.

Submitting authorization requests electronically allows you to submit prior authorization requests and receive status updates without having to pick up a phone or fax information.

The authorization application is available through an existing Availity account with the appropriate role designation (assigned by your Administrator). Log in to Availity Essentials and select **Patient Registration | Authorizations and Referrals**.

Don't have an Availity account? You can register here.

Benefits of using Availity

Accessing the authorization application digitally offers a free, electronic solution with a variety of features to simplify the prior authorization process. Benefits include:

- Creation and submission of prior authorization cases
- Ability to attach documents for review - no faxing required and no need to call
- Instant access from any location at any time of day
- Check Status for any case
- A complete record of all submissions and dispositions in one place

Request authorization or check status

To request authorizations:

1. From the Availity home page, select Patient Registration from the top navigation.
2. Select Authorizations and Referrals.
3. Select Auth/Referral Inquiry or Authorizations.

Prior authorization lookup tool

To check if authorization is required:

1. From the Availity home page, select Payer Spaces from the top navigation.
2. Select the appropriate health plan tile.
3. From the payer spaces home page, select the Applications tab.
4. Select the Prior Authorization Lookup Tool.

CLAIMS RESOLUTION

Reminder: The Claims Based Dispute Form is a resources meant to assist providers in the Claims Resolution process. To file an appeal based upon the denial of a payment request, please use the Provider Claims Based Dispute Resolution Request Form located in the Billing and Claims section of the Carelon Behavioral Health Forms and Guides webpage. Upon completing the form, mail to the address given in the PSV or mail to the following address:

Provider Dispute Resolution
P.O. Box 1850 Hicksville, NY 11802-1850

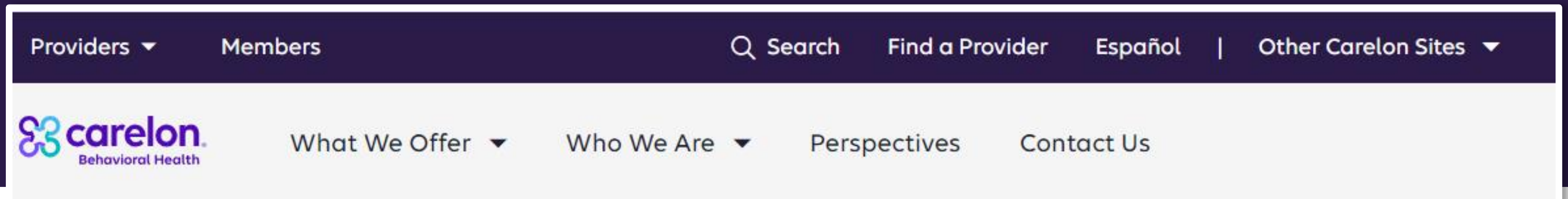
Claims request must be submitted in writing to the address given in the PSV or the address above. A complete appeal request must be received within 60 calendar days from the date of the payment determination being appealed, unless the provider agreement or applicable laws or regulations establish a longer filing period.

For a more detailed explanation of the complaint and appeal processes please refer to the Carelon Behavioral Health Provider Handbook.

Getting claims paid efficiently and effectively is a mutual effort between Carelon and you, the providers! Here is a cheat sheet of the things you can control to ensure a smooth claims process:

1. DO ensure your claims are submitted timely!
2. DO use the appropriate claim form so that you don't have to rebill with the correct claim form
3. DO ensure your NPI is filled, complete and active on the date of service
4. DO ensure the claim line identifier (Claim Line ID) entered is correct!
5. **DO NOT bill separately from a valid primary procedure code!**

PROVIDER TRAININGS



We provide a full range of trainings year-round to educate, inform, and share industry-wide best practices and policies.

Trainings cover a variety of topics ranging from claim submission guidelines and provider portal support to behavioral health in youth and motivational interviewing.

Registration is on a first come first serve basis. To see our upcoming trainings and to register for a training, visit www.carelonbehavioralhealth.com/providers/resources/trainings.

Home / ... / Trainings

HELPFUL REMINDERS

Member Rights and Responsibilities

Carelon Behavioral Health's Member Rights and Responsibilities Statements are available in English and Spanish for download from our website.

Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

Learn more

Reminders Regarding Carelon's Ethical Approach to Utilization Management Decisions

Licensed behavioral health care professionals work cooperatively with practitioners and provider agencies to ensure member needs are met. Utilization management decisions are based on the clinical needs of the members, benefit availability, and appropriateness of care. Objective, scientific-based criteria and treatment guidelines, in the context of provider or member-supplied clinical information, guide the decision-making process.

Carelon Behavioral Health does not provide rewards to any of the individuals involved in conducting utilization review for issuing denials of coverage or service. There are no financial incentives to encourage adherence to utilization targets and discourage under-utilization. Financial incentives based on the number of adverse determination or denials of payment made by any individual involved in utilization management decision making are prohibited.

Appointment Access Reminder

Carelon Behavioral Health strives to provide members with accurate, current Provider Directory information. Participating providers are expected to maintain established office hours and appointment access. Carelon Behavioral Health's provider contract requires that the hours of operation of all network providers be convenient to the members served and not discriminatory. Participating providers are required to maintain the following access standards:

If a member has a:	They must be seen:
Life-threatening emergency	Immediately
Non-life threatening emergency	Within 6 hours
Urgent needs	Within 48 hours
Routine office visit	Within 10 business days
Routine Follow-up office visit (non-prescriber)	Within 30 business days of initial visit
Routine Follow-up office visit (prescriber)	Within 90 business days of initial visit

The table above reflects the access standards that are the minimum standards for Appointment Accessibility for all states. Some state or market specific requirements may be stricter.

As a reminder, if at any time your practice is not able to meet the appointment access requirements, please update your Provider Directory information:

- Practitioners: Visit CAQH, update, and attest
- Provider Groups and Facilities: Visit our provider portal or call our National Provider Service Line at 1-800-397-1630

CONTACT US

Claims Related Questions

If you have general questions about claims, call 800-888-3944. For questions regarding claims submission addresses, please reference the member's identification card, as the address may vary based on payment location.

Grievances and appeals

To file an appeal based upon the denial of a payment request, please use the Provider Claims Based Dispute Resolution Request form and mail to the address given in the PSV or mail to:

Provider Dispute Resolution
P.O. Box 1850 Hicksville, NY 11802-1850

Credentialing status

To obtain information pertaining to your network status, contact our National Provider Services Line at **800-397-1630**, Monday to Friday, 8 a.m. to 8 p.m. Eastern time.

Update your contact information

If you are a participating Council for Affordable Quality Healthcare (CAQH) provider, please update your information with CAQH. If you do not participate with CAQH, please log into ProviderConnect and select the "Update Demographic Information" option.

For more information, click here to access our provider handbook or visit www.carelonbehavioralhealth.com/providers/resources/provider-handbook

YOU CAN NOW SUBMIT A CMS 1500 CLAIM FORM FOR REIMBURSEMENT OF EAP SERVICES!

APPLIES ONLY TO THE CARELON BEHAVIORAL HEALTH (CARELON) EAP NETWORK

Effective December 2, 2024, providers can now submit a CMS 1500 Claim Form via Availity for reimbursement for EAP services rather than the Case Activity Form (CAF)

In an effort to create administrative ease, Carelon is pleased to announce a recent change to our EAP reimbursement process. Effective December 2, 2024, providers can now submit a CMS 1500 Claim Form via Availity for reimbursement for EAP services rather than the Case Activity Form (CAF). This applies for dates of service on or after December 2, 2024.

Providers should select **CPT code 99404 with an HJ modifier** and a suggested diagnosis code of R69 for EAP services. Please note that a claim will be processed if another diagnosis code is selected. If a CMS 1500 Claim Form is submitted for EAP dates of service prior to December 2, 2024, the claim will be denied. Claims submitted via a CAF will continue to be processed up to 90 days after the December 2, 2024, effective date.

Providers can submit and check the status of their EAP claims via Availity Essentials. Providers who are not yet registered with Availity, may register at apps.availity.com/web/onboarding/portal-entry.

Please note that this change does not apply to Anthem EAP claim submissions.

Click here to access the EAP Provider Claims Submission Using Availity Essentials FAQ

New to Availity?
Providers who are not yet registered with Availity, can learn more, and sign up today, at **no charge** by visiting **Availity.com**.

You can also visit the Register and Get Started with Availity Essentials page to learn more. Here you can register for live webinars to guide you through registering an account and organization with Availity, access pre-recorded webinars, and download Availity registration guides. If you need further assistance, contact Availity Client Services at 1-800-282-4548. Assistance is available Monday through Friday 8 AM – 8 PM ET.

