



# Magellan Health Services of California, Inc. – Employer Services Human Affairs International of California

## California Provider Handbook Supplement to the Magellan National Provider Handbook\*

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Appendix C:	<b>California Medical Necessity Criteria</b> - The Magellan California subsidiaries, Human Affairs International of California and Magellan Health Services of California, Inc. – Employer Services, have adopted Magellan’s <a href="#">Medical Necessity Criteria</a> as outlined in the National Provider Handbook.
Appendix E:	<b>Clinical Practice Guidelines</b> - The Magellan California subsidiaries, Human Affairs International of California and Magellan Health Services of California, Inc. – Employer Services, have adopted Magellan’s <a href="#">Clinical Practice Guidelines</a> as outlined in the National Provider Handbook.
Appendix F:	<b>California Member Grievance Forms</b> (English and Spanish)
Appendix G:	<b>Independent Medical Review Policy</b>
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\* Please refer to the Magellan [National Provider Handbook](#) and its [Appendices](#) section for all policies and procedures (including Appendices A, B and D) with the exception of the pages and appendices set forth above. This Handbook Supplement provides additional guidance in connection with HMO plans and Employee Assistance Programs regulated under the Knox-Keene Health Care Service Plan Act; this Supplement does not apply to services in connection with other group health plans. All references in this Supplement and in the National Provider

*Handbook, including Appendices, to “Magellan Behavioral Health” should be read as referring to Human Affairs International of California and/or Magellan Health Services of California, Inc. – Employer Services.*

## **Knox-Keene Regulations Introduction**

Magellan Health Services, Inc. conducts its behavioral health business in California that is regulated under the Knox-Keene Health Care Service Plan Act (“Knox-Keene”) through two California-based subsidiaries: Magellan Health Services of California, Inc. – Employer Services and Human Affairs International of California. Magellan is committed to meeting the quality assurance and consumer protection and provider protection requirements of the Knox-Keene Act and regulations issued by the Department of Managed Health Care (“DMHC”). This section sets forth special obligations of Magellan and providers contracted with Magellan designed to ensure compliance with Knox-Keene requirements.

## **Provider Network Continuous Credentialing**

**Our Philosophy** In support of our ongoing commitment to promoting quality care for our members, we regularly re-review provider licensure.

**Our Policy** Re-credentialing of providers with respect to licensure is conducted on a continuous basis.

**What You Need to Do** In support of this policy, you are responsible to renew your professional license on a timely basis to avoid any lapse in licensure.

**What Magellan Will Do** If you fail to renew your license on a timely basis, we will send you a reminder and suspend your network status. If you fail to renew within 60 days, we will terminate your network participation.

## Appointment Access Standards

**Our Philosophy** Members are to have timely access to appropriate mental health, substance abuse, and/or EAP services from an in-network provider 24 hours a day, seven days a week.

**Our Policy** Our access-to-care standards allow members to obtain behavioral health services by an in-network provider within a time frame that reflects the clinical urgency of the situation.

**What You Need to Do** In support of that commitment we have established appointment and telephone access standards. We strongly encourage you to follow these standards.

### Appointment Access Standards

- Life-Threatening Emergency Access – If you are unable to see a member with a life-threatening emergency immediately, we ask that you immediately refer the member to the nearest emergency room, advise the member to call 911, or advise the member to call the nearest Psychiatry Emergency Team (PET).
- Non-Life-Threatening Emergency Access – We expect you to see members with non-life-threatening emergencies within 6 hours of contact.
- Urgent Access – We expect you to see health plan and other managed care members with urgent situations within 48 hours of contact and Employee Assistance Program (EAP) members with urgent situations within 24 hours of contact.
- Routine Access – We expect you to see health plan and other managed care members for routine care within 10 business days of contact (15 business days for psychiatrists) and EAP members for routine care within 3 business days of contact.
- Unavailability - Notify us immediately when you become unavailable for new referrals.

### Telephone Access Standards

If you are unavailable when a member calls, we expect you to return the member's call within two business days and to communicate your telephone response time to members via your phone message and/or answering service. Of course, if a member message indicated urgency, please respond immediately or in accordance with good professional practice guidelines. We also ask that your phone message or answering service informs members that if they believe their situation requires immediate intervention, they should:

- Go to the nearest emergency room
- Call 911
- Page you (if an available option)

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- Contact the nearest Psychiatry Emergency Team (PET)

## **In-Office Wait Times**

Members should not have to wait more than 15 minutes after the scheduled appointment time except when an emergency interrupts your schedule.

## **What Magellan Will Do**

In support of our commitment to these standards and to meet our regulatory obligations, we may contact you through random audits to gauge your ability to meet these standards. Failure to meet these standards may result in sanctions, up to and including termination of your provider participation agreement. If you have any concerns or comments, please contact us toll-free at 1-800-288-0558.

