

# Magellan Health Services, Inc.\* Organization Provider Supplement to the Magellan National Provider Handbook

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\*Magellan Behavioral Health, Inc.; Magellan Behavioral Health Systems, LLC, f/k/a Human Affairs International; CMG Health, Inc.; Green Spring Health Services, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Health Services of California, Inc.-Employer Services; Human Affairs International of California; Magellan Behavioral Care of Iowa, Inc; Magellan Behavioral Health of Florida, Inc; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Behavioral Health Providers of Texas, Inc.; and their respective affiliates and subsidiaries are affiliates of Magellan Health Services, Inc. (collectively “Magellan”).



The Magellan Organization Provider Handbook Supplement augments the [Magellan National Provider Handbook](#) and provides policy and procedure information to organization providers, including facilities, agencies and community mental health centers (CMHCs). As such, this supplement is designed to be used as a reference tool in conjunction with the Magellan National Provider Handbook.



## 2. Organization Provider Network - Credentialing

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### **Our Philosophy**

Magellan is committed to the provision of quality care to our members. In support of this commitment, organizations must meet or exceed a set of credentialing criteria to be eligible to provide services to our members.

### **Our Policy**

Magellan employs credentialing criteria and decision-making processes in the review and selection of behavioral health care organizations for inclusion in our provider network. Our [organization credentialing criteria](#) satisfy the requirements of applicable regulatory bodies and our customers.

### **What You Need to Do**

Your responsibility is to:

- Complete and submit all required application materials and related documents, including any documentation of current accreditation, and attest to their accuracy. We cannot process incomplete applications.
- Be in good standing with state and federal regulatory entities, as applicable.
- Hold current licensure or certification without contingencies or provisions in accordance with applicable state and federal laws.
- Hold appropriate current accreditation. If not accredited, Magellan will perform a site visit.
- Provide primary source verification (PSV) of professional licenses of your medical and clinical staff members. This means contacting state licensing boards to verify that professionals hold a current license, education and training to practice without restrictions or sanctions. Additional required queries include the National Practitioner Data Bank (NPDB), the Health Inquiry and Protection Data Bank (HIPDB), and the Office of Inspector General/General Services Administration (OIG/GSA) databases for Medicare/Medicaid sanctions. For physicians, PSV also includes verification of Board Certification, and current, Drug Enforcement Agency (DEA) Registration, and, if applicable, state Controlled Dangerous Substance (CDS) registration.
- Attest that there are no Medicare or Medicaid sanctions or exclusions for the organization or its clinical staff.
- Fulfill Magellan requirements for malpractice claims history review.
- Meet Magellan's minimum requirements for professional and general liability insurance coverage, as outlined in your Provider Participation Agreement.
- Participate in a site visit upon request.
- Participate in re-credentialing every three years or in compliance with regulatory and/or customer requirements.

### **What Magellan Will Do**

Magellan's responsibility to you is to:

- Provide you with initial application and re-credentialing materials with instructions for completion.
- Complete the credentialing and re-credentialing process in a timely manner that is, at a minimum, within industry, state- or customer-established timeframes.
- Have your credentialing or re-credentialing application reviewed by a Magellan

## 2. Organization Provider Network - Credentialing

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Regional Network and Credentialing Committee (RNCC).

- Notify you in writing upon completion of the credentialing or re-credentialing process.
- Perform site visits as needed.

## 2. Organization Provider Network - Contracting

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<b>Our Philosophy</b>	A legally binding agreement between Magellan and its network providers serves to clearly outline each party's responsibilities.
<b>Our Policy</b>	Participating organizations must have an executed agreement with Magellan. The agreement sets out expectations on Magellan's policies and procedures, provider reimbursement, and terms and conditions of participation as a network provider.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Review and understand your obligations under your participation agreement with Magellan.</li><li>• Successfully complete the credentialing process.</li><li>• Be familiar with and abide by the policies and procedures contained within the Magellan National Provider Handbook, this facility supplement and the applicable state- and plan-specific supplements.</li></ul>
<b>What Magellan Will Do</b>	Magellan's responsibility to you is to: <ul style="list-style-type: none"><li>• Provide a Magellan Facility and Program Participation Agreement to organizations identified for participation in the Magellan provider network.</li><li>• Execute the agreement after your organization has successfully completed the credentialing process and completed, signed and returned the agreement to Magellan.</li><li>• Provide the fully executed agreement, signed by both parties, for your records.</li><li>• Comply with the terms of the agreement, including reimbursement for covered services rendered.</li></ul>

## 2. The Role of the Organization Provider – Communication

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### **Our Philosophy**

Magellan believes that in order to serve our members effectively, providers should have access to key information. The use by providers of self-service website resources available on [MagellanHealth.com/provider](http://MagellanHealth.com/provider) will positively impact health care system efficiency and costs.

Information about our providers should be kept up-to-date to facilitate referrals and claims payment.

### **Our Policy**

Magellan uses a variety of media to communicate with providers about policies, procedures and expectations, including but not limited to the [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) website, Magellan National Provider Handbook and handbook supplements. The day-to-day relationship between Magellan and our providers is managed through provider network and clinical management staff who are located in our Care Management Centers. Magellan strives to maintain accurate information about providers in our data systems and verifies all changes with the provider.

### **What You Need to Do**

Your responsibility is to:

- Become familiar with the information in your participation agreement and in the [Magellan National Provider Handbook](#), this facility supplement, and the applicable state- and plan-specific supplements.
- Sign in, become familiar with and use the extensive self-service resources available on the [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) website.
- Contact Magellan for assistance with benefit eligibility by calling the number on the back of the member’s health benefit card.
- Get to know your Magellan area contract manager and other [field network staff](#).
- Notify Magellan of changes in your service or program information, including but not limited to, changes of name, address, telephone number, Taxpayer Identification Number, National Provider Identifier (NPI) and ability to accept referrals, including any program closure. Submit changes to your area contract manager or online at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) by signing in and choosing “Display/Edit Practice Information.” You may mail or fax written requests to:

Magellan Health Services  
Attention: Data Management  
14100 Magellan Plaza  
Maryland Heights, MO 63043  
Fax number: 314-387-5584

### **What Magellan Will Do**

Magellan’s responsibility to you is to:

- Offer assistance regarding benefit eligibility 24 hours a day, seven days a week.
- Offer assistance with claims payment questions through national and local customer service lines during business hours.
- Offer assistance regarding credentialing and contracting through national and local provider services lines during business hours.