UPDATES TO MEDICAL NECESSITY CRITERIA IN 2025

Specific to **Commercial** Plans in California, Cal. Code Regs. tit. 28 § 1300.74.721(c) requires clinical criteria developed by nonprofit professional associations be used to make utilization review determinations that are within the scope of the criteria. For those benefit plans that require prior authorization for Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), and Behavioral Health Treatment (BHT) services, **Carelon Behavioral Health of California, Inc.** and **Carelon Health IPA (CHIPA)** will begin to utilize the following nonprofit criteria sets in 2025:

Canadian Network for Mood and Anxiety Treatments (CAMAT)

- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)

Council of Autism Service Providers (CASP)

- Behavioral Health Treatment (BHT)

ASSERTIVE COMMUNITY TREATMENT (ACT) UPDATE

This article provides important updates regarding changes in Assertive Community Treatment (ACT) billing and reimbursement, mandated by the New York State (NYS) Office of Mental Health (OMH). As a reminder, these changes went into effect October 1, 2023, and align with the SFY 2023-2024 Enacted State Budget.

Key Updates for ACT Providers

For Adults:

- 100 Slot ACT Teams: A new reimbursement rate for 100 Slot ACT teams will be established. Initially, only 68 Slot ACT teams are eligible to apply for conversion to 100 Slots.
- Rate Increase for 36 Slot ACT Teams: As of October 1, 2023, 36 Slot teams saw an increase in their reimbursement rate.

For Youth:

- Slot Adjustments:
    - New 28 Slot ACT teams will be established.
    - Current 36 Slot teams will convert to 28 Slot teams.
    - Current 48 Slot teams will convert to 36 Slot teams.
- Rate Increases for Youth ACT Providers: As of October 1, 2023, all Youth ACT providers received a rate increase.
- **New Rate Codes: Effective 1/1/2025**, new rate codes (4513-4515) will be introduced to improve service utilization tracking for Youth ACT services.

Important Reminders:

Providers will need to ensure they use the new rate codes for Youth ACT services delivered starting 1/1/2025. Adult ACT billing codes will remain unchanged and should continue to be used for the Young Adult ACT population (ages 18-25).

For full details on these changes, please refer to the official guidance provided by the New York State Office of Mental Health at the following link: https://omh.ny.gov/omhweb/bho/act-billing-reimbursement-changes.pdf

For questions or more information, contact Provider Relations at 1-800-397-1630.

CREATING A CULTURE OF CELEBRATION

This quarter, Carelon invites you to join us in recognizing Glenbeigh Hospital and the work they are doing in our neighboring Ohio community with their Earn/Learn/Live program. With a heavy focus on social determinants of health, this program aims to strengthen outcomes for members by breaking down common barriers faced by individuals in recovery. Upon completion of a residential program, eligible participating patients can transition into one of Glenbeigh's recovery houses where they are offered an opportunity to obtain education towards receiving their Chemical Dependency Counselor Assistant Certification (CDCA), STNA, or Peer Support Certification. These residents are provided transportation to and from their education sessions and provided on-the-job training upon completion. Many of those who have completed this training have gone on to join Glenbeigh's staff or another treatment center in the community, serving Carelon members and the recovery community at large.

Regarding this program and its success, Donnie Reed, Director of Operations at Glenbeigh Hospital, points to the sense of purpose it has instilled in participants. "We have individuals in this program that have been to treatment, been to recovery housing, followed all recommendations but were missing a purpose. This program sets goals and gives them opportunities." At Carelon, we celebrate the positive impact Glenbeigh and the Earn/Learn/Live program has made on the community, both for participants and all of the individuals whose lives they will touch in their new roles as recovery professionals.

If you are interested in contributing towards this program's success, please scan the QR code to donate.

THE POWER OF COLLABORATION

In the evolving landscape of healthcare, the importance of collaboration between different types of practitioners has never been more paramount. For behavioral health providers, engaging in cross-disciplinary partnerships can profoundly influence patient outcomes, enhance professional satisfaction, and enrich the overall quality of care.

- **Holistic Patient Care**
  Behavioral health is deeply intertwined with physical health. A patient suffering from chronic pain may develop depression; conversely, an individual dealing with severe anxiety might experience gastrointestinal issues. Collaborating with primary care physicians, specialists, and other healthcare providers ensures a comprehensive approach to treatment. For instance, coordinated care involving a psychiatrist, psychologist, and a primary care doctor allows for seamless integration of medication management, psychotherapy, and medical treatments. This holistic care model addresses the multifaceted needs of patients, reducing the risks of fragmented care.