## 2. Organization Provider Network – Communication

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- Offer assistance with using the features and functionality of the Magellan provider self-service website.
- Communicate information about policies, procedures and expectations in a timely manner.
- Update provider records in an accurate and timely manner, verifying changes with the provider.



### 3. The Role of the Organization Provider – Authorization

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#### **Our Philosophy**

We are committed to promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment while addressing the member’s biopsychosocial needs.

#### **Our Policy**

Authorization-of-care decisions are based on clinical information relevant to the type and level of service being requested, using Magellan’s Medical Necessity Criteria or other state- or customer-specific medical necessity criteria for preauthorization, initial review, concurrent stay review and discharge planning.

#### **What You Need to Do**

Your responsibility is to:

- Become familiar with Magellan’s clinical review documentation guidelines in preparation for:
  - Pre-authorization (see [Appendix C](#))
  - Initial Review (see [Appendix C](#))
  - Concurrent Review (see [Appendix D](#))
  - Discharge Planning (see [Appendix E](#)).
- Contact Magellan for initial authorization of care.
- Provide the Magellan care manager with a thorough assessment of the member so that an appropriate authorization determination can be made.
- Be familiar with Magellan’s [Medical Necessity Criteria](#)
- Contact Magellan if additional care is needed prior to expiration of the current authorization.
- Contact Magellan before referring a member in care to another provider, including other Magellan network providers.
- Call Magellan for a treatment review if, during the course of treatment, you determine that services other than those authorized are needed.
- Collaborate with the Magellan care manager to develop and implement discharge plans prior to the member being discharged from an inpatient setting. Members being discharged from an inpatient setting should have a discharge appointment scheduled and in place prior to the actual discharge. See [Appendix F](#) for Q & A with additional details.
- Not bill a member for services that have not been authorized by Magellan.
- Consider selecting the environmentally friendly option to receive authorizations electronically and suppress U.S. Mail. After signing in on [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider), see “Manage Mail Options” for instructions.

#### **What Magellan Will Do**

Magellan’s responsibility to you is to:

- Provide prompt, fair review of the information received.
- Notify you promptly of the decision by mail or electronically.
- Facilitate your referrals to other providers and coordinate member changes in levels of care.
- Inform you of your appeals rights and process.

### 3. The Role of the Organization Provider – Eligibility

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<b>Our Philosophy</b>	Our philosophy is to work with our customers to provide a benefit structure designed to meet the needs of the customer’s eligible members. We rely on our customers to notify us of member eligibility.
<b>Our Policy</b>	Based on the member’s benefit plan and eligibility information provided by our customers, we assist providers in determining member eligibility.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Obtain the member’s health benefit plan card at the time of admission and copy both sides of the card for the member’s file.</li><li>• Call the number listed on the member’s health benefit plan card to check eligibility, benefits, co-payment and claim submission information*.</li><li>• Document the phone number you called, the date, time of day and name of person with whom you spoke. You will likely then speak with a Magellan clinical employee to obtain authorization for the appropriate level of care. See the section on “Authorizing Care.”</li></ul>
<b>What Magellan Will Do</b>	Magellan’s responsibility to you is to: <ul style="list-style-type: none"><li>• Based on the information provided to Magellan by the customer, inform you of the member’s eligibility*.</li></ul>

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*\* Checking eligibility does not guarantee claims payment. Claims payment depends on a variety of factors including but not limited to whether the service is covered, whether any applicable deductibles have been met, whether the member has benefits available or whether the insurer is the primary or secondary payer.*

### 3. The Role of the Organization Provider - Appeals

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<b>Our Philosophy</b>	We support the right of members or their providers to appeal adverse benefit determinations.
<b>Our Policy</b>	Customer requirements, applicable state and federal laws, and accreditation standards govern Magellan's appeal policies.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Review the non-authorization letter or explanation of benefit (EOB)/explanation of payment (EOP) notification for:<ul style="list-style-type: none"><li>○ the specific reason(s) for the adverse determination,</li><li>○ appeal rights,</li><li>○ appeal procedures and submission timeframe, and</li><li>○ any specific documents required for submission in order to complete a review of your appeal.</li></ul></li><li>• Follow the process described in the non-authorization letter or EOB/EOP determination notice to submit an appeal.</li><li>• Submit all the appeal information in a timely manner.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"><li>• Inform you in writing, in a clear and understandable manner, the specific reasons for the adverse determination.</li><li>• Identify specific information, documents, records, etc. needed to assist in a favorable appeal determination.</li><li>• Thoroughly review all information submitted for an appeal.</li><li>• Respond to appeals in a timely manner.</li><li>• Notify you of any additional appeal options that may be available when an unfavorable appeal determination is rendered.</li></ul>



### **Our Philosophy**

Magellan believes that site visits are an important part of our quality assurance program. Magellan performs site visits:

- as a quality measure in selecting providers for our network,
- to communicate performance expectations and standards to providers,
- as an assessment of non-accredited organizations prior to initial credentialing and at re-credentialing,
- as a component of a quality review, and
- to promote compliance with standards of regulatory entities and accrediting organizations.

### **Our Policy**

Magellan conducts site visits of organization providers:

- that are not currently accredited by a recognized accrediting agency\*,
- to evaluate programmatic services, staffing, facilities, documentation, etc., or
- for further review of quality of care and service concerns.

*\* Acceptable recognized accreditation for organization providers includes: The Joint Commission (TJC), American Osteopathic Association Healthcare Facilities Accreditation Program (HFAP), Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), and Accreditation Association for Ambulatory Healthcare (AAAHC) accreditation. Site visit requirements for initial and re-credentialing may be satisfied by a CMS site visit or a state licensure site visit when these requirements are equivalent to Magellan assessment standards.*

### **What You Need to Do**

Your responsibility is to:

- Cooperate with the quality reviewer's requests.
- Provide all necessary documents.
- Facilitate an on-site review, if requested.
- Collect your policy and procedure materials and forms, and have them in one location for ready access.
- Have a sample of blinded charts available for the reviewer to demonstrate that record-keeping practices are consistent with Magellan requirements.
- Have evidence of credentialing and primary source verification of clinical staff available for the reviewer.
- Make training logs and other evidence of required training available.
- Make available any specific treatment records or other documents requested by Magellan clinical staff.

### **What Magellan Will Do**

Magellan's responsibility to you is to:

- Conduct site visits for organization credentialing of non-accredited organization providers and other organizations, as appropriate.
- Conduct site visits of individual and group providers, as appropriate.
- Provide timely, written communication regarding site visit results, including a description of strengths and opportunities for improvement noted by the reviewer.



## 5. Provider Reimbursement – Claims Filing

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### **Our Philosophy**

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to facilitate prompt processing of their claims.

Magellan strongly encourages providers to submit claims electronically either through the Direct Submit process, through Claims Courier at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) or through a clearinghouse. Electronic claims filing improves efficiency and accuracy, and is less costly than submitting paper claims. You can find detailed information on electronic claims submission in [Appendix G](#) - “Claims Tips and Information.”

### **Our Policy**

Magellan reimburses organization providers within prompt payment standards for inpatient and program services, according to member eligibility and benefit plans, using contracted rates and reimbursement schedules.

### **What You Need to Do**

Your responsibility is to:

- Contact the Magellan care management center prior to rendering care, if the member’s benefit plan requires authorization for the service.
- Complete all required fields on the electronic UB-04 or CMS-1500 claim form accurately.
- Collect applicable co-payments or co-insurance from members.
- Submit a clean claim to be reimbursed for the remainder of your contracted reimbursement amount. (See Section 5 of the [Magellan National Provider Handbook](#).)
- Submit claims for professional services delivered in conjunction with inpatient per diems as inclusive or exclusive, in accordance with the terms of your agreement with Magellan.
- Use standard codes sets as established by the Centers for Medicare and Medicaid Services (CMS) for the specific claim form (UB-04 or CMS-1500) you are using. (You can find additional information under: [Billing Codes and HIPAA Compliance](#).)
- Submit claims within 60 days of the provision of covered services or as set forth in your agreement with Magellan.
- Bill only for services rendered within the time span of the authorization.
- Submit claims with your non-discounted billed charge even if it is lower than the Magellan contracted rate.
- Contact Magellan for direction if authorized services need to be used after the authorization has expired.
- Not bill the member for any difference between your Magellan contracted reimbursement rate and your standard rate. This practice is called balance billing and is not permitted by Magellan.
- Check [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) or call your [field network contact](#) if you are not certain which reimbursement rate applies to the member in your care.

## 5. Provider Reimbursement – Claims Filing

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- Call the customer service number indicated on the member’s health benefit plan card for assistance if you are unsure of the care management center managing the member’s care.
- Review [Appendix G](#) - “Claims Tips and Information.”

### **What Magellan Will Do**

Magellan’s responsibility to you is to:

- Provide verbal notice, send an authorization letter, and/or provide electronic authorization when we authorize services.
- Process your claim promptly upon receipt and complete all transactions within regulatory and contractual standards.
- Inform you of any reasons for administrative denials and action steps required to resolve the administrative denial.
- Send you or make available online an explanation of payment (EOP) or other notification for each claim submitted, including procedures for filing an appeal.
- Provide appropriate notice regarding corrective action or information required if a claim is denied.
- Reopen your claim and process to final payment upon receipt of requested information.
- Adjudicate claims based on information available. If we don’t receive the information requested within 45 days, the claim may be denied for insufficient information, subject to applicable state and federal law.
- Regularly update the recommended HIPAA-compliant billing codes for behavioral services, posted on the [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) website.
- Review our reimbursement schedules periodically in consideration of industry-standard reimbursement rates and revise them when indicated.
- Include all applicable reimbursement schedules as exhibits to your contract.
- Comply with applicable state and federal regulatory requirements regarding claims payment.
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

## 5. Provider Reimbursement - Billing Codes and HIPAA Compliance

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### **Our Philosophy**

We offer support to our providers by supplying recommended HIPAA-compliant billing codes. Using these codes for both paper and electronic transactions benefits Magellan and our providers, resulting in prompt and accurate claims payment.

### **Our Policy**

Providers must use standard code sets approved by the Centers for Medicare and Medicaid Services (CMS) for HIPAA compliance on both paper and electronic claims. Standard code sets include ICD-9-CM diagnosis codes, and CPT<sup>®</sup> and HCPCS procedural codes with modifiers, revenue, Type of Bill, discharge status codes and Place of Service codes.