- **Enhanced Diagnosis and Treatment**
  Each healthcare discipline brings a unique perspective to the table. By working together, behavioral health providers and other practitioners can share insights that lead to more accurate diagnoses and effective treatment plans. For example, a neurologist's input might be crucial for a patient with suspected neuropsychiatric disorders, while a social worker's perspective could uncover essential social or environmental factors affecting a patient's mental health.

- **Continuity of Care**
  Behavioral health conditions often require ongoing and consistent management. Collaboration among various practitioners ensures a continuous and coordinated care pathway. By maintaining open lines of communication, healthcare teams can monitor a patient's progress, promptly address any emerging issues, and adjust treatment plans as necessary. This collaborative approach mitigates the risks of patients falling through the cracks and enhances long-term outcomes.

- **Improved Patient Satisfaction**
  Patients are more likely to feel satisfied with their care when they perceive it as coordinated and comprehensive. Collaboration among healthcare providers demonstrates a commitment to addressing all aspects of their health. When patients see their healthcare team communicating and working together, they are more likely to trust the care process and adhere to treatment plans, ultimately improving their health outcomes.

The Power of Collaboration *continued*

Challenges and Solutions
While the benefits of collaboration are clear, implementation can present challenges. These might include logistical issues, differences in practice culture, or communication barriers. However, these obstacles can be overcome through strategic initiatives:

- **Implementing Integrated Care Models:**
  Establishing structures where multiple providers work under one roof or within a single network can facilitate easier collaboration.
  The ICP is shared with the member, other network providers, and stakeholders to ensure comprehensive care coordination.

- **Regular Interdisciplinary Meetings:**
  Scheduled meetings or case conferences can ensure all team members are aligned on patient care plans.

- **Utilizing Technology:**
  Shared electronic health records (EHRs) and telehealth platforms can streamline communication and allow for real-time updates on patient status and treatment adjustments.

- **Completing Integrated Care Plans:**
  For members with higher medical and behavioral health needs, Carelon can support collaboration through Integrated Care Plans (ICPs). An ICP is a plan that outlines a member's healthcare needs and goals, and the services they will receive. The ICP is created by the Interdisciplinary Care Team (ICT) in collaboration with the member, their physical health Managed Care Organization (MCO), and other healthcare and social services staff as applicable An ICP includes:
    - Person-centered problems, interventions, and goals
    - Services the member will receive, such as medical conditions management, long-term services and supports, and behavioral health
    - Measurable outcomes and progress
    - Recognition of potential barriers and progress towards goals

The importance of collaboration in behavioral health cannot be overstated. By fostering partnerships with other healthcare practitioners, behavioral health providers can enhance the quality and effectiveness of care, leading to better patient outcomes and a more rewarding professional experience. Embracing a collaborative approach not only addresses the intricate connections between mind and body but also represents the future of comprehensive healthcare. As the adage goes, "Together, we achieve more," — in the realm of behavioral health, this rings particularly true.

REGIONAL NEWS
Pennsylvania [Medicaid]

HELPFUL TIPS FOR MEDICAL ASSISTANCE PROVIDERS

The Pennsylvania Department of Human Services offers **Quick Tips** for Medical Assistance Providers. Join their listserv or check their website for documents that contain helpful tips for you and your staff.

Medicaid/Medical Assistance Provider Quick Tips | Department of Human Services | Commonwealth of Pennsylvania

REGIONAL NEWS
Pennsylvania [Medicaid]

THE IMPORTANCE OF TREATMENT PLANS

Behavioral Health treatment plans are like road maps for our members, your patients on their behavioral health journey. Behavioral health journeys are unique to every individual, but they need the help of their care team to get there. Take care to collaborate on the best path forward. Whether you are a direct care worker or a supervisor or any other member of the patient's team, the treatment plan is key and should minimally include:

1. Treatment plan date
2. Diagnoses and/ or symptoms addressed
3. Clinician's signature, credentials, and signature date
4. Member or guardian's signature and signature date
5. Evidence member or guardian participated with treatment plan development
6. Goals and objectives based on evaluation and mental health strengths and needs
7. Treatment goals/objectives are measurable
8. Treatment goals have established timeframes
9. Treatment plan address notes less restrictive alternatives that were considered
10. Treatment plan is easy to read and understand
11. Treatment plan documents necessity for services
12. Treatment plan documents the utilization of services
13. Treatment plan reviews must be completed with the member or guardian and have a corresponding signature and signature date
14. And must be completed according to the level of care/service requirements

REGIONAL NEWS
Pennsylvania [Medicaid]

MENTAL HEALTH ADVANCED DIRECTIVES

In 2004, Pennsylvania enacted legislation (Act 194) that provides the opportunity for individuals living with mental illness to create a Mental Health Advance Directive and plan ahead for mental health services and supports in the event they become unable to make decisions for themselves. A Mental Health Advance Directive (MHAD) offers a clear written statement of an individual's mental health treatment preferences or other expressed wishes or instructions should they become incapacitated. It can also be used to assign decision-making authority to another person who can act on that person's behalf during times of incapacitation. The Mental Health Association in Pennsylvania offers forms and instructions that may be printed out should your organization wish to assist.

Mental Health Advanced Directives – Mental Health Association in Pennsylvania

MENTAL HEALTH ADVANCE DIRECTIVES FREQUENTLY ASKED QUESTIONS

Q. What is a Mental Health Advance Directive?
A. A Mental Health Advanced Directive is a document that allows a person to make preferences regarding mental health treatment known in the event that the person is incapacitated by his/her mental illness. In effect, the person is giving or withholding consent to treatment in advance of when treatment is needed. This allows a person to make more informed decisions and to communicate his/her wishes more clearly. A new law was passed in Pennsylvania, effective January 28, 2005, that makes it possible for a person to make and enforce a mental health advance directive. Pennsylvania law allows for three types of mental health care advance directive: a declaration, a power of attorney, or a combination of both.

Q. What are my responsibilities as a provider?
A. You must do the following things:
- Inquire whether or not a person has a mental health care advance directive.
- Inform people who are being discharged from treatment about mental health care advance directives as part of discharge planning.
- You may not choose whether to accept someone as a patient based solely on the existence or absence of a mental health care advance directive.
- Upon notification of the existence of an advance directive, you must place a copy in the person's mental health care record.
- You must make any revocation or amendments part of the person's mental health care record.
- You must comply with the instructions unless the instructions are contrary to accepted clinical practice and medical standards or because medical treatment is unavailable, or if the policies of the provider preclude compliance.
- If you are the mental health care provider that makes a determination regarding capacity to mental health care decisions, you must make that determination part of the person's mental health record.

Mental Health Advance Directives Frequently Asked Questions *continued*

Q. What if I can't comply with the instructions in the mental health care advance directive?
A. As soon as the possibility of non-compliance becomes apparent, you must inform the person, agent, guardian, and/or any other legal representative. It may be possible to discuss and resolve the issue with the person or agent. If compliance is still not possible, you must make every reasonable effort to transfer the person to another mental health care provider who will comply with the instructions. While the transfer is pending, you must treat the patient in a way consistent with his/her advance directive. If all efforts to transfer fail, you may discharge the patient.
Remember that just because consent is provided in advance to a particular medication or treatment, that you will not prescribe that treatment or drug unless it is appropriate treatment at the time of the person's illness. Consent only means that consent is given to treatment if it is a suitable choice at that time within the standards of medical care. You will also have to consider if a particular treatment option is covered by the person's insurance. If, for example, the HMO does not cover a certain drug on its formulary, you may prescribe a drug that is similar, but is on the HMO formulary (unless the person has specifically withheld consent to that drug).

Q. What if compliance with the instructions could cause irreparable harm or death?
A. You may file a petition with the court seeking a determination that following the instructions may cause irreparable harm or death. The court may invalidate some or all of the provisions of the mental health advance directive and issue an appropriate order within 72 hours from the filing of the petition. Even if the court invalidates some of the provisions of the directive, the remaining provisions will remain in effect.

Q. What if there is a conflict with instructions in another power of attorney or declaration?
A. If there is a conflict, the provisions of the document latest in date of execution must be followed.

Q. How does a Mental Health Advance Directive affect commitment under the Mental health Procedures Act?
A. The voluntary and involuntary commitment provisions of the Mental Health Procedures Act are not affected by having a mental health care advance directive. What is affected is the provision of treatment after a person is committed.