### **What You Need to Do**

Your responsibility is to:

- Use the current version of ICD-9-CM codes (not DSM-IV) on claim submissions.
- Order ICD-9-CM manuals from the American Medical Association (AMA) by calling 1-800-621-8335 or from Channel Publishing at 1-800-248-2882. A CD-ROM of the complete listing can be ordered from the United States Government Printing Office at: U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7594, or by calling the Ordering Office at 1-866-512-1800.
- Use current CPT<sup>®</sup> codes to bill for professional services.
- Obtain CPT<sup>®</sup> codes that are copyrighted by and can be obtained through the [American Medical Association](#).
- Obtain HCPCS codes from the Centers for Medicare & Medicaid Services (CMS) at [www.cms.hhs.gov](http://www.cms.hhs.gov).
- Use the industry-standard HIPAA-compliant code recommendations from the [Magellan Universal Services List](#) when billing for organization services. These codes are posted on [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider). (Choose “Getting Paid” from the top menu, then “HIPAA” and “[Coding Information](#).”) *Note:* for state-specific code sets/Universal Services Lists for use when billing services rendered to Medicaid members, see section titled, “**State-Specific Code Sets for Medicaid**” under “[Coding Information](#).”
- Submit a license level modifier for the clinical professional rendering outpatient behavioral health service on behalf of an organization listed in Appendix G Billing Tips, number 14.
- Obtain your National Provider Identifier (NPI) for use in submitting HIPAA-standard electronic transactions or paper claim forms to Magellan, and submit on all claims. To ensure accurate claims payment, we strongly encourage organizations to enumerate subparts at the site address level. Review the “[NPI FAQs](#)” on our provider website for more information.
- Review the [claims information section](#) in this supplement and in the [Magellan National Provider Handbook](#) for additional claims submission information.

## 5. Provider Reimbursement – Billing Codes and HIPAA Compliance

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### **What Magellan Will Do**

Magellan's responsibility to you is to:

- Through [www.magellanprovider.com](http://www.magellanprovider.com), post HIPAA-compliant codes for both the standard and public sector services as they are approved and assigned by CMS and industry code-set owners.
- Inform you of how to find the current HIPAA-compliant code sets through CMS and the AMA.
- Identify coding gaps for services required by our customers, in conjunction with other behavioral health industry leaders, including National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).
- Request from CMS, and/or the code-set owners, assignment of appropriate coding for standard and public sector services, when gaps are identified.
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions.

## 5. Provider Reimbursement – Electronic Claims Submission

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### **Our Philosophy**

We offer a variety of methods in which providers can submit claims electronically to support our providers' submission preferences. This enhances our ability to pay providers in a timely and accurate manner.

### **Our Policy**

Magellan is committed to meeting the Centers for Medicare and Medicaid Services (CMS) and HIPAA compliance standards. Magellan offers an online claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. Both of these options are available on Magellan's website and are provided at no cost to our providers. In addition, we have several [contracted clearinghouses](#) through which both facility-based claims and professional claims can be submitted.

### **What You Need to Do**

Your responsibility is to:

- Submit claims to Magellan, including those typically submitted on a UB-04 or a CMS-1500, through a direct-submit upload process if you are able to transmit data in a HIPAA-compliant 837 format. To establish this process go to our [EDI Testing Center](#) (at [www.edi.MagellanProvider.com](http://www.edi.MagellanProvider.com)), create a unique username/password, download the Abbreviated Companion Guide, and upload a test file to run through HIPAA validation. You will need to repeat this test successfully twice. Once HIPAA validation has been successfully completed using this automated tool, Magellan will contact you to initiate the process to production status so that you can submit actual claim files. If you have any questions or need assistance, feel free to contact [EDI Support](#) by e-mail or our EDI Hotline at 1-800-450-7281, ext. 75890.
- If you do not have the ability to transmit data in a HIPAA-compliant 837 format and you need to submit claims typically completed on a CMS-1500, evaluate the Claims Courier application on Magellan's website (also referred to as "Submit a Claim Online" after provider site sign-in). This application allows providers to efficiently submit a new claim, view the status of a claim, use previously submitted claims to create a new claim, edit a claim submitted earlier the same day, and resubmit a claim for correction of place of service, units and/or charge amount. For more information, view our [Claims Courier online demo](#).
- Consider using the services of one of our [contracted clearinghouses](#) (see list in Appendix H).

### **What Magellan Will Do**

Magellan's responsibility to you is to:

- Continue to maintain online claims applications and relationships with clearinghouses to assure flexibility in the claims submission process.
- Provide Electronic Funds Transfer (EFT) and Electronic Remittance Advice (835) for electronic claims.



Appendix A  
Magellan Organization - Site Review Preparation Guide



# ORGANIZATION SITE REVIEW PREPARATION GUIDE

Please have documentation listed below available for the Magellan reviewer on the day of your review.

## DOCUMENTS WE NEED COPIES OF The Magellan site reviewer will need copies of the following documents during the review:

1. One of the following accreditations, if applicable:
  - a) Joint Commission (TJC) accreditation (inclusive of all sites contracted by Magellan) or copy of feedback and any plan of correction if deficiencies were cited, OR
  - b) Healthcare Facilities Accreditation Program (HFAP) or copy of feedback and any plan of correction if deficiencies were cited, OR
  - c) Commission on Accreditation of Rehabilitation Facilities (CARF) or copy of feedback and any plan of correction if deficiencies were cited, OR
  - d) Council on Accreditation (COA) or copy of feedback and any plan of correction, if deficiencies were cited OR
  - e) Accreditation Association for Ambulatory Health Care (AAAHC) or copy of feedback and any plan of correction, if deficiencies were cited,
2. State licensure/certification (all that apply)

## DOCUMENTS TO SEE AND REVIEW The Magellan site reviewer will need to review the following documents during the review:

1. Organizational chart
2. Clinical documentation that outlines program content and structure
3. Referral source procedures and supporting documents, including both incoming and outgoing referrals
4. Quality management program documents, including description, plan, minutes, studies, satisfaction surveys, etc.
5. Policies, procedures for reporting critical incidents; logs of reporting
6. Utilization management (UM) procedures, supporting documents
7. Policies, procedures for member/patients' rights; rights statement, evidence of distribution of same.
8. Complaint policy, procedures, tracking logs
9. Policies, procedures regarding advanced directives (if applicable)
10. Policies, procedures on confidentiality of member information, disclosure of information
11. Policies, procedures on treatment/case record documentation; sample of blinded records
12. Safety management policies, procedures
13. Disaster plan; evacuation plan; fire marshal inspection certificate; record of drills, etc.
14. Job descriptions
15. Human resource policies, procedures related to hiring of professional staff and other staff providing direct services; includes verification of training, experience, license checks, reference checks, drug/alcohol testing supporting documents, etc. Sample of files
16. Policies, procedures related to credentials verification of licensed professional staff, including primary source verification procedures. Sample of credentials files
17. Supervision policy, procedures and supporting documents
18. Orientation, training, ongoing professional development program tracking



Appendix B  
What You Need to Know About  
Organization Credentialing and Contracting





## What You Need to Know About Organization Credentialing and Contracting

Understanding the steps required to become an in-network organization provider for Magellan may be somewhat confusing. To help make the process a little easier, we've compiled a list of some of the most frequently asked questions we receive about organization credentialing and contracting. These are general guidelines. We invite you to visit us online at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) for more information about Magellan and our provider networks. If you have specific questions, please contact your area contract manager.

### ***What does an organization need to do to be considered an in-network provider with Magellan?***

To be an in-network provider, the organization must be contracted and credentialed with Magellan. Only when both the credentialing and contracting processes are completed is the organization considered a Magellan in-network provider eligible to treat members.

### ***What is credentialing?***

Credentialing is the process we use to verify and periodically re-verify an organization's credentials in accordance with our organization credentialing criteria. In addition, organizations are to be accredited, or have specific programs accredited, by The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Health Care (AAAHC), or Council on Accreditation (COA).

### ***What does the organization credentialing process include?***

The credentialing process includes:

- ***Credentials Verification*** – We verify your organization's licensure, accreditation, insurance and Medicaid /Medicare program participation status and sanctions history.
- ***Committee Review*** - If your organization's credentials satisfy Magellan's standards, your organization's application is sent to a Regional Network and Credentialing Committee (RNCC) consisting of Magellan clinical staff and professional peers. The RNCC reviews applications subject to applicable state laws and our business needs. If your organization successfully completes the credentialing process and the programs and services are needed for members in your area, your organization will be accepted into the provider network pending execution of your organization's agreement.

### ***How long does the credentialing process take?***

Once all the required documents have been submitted, the credentialing process generally can be completed within 90 days. Site visits required for non-accredited organizations may lengthen the time.

### ***Do individuals within the organization need to be credentialed in order to render services to Magellan members?***

The organization must have a process to credential its practitioners. Practitioners who provide traditional outpatient professional services to members should meet Magellan's credentialing requirements for individual practitioners. If the organization can demonstrate that it performs primary source verification (PSV) of the credentials for its staff members, no credentialing of individual staff members by Magellan is required. If the organization cannot demonstrate that it performs PSV, the individual professional providers may not render outpatient services to Magellan members until they are credentialed by Magellan.

## What You Need to Know About Organization Credentialing and Contracting

### ***How will our organization be notified if we are accepted into the Magellan networks?***

Upon acceptance into the Magellan provider networks, your organization will receive a welcome letter along with your fully executed Facility and Program Participation Agreement.

### ***Will we be notified if our organization is not accepted into the Magellan provider networks?***

In the event that your organization is not accepted into the Magellan provider networks, your organization will be notified in writing.

### ***Once our organization completes the credentialing process, are the credentials good for the life of the contract?***

No. We re-review organization provider credentials every three years as a measure of our provider network quality. During this process, the organization's credentials are re-verified and the Regional Network and Credentialing Committee (RNCC) reviews your organization's re-credentialing application subject to applicable state laws and business needs. If your organization's programs and services match our service needs in your area, your organization will be re-credentialed to continue as a Magellan provider.

### ***What is the Magellan Facility and Organization Provider Participation Agreement?***

Your Magellan Facility and Organization Provider Participation Agreement is the contract between your organization and Magellan to render behavioral health care services to members whose care is managed by Magellan. The contract sets forth the terms and conditions of your organization's participation in the Magellan network as well as the terms and conditions applicable to Magellan.

### ***If we sign this Agreement, will each practitioner in the organization be eligible to see all members whose behavioral health care is managed by Magellan?***

Practitioners within the organization will be eligible to treat members for the lines of business for which the organization is contracted to provide services within their scope of practice, and if their specialty, license and training meet Magellan's requirements. If your organization does not PSV the credentials of your staff members and Magellan requires that the individual staff members be individually credentialed, only those providers who are credentialed by Magellan can provide services to Magellan members.

### ***What Magellan lines of business is our organization contracted for?***

The lines of business for which your organization is contracted are based on the reimbursement schedules included with your Agreement.

### ***When does our contract become effective?***

Your Magellan Facility and Organization Provider Agreement is effective as of the date on the signature line where Magellan countersigns and executes the Agreement.

### ***Where can I find out more about Magellan's policies and procedures?***

The Magellan National Provider Handbook, the state- and plan-specific supplements to the national handbook, Medical Necessity Criteria, Clinical Practice Guidelines and many resources can be accessed online at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider).

Appendix C  
Authorization: Initial Review



When a facility requests an initial authorization, Magellan requires the following information:

### ***Utilization Review (UM) Contact (caller's) Information***

- name
- title
- credentials
- phone number
- location of patient

### ***Patient Information***

- name
- age
- date of birth
- address
- member's name
- member's Social Security or identification number
- location of patient

### ***Facility Information***

All Patients	HMO Patients
<ul style="list-style-type: none"> <li>• date admitted, or proposed date for pre-admission</li> <li>• level of care requested</li> </ul>	<ul style="list-style-type: none"> <li>• date admitted, or proposed date for pre-admission</li> <li>• level of care requested</li> <li>• primary care physician (PCP) name</li> <li>• PCP phone number</li> <li>• when PCP was contacted</li> </ul>

### ***Clinical Documentation Elements***

- Name and phone number of attending or treating physician
- Medical necessity criteria
- Presenting symptoms
- Mental status
- Precipitants (chief complaint) and why now
- Risk Assessment and history
  - Past and present danger potential:
    - Suicidal/homicidal ideation, threats, gestures, intent
    - Self abuse attempts/physical aggression
    - Other risk factors/severity
    - Lethality potential, plan
    - Judgment/impairing safety
- Substance use/abuse
  - History
  - Current use
  - Current withdrawal symptoms
  - Dual diagnosis issues being addressed