*Instructions and forms for Mental Health Advanced Directives for Pennsylvanians https://www.dhs.pa.gov/docs/For-Providers/Documents/Behavioral%20Health%20Services/Instructions%20%20Forms%20-%20English.pdf

SEND US YOUR NEWSLETTERS

We love to read our providers' newsletters. If you haven't already, please add your Provider Field Coordinator to your distribution list. AMI, Inc has a publication they call The Lion, and they recently hosted their 15th Annual Art Show, showcasing the incredible talents of individuals who identify as having mental and/or co-occurring disorders.

Thank you, AMI, for including Jill Piasecki and Lisa Ciccarelli in your October issue and welcoming us into your amazing space!

SUBMITTING CLAIM APPEALS, CLINICAL APPEALS, AND TIMELY FILING RECONSIDERATIONS

Administrative Claim Appeals and Clinical Appeals should be sent to PO Box 1856 with the coversheet clearly marked as Claims Appeals or Clinical Appeals.

Timely Filing Waiver - Timely Filing is not an appeal.

Timely filing requests to override timely filing due to things such as retro-eligibility enrollment, submitting to the wrong payer initially, and COB retro-terminations. The coversheet with these should be sent to PO Box 1866 and clearly state "timely filing waiver". Only one waiver form is needed along with any supporting documentation and the resubmitted claim image.

Timely filing requests for any other reason should be submitted to PO Box 1866 and clearly state "timely filing reconsideration" along with a letter of reconsideration, which you can write. Please make clear reference to waiving timely filing due to extenuating circumstances, along with any supporting documentation and the resubmitted claim image.

If you have any additional questions, please reach out to TexasProviderRelations@carelon.com

Paper Claims and General Correspondence	Carelon Behavioral Health Attn: Customer Service P.O. Box 1866 Hicksville, NY 11802-1866
Appeals **Grievances** **Prior Authorizations Team (PAT) Charts** **Outpatient Treatment Requests (OTRs)**	Carelon Behavioral Health Attn: Claims Appeals Coordinator P.O. Box 1856 Hicksville, NY 11802-1856

CLAIMS SUBMISSIONS - NPIs AND TAXONOMY CODES

Billing NPIs and Billing Taxonomy codes are required on all claim's submissions per the Texas Medicaid Provider Procedures Manual, which Carelon does follow. Billing NPI's and Taxonomy codes must not only be present on all claim's submissions, but they also must match the State Master Provider File, which is generated by the information contained within PEMS and sent to MCO's on a weekly basis for validation purposes.

Rendering NPIs are also required on all claim's submissions, but Carelon had not been validating the rendering NPIs to ensure they are also found on the State Master Provider File, which is not in compliance with TMPPM or HHSC requirements. **Carelon will begin validating all rendering NPI's on all claim's submissions beginning 12/1/2024**.

Carelon will also begin requiring Rendering Taxonomy codes on UB-04 claims submissions to follow the TMPPM effective 12/1/2024.

Each NPI has a corresponding Taxonomy code and address linked to it. This all must match what is on file with TMHP and PEMS in order for claims to be adjudicated correctly.

Providers/Clinicians unable to obtain an NPI can obtain an API or Atypical Provider Identifier.

Please see below for resources and information related to claims submissions and NPI/API/Taxonomy Code Requirements.

- https://www.tmhp.com/resources/provider-manuals/tmppm
- https://www.tmhp.com/topics/provider-enrollment
- https://www.youtube.com/playlist?list=PLIe60BLvrbETbsHtKqwWrcvMmJ_6MH9n-

REGIONAL NEWS
Texas

PROVIDER RESOURCE – H.B. 12 POSTPARTUM MEDICAID AND CHIP COVERAGE EXTENSION

The Texas Health and Human Services Commission has developed a recorded presentation for Medicaid and CHIP providers about the extended postpartum coverage to 12 months for eligible Medicaid and CHIP recipients as directed by House Bill 12, 88th Legislature, Regular Session, 2023.

The presentation can be found here. It includes information on:

› House Bill 12 Background
› Eligibility and exceptions
› Coverage transitions
› Covered services
› Additional resources

We encourage providers to share the presentation link with colleagues and staff who may also benefit from this information. For any questions, please reach out to managed_care_initiatives@hhs.texas.gov

Further information on the postpartum extension is available at: https://www.hhs.texas.gov/services/health/women-children