- Vital signs and blood alcohol level
- Provisional diagnoses (Axis 1 thru 5 diagnoses)
- Medical and/or neurological disorders
- Medical clearance, when applicable
- School, work, financial, or legal issues
- Family history of mental health or substance abuse
- Current family status
- Support system, family, other

### ***Treatment History (Chemical Dependency/Mental Health)***

- Previous treatment
- Compliance
- What has and what has not worked

### ***Treatment Plan***

- Planned treatment to resolve problems causing admission
- Medication doses and adjustments
- **Modalities:** medication management; group, family therapy
- Goals
- Length of stay anticipated at requested level of care

### ***Discharge Plan***

- Expected discharge date
- Preliminary discharge plans

### ***Follow-Up***

- Name and contact information of organization representative for concurrent review if different than utilization review contact

Appendix D  
Authorization: Concurrent Review



When a facility requests a concurrent review authorization, Magellan requires the following information:

### ***Utilization Review (UR) (caller) Contact Information***

- Caller name, title, credentials, phone number
- Name of facility

### ***Patient Information***

- Patient name, Social Security Number or ID number

### ***Patient's Current Status (Axis I-V)***

- Updated diagnoses if changed from admission
- Progress since last review
- Current mental status including orientation, affect, cognitive functioning, psychosis, mood, appearance, attitude, appetite, sleep, speech, attention, activities of daily living
- Changes in patient's medical condition
- Changes in medications, including start date, dosage and frequency
- Psychotherapies, engaging social support
- Relevant results
- If detox, include vitals and status of other detox protocols
- Complicating factors, current risk, follow-up
- Dual diagnosis and/or co-morbid medical disorders
- Symptoms, behaviors, interactions with staff and patients, sleep, appetite
- Family/social support involvement since last review
- Risk Assessment:
  - Suicidal/homicidal ideation, threats, gestures, intent
  - Self abuse attempts/physical aggression
  - Other risk factors/severity
  - Lethality potential, plan
  - Judgment/impairing safety
- Follow-up on dual diagnosis and/or co-morbid medical disorders
- Barriers to improvement

### ***Treatment Plan***

- Identify plan to resolve problems that resulted in admission and are preventing discharge
- Expected medication adjustments
- Psychotherapies
- Engagement of social support
- Family/significant other involvement, names, whether or not they are involved in family sessions
- Level of care requested
- Length of stay anticipated

- Reason(s) patient cannot be discharged or stepped down

### *Discharge Plan*

- Step down level of care
- Name and phone number of the provider to whom the patient is being referred
- Date of first post-discharge appointment

### *Follow-Up*

- Discuss next follow-up date or follow discharge protocol (Appendix E)

Appendix E  
Authorization: Discharge Review



When a facility requests a discharge review, Magellan requires the following information:

### ***Utilization Review (UR) (caller) Contact Information***

- Caller name, title, credentials, phone number
- Name of facility

### ***Patient Information***

- Patient name, Social Security Number or ID number

### ***Discharge Plan***

- Support for patient outside of hospital setting, including name and relationship
- Step-down level of care
- Follow-up appointment within seven days of discharge including:
  - date
  - time
  - name of psychiatrist and/or therapist
  - phone number
- Medications
- Additional elements for substance abuse
  - Relapse prevention plan
  - Community support (Alcoholics Anonymous/Narcotics Anonymous):
    - name and address of group that member will attend
    - number of group sessions to be attended in the next 90 days
  - Step, work and sponsor status
  - Vital signs (blood pressure and pulse) upon discharge
- When requested, administer the SF-12<sup>®</sup> (a brief symptom and functional questionnaire) to the member and fax results to the care manager



Appendix F  
Frequently Asked Questions



## Frequently Asked Questions

Question	Answer
How do I confirm that a member is covered?	Call the phone number on the member's health benefit plan card.
When do I call for pre-authorization?	Call for pre-authorization before the member is admitted or non-emergency services are rendered.
What do I do for an admission after business hours or on holidays?	Most benefit plans have a 24-hour access number that is usually the same as the number to call during business hours, and can be found on the member's health benefit plan card. If the plan does not have 24-hour access and asks you to call on the next business day, document the phone number you called, the date, time of day, a description of the voice message received and the name of the person calling for authorization, then place another call on the next business day.
What pre-authorization information is needed?	Refer to <a href="#">Appendix C</a> of this Supplement.
Where do I find Magellan's Medical Necessity Criteria?	Magellan's Medical Necessity Criteria is available on Magellan's provider website, <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a> , in <a href="#">Appendix C</a> of the Magellan National Provider Handbook.
What do I do if an adverse incident occurs?	Contact the Magellan care manager handling the case.
What do I do in emergency situations?	Handle the emergency in the most appropriate manner in order to protect the member. Then notify Magellan by calling the phone number on the member's health benefit plan card. Most plans offer a 24-hour access phone number. If the plan does not have 24-hour access and instructs you to call on the next business day, document the phone number you called, the date, time of day, a description of the voice message received and the name of person calling for certification. Be sure to place another call on the next business day.
What is the time line for physician-to-physician reviews?	Physician-to-physician reviews must occur within one business day of the request.
What does Magellan consider an adequate mental status exam?	A mental status exam must include the following: Appearance, level of consciousness, attitude, orientation, memory, cognitive functioning, attention, psychosis/perceptual disturbance, mood, affect, psychomotor activity, thought process, speech/language, thought content, insight, and judgment.

## Frequently Asked Questions

Question	Answer
Do facilities need to use current diagnosis codes?	Yes. Facilities should use DSM-IV (the professional standard coding system for behavioral health) to determine the clinical diagnosis and the corresponding ICD-9-CM codes for billing purposes to satisfy HIPAA compliance requirements.
What is the appeals process?	Because the appeal process varies depending on client requirements and state laws, clinical or administrative non-authorization appeal procedures are outlined in the non-authorization letter.

Appendix G  
Claims Tips and Information



## Claims Tips

1. Electronic claims filing is the most cost-effective way to receive reimbursement quickly. Magellan offers both an online claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. In addition, Magellan works with several clearinghouses (see details below).
2. Submit claims on the UB-04 form for facility and program services. Submit professional services claims on the CMS-1500.
3. Complete all the fields on the claim form to prevent your claim from being delayed or returned. Guidelines for clean claim filing are provided in Section 5 of the [Magellan National Provider Handbook](#).
4. The Taxpayer Identification Number (TIN) submitted on the claim must be for the practice or location where the care was authorized *and* where the services were rendered. To notify Magellan of any change in TIN or address, just sign in at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider). From My Practice, choose “Display/Edit Practice Information.” You can find the W-9 Form there with a “Submit Online” button, or you can notify Magellan’s Provider Relations department in writing. Then submit the claim with the current information.
5. If the member self-refers, call the customer service number on the member’s health benefit plan card prior to rendering services to verify the member’s active coverage, your status in the Magellan network serving that member and pre-authorization requirements.
6. Contact Magellan for reauthorization if the type of service and/or primary diagnosis change after an authorization is given. Benefits are paid according to the primary diagnosis. The level of service and level of care authorized by Magellan must match the care billed.
7. A service may be pre-authorized yet payment denied for a number of reasons including but not limited to:
  - a. Member plan benefits are exhausted
  - b. Eligibility/benefit coverage
  - c. Coordination of benefits form not on file
  - d. Incorrect or incomplete information on the claim
  - e. Claims components such as CPT codes, revenue codes or place of service may differ from the authorization
  - f. Per diem rate includes the professional service pursuant to the terms of your agreement with Magellan.

8. Submit your claim to the correct address. The member's health plan benefit card and the authorization letter include the correct address for submission of your claim for the services provided to the member and a telephone number for questions about claims submission.
9. Contact your Magellan area contract manager or local provider service representative for assistance if your organization's claims payment does not match your organization's contracted rate and a Magellan customer service representative advises you that your claim has been paid correctly. As an alternative, you may submit a written appeal, including a copy of your organization's contract.
10. Call Magellan's customer service before re-submitting a claim that has a paid status, if there are no changes to the original claim submission. If there is a change to the original claim, (e.g., CPT<sup>®</sup> code change or billed amount) then the claim must be resubmitted with a clear indication that this is a corrected billing.
11. Submit claims within 60 days of rendering service to meet Magellan's timely filing requirements or as specified by regulatory amendment and/or state requirements. Depending upon the benefit plan, submitting a claim after the timely filing requirement may result in a denial of the claim.
12. Do not bill ancillary services, including history and physicals or services by an outside clinician (Ph.D., M.A., M.S.W., etc.) rendered in a participating facility separately from the per diem charge.
13. Bill for emergency room charges only if the member is not admitted. Per diems include emergency room charges when the member is admitted.
14. Submit claims using behavioral health codes:
  - a. Residential Treatment: submit on a UB-04 with
    - i. Revenue Codes 1001 - Residential Treatment, Psychiatric or
    - ii. Revenue Codes 1002 - Residential Treatment, Chemical Dependency,
  - b. Intensive Outpatient (IOP) services: when submitted on a UB-04, use:
    - i. Revenue Code 0905 - IOP Psychiatric or
    - ii. Revenue Code 0906 - IOP Chemical Dependency.
  - c. If you submit IOP claims with the CMS-1500 form, use the correct HCPCS Code (S9480 - Psychiatric IOP or H0015-Alcohol/Drug IOP).
  - d. Group therapy CPT<sup>®</sup> or Revenue Codes do not accurately describe IOP and cannot be accepted.

- e. Magellan recommends (for organization providers only) the following **professional service modifier** for each outpatient service claim line submitted, based on the **license** of the rendering provider, so that claims can be paid correctly on first submission:

AF – Specialty Physician  
AG – Primary Physician  
AH – Clinical Psychologist or  
HP – Doctoral Level (Psychologist)  
AJ – Clinical Social Worker  
HO – Master's Degree Level (Counselor)  
SA – Nurse Practitioner or  
TD – Registered Nurse  
HF – Substance Abuse Program (National Certified Addictions Counselor or State Substance Abuse Certifications).

*Note: Select the code that best applies. Nurses and other professionals may only provide services and bill for CPT codes that fall within the scope of practice allowed by their professional training and state licensure.*

*Examples:*

*CMS-1500 Form: insert modifier in Field 24d under “Modifier” or*

*UB-04 Form: insert modifier with CPT or HCPCS code in Field 44, e.g., “90801 AH.”*

- f. Public sector accounts may have unique HIPAA modifiers. These can be found on [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) under “coding information.”

## Coordination of Benefits (COB) Procedures

Magellan coordinates benefits with other payers when a member is covered by two or more group health benefit plans. During benefit enrollment or whenever there is a change in coverage, the member is required to provide information to each carrier if s/he has more than one benefit carrier.

To facilitate prompt claims processing, this information must be forwarded to Magellan along with other essential eligibility information. By verifying eligibility information prior to seeing members, providers help make sure that benefit updates and changes are completed thereby avoiding claims processing delays. There are specific boxes on all claims forms that request coordination of benefits information.

When any of the following circumstances exist, Magellan generally investigates the possibility of primary coverage and other party liability (OPL) prior to paying the claim.

- The claim is not an outpatient level of care.
- An explanation of benefits (EOB) from another health insurance carrier is attached to the claim.
- Other insurance information is printed in Box 9 A-D on the CMS-1500 claim form.
- Box 11D on the CMS-1500 is checked “yes.”
- Box 29 on the CMS-1500 indicates that a payment has already been made to the provider by a source other than Magellan.
- Box 50 and Boxes 58-61 on the UB-04 claim form indicate other insurance information.
- Any information on the claim or attached to the claim indicates the possibility of other insurance. (Example: copy of an insurance card from another carrier, or letter from another insurance company.)
- The claimant is 65 years of age or older.
- COB information is on file for other family members.
- The member's last name is different from the subscriber(s) listed on the claim.

Specific health plan contractual arrangements or state regulatory requirements may require that Magellan pay the claim first and then investigate the possibility of dual coverage. In most instances, however, Magellan will attempt to contact the member to clarify the situation prior to paying the claim. Claims falling within this description are considered “unclean” and are not subject to most prompt payment laws until the issue has been resolved. In these cases, providers and members are notified in writing that the claim will remain unpaid until further information is received from the member, and that if payment and/or nonpayment notice is not received within 120 days of the date of the EOB/EOP, then providers may pursue payment from the primary carrier or the member.



## Checklist for Submitting Electronic Transactions to Magellan

If you are a Magellan-contracted provider, you should already have obtained an MIS number/username from Magellan. This is found in your Welcome letter sent to you from the Magellan Network Services.

**Please follow these steps in order to submit electronic transactions to Magellan:**

### **Direct Claims Submission**

- Initiate the direct submit process with Magellan and/or contact Magellan EDI Support.
- Download and review companion guides and FAQs.
- Complete the EDI survey.
- Magellan will review your completed survey, and if you meet the criteria for direct submission, we will give you access to start submitting test files. If you do not meet the qualifications, we will direct you to use one of our alternative electronic submission options.
- Once testing is complete, you will receive another e-mail notifying you that you are able to send production files.

- or -

### **Submission on Magellan's Website**

- Go to [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) and sign in with your secure username and password.
- View the Claims Courier Online Demo.
- Click on "Submit a Claim Online" and follow the prompts.

- or -

### **Clearinghouse Submission**

- Research clearinghouses contracted with Magellan (see the list on the next page). Choose and enroll with a clearinghouse.
- After enrolling with a contracted clearinghouse, begin testing with your clearinghouse according to their instructions. Once testing is complete, you will be ready to send production files.
- Submit and/or receive electronic transactions.

**Provider questions:** Magellan's Provider Services Line, 1-800-788-4005

**Technical questions or support:** Magellan EDI Support, 1-800-450-7281, extension 75890

**Enrolling with a Clearinghouse:** See the list below.

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## Approved Clearinghouse Contact Information

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**Payerpath (formerly Mysis and also known as Allscripts)**

9030 Stony Point Pkwy  
Suite 440  
Richmond, VA 23235  
1-877-623-5706  
[www.payerpath.com](http://www.payerpath.com)

**Capario (formerly MedAvant and ProxyMed)**

1901 E Alton Ave, Suite 100  
Santa Ana, CA 92705  
1-800-586-6938  
[PayerAdvocacy@Capario.com](mailto:PayerAdvocacy@Capario.com)

**Availity (formerly THIN)**

PO Box 550857  
Jacksonville, FL 32255-0857  
1-800-282-4548  
[www.availity.com](http://www.availity.com)

**Emdeon Business Services (formerly WebMD)**

One Century Place  
26 Century Blvd, Suite 601  
Nashville, TN 37214  
1-877-469-3263  
<http://transact.emdeon.com/>

**Gateway EDI, Inc.**

One Financial Plaza  
501 North Broadway 3rd Floor  
St. Louis, MO 63102  
1-800-969-3666  
[www.gatewayedi.com](http://www.gatewayedi.com)

**NaviNet Claims (also known as AmpMed Corporation)**

PO Box 31430  
Santa Fe, NM 87594  
1-866-398-7076  
Fax: 505-988-7629  
[www.navinetclaims.com](http://www.navinetclaims.com)

**RelayHealth (also known as McKesson)**

700 Locust Street  
Suite 500  
Dubuque, IA 52001  
1-800-527-8133, Option 2  
[www.relayhealth.com](http://www.relayhealth.com)

**Office Ally**

PO Box 872020  
Vancouver, WA 98687  
1-866-575-4120  
Fax: 360-896-2151  
[www.officeally.com](http://www.officeally.com)

*Note: You also can submit electronic claims to a non-approved clearinghouse, as long as your clearinghouse contacts one of the Magellan-approved clearinghouses to arrange to transmit the claims.*



Appendix H  
Organization Provider Selection Criteria



## Credentialing of Organizations

Administrative credentialing of organizations includes verification that the organization:

1. Is in good standing with state and federal licensing and regulatory agencies, as applicable;
2. Has no Medicare and/or Medicaid sanctions;
3. Has current state licensure or certification in accordance with applicable state law;
4. Has appropriate current accreditation by The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Healthcare (AAAHC), Commission on Accreditation of Rehabilitation Facilities (CARF) and/or Council on Accreditation (COA):
  - a) If the organization does not hold such accreditation, an onsite review is required. CMS site visit or a state licensing site visit that meets Magellan's assessment standards may substitute for a Magellan site visit;
5. Is not subject to any contingencies or provisions placed on licensure and/or accreditation;
6. Meets Magellan minimum requirements for professional and general liability insurance coverage of \$1 million per occurrence and \$3 million aggregate;
7. Successfully completes Magellan requirements for malpractice claims history review;
8. Credentials its practitioners, including primary source verification of licensed practitioners;
9. Completes and submits all required application materials and related documents, including any documentation of current accreditation;
10. Submits staff rosters, if requested by Magellan:
  - a) Staff rosters are to be submitted electronically and contain data fields, as defined by Magellan,
  - b) If a staff roster is requested and the organization is unable to comply with 10a above, an exception to the format may be made by Magellan, in its sole discretion.

All organizations are reviewed and approved by the appropriate Magellan Regional Network and Credentialing Committee (RNCC) prior to network participation and at re-credentialing.