## Member Complaints and Appeals

### Our Philosophy

We support the right of members to appeal adverse decisions and to comment on service or care concerns.

### Our Policy

We provide a formal mechanism for members to appeal adverse decisions, to express comments related to care or service, to have appeals or complaints appropriately investigated, and to receive a timely and professional response.

An *appeal* is a formal request for reconsideration of a non-authorization decision or adverse claim determination) with the goal of finding a mutually acceptable solution. For an appeal prior to the provision of the services, the member may submit the appeal or the provider, acting on the member's behalf, may submit an appeal. Examples of actions that can be appealed include, but are not limited to, the following:

- ◆ Denial or limited authorization of a requested service, including the type or level of service
- ◆ Reduction, suspension or termination of a previously authorized service
- ◆ Denial, in whole or in part, of payment for a service.

An *expedited appeal* is a request that is made when the routine decision-making process might seriously jeopardize the life or health of a member, or when the member is experiencing severe pain. An expedited decision may involve an admission, continued stay, or other health care services.

Our mechanism for clinical appeals includes access to independent medical review when required by Knox-Keene, the Patient Protection and Affordable Care Act (Health Care Reform law), other applicable law, and/or our customer contracts.

### What You Need to Do

To support this policy, your responsibility is to:

- Furnish a copy of our complaint form (See [Appendix F](#)) to each member with a complaint.
- Cooperate with us in investigating and resolving member complaints and/or appeals.
- Support a member's application for independent medical review. When our denial is based on our conclusion that the treatment is experimental or investigational, we expect you, as appropriate, to furnish written certification that (i) standard treatments have not been effective in improving the member's condition, (ii) standard treatments would not be medically appropriate for the member, or (iii) there is no more beneficial standard therapy covered by the plan than the requested treatment, and that the treatment is likely to be more beneficial than any

standard therapy.

Please see [Appendix G](#) for a description of our Independent Medical Review policy.

## What Magellan Will Do

Except when a member declines written communication, we will send a letter acknowledging a grievance within five calendar days of receipt and a resolution letter or a pended resolution letter within 30 calendar days of receipt.

We will furnish determinations on expedited appeals within the shorter of one business day or three calendar days, regarding standard pre-service appeals within 15 calendar days, and regarding post-service appeals within 30 calendar days.

We will provide a copy of all relevant documents to the independent review organization within three business days of receipt of an independent review request from the DMHC and provide the member an annotated list of the documents sent to the review organization. We will implement an independent medical review decision within three business days of receiving the decision from the DMHC.

## Claims and Provider Disputes

### Our Philosophy

We are committed to reimbursing our providers promptly and accurately in accordance with our provider contracts. We believe that informing providers of claims processing requirements helps avoid administrative denials that delay payment and require resubmission of claims. We recognize that we may make mistakes from time-to-time and are committed to addressing appropriately submitted provider concerns.

### Our Policy

Magellan reimburses behavioral health treatment providers using current procedural terminology (CPT<sup>®</sup>) fee schedules for professional services. Magellan's professional reimbursement schedules include the most frequently utilized CPT codes for professional services. *Our provider contracts require claims to be submitted within 90 days of the provision of covered services. We will deny claims not received within 90 days except when delay is caused by extraordinary circumstance.* A claim must contain no defect or impropriety, including a lack of any required substantiating documentation, HIPAA-compliant coding or other particular circumstance requiring special treatment that prevents timely payments from being made. If the claim does not contain all required information, it may be denied.

Magellan complies with section 1371.8 of Knox-Keene by reimbursing providers for services rendered in good faith pursuant to a written authorization for a specific type of treatment even if after the authorization Magellan determines that the service was not covered under the plan.

To help resolve provider disputes, we maintain a formal provider dispute mechanism.

### What You Need to Do

To support this policy, your responsibility is to follow the detailed claim submission guidelines and, as necessary, provider dispute guidelines in [Appendix H](#) of this Handbook Supplement.

To be eligible for payment for services notwithstanding that the services are not covered, the following must be present:

- Written authorization for services that was not revoked prior to delivery of the services
- Services rendered in good faith reliance on the written authorization
- A complete clean claim filed within the timely filing standards.

You will not be considered to have relied in good faith on the authorization unless you re-check eligibility with Magellan or, if available, a plan's online eligibility site whenever the authorization was issued more than five days prior to service delivery. Keep evidence of this eligibility check to verify the member was eligible (e.g., print screen of website

showing eligibility, documentation of a call, etc.).

## What Magellan Will Do

Within 15 working days of receipt of a clean claim, we will either (i) pay or deny your claim and send you a written explanation or (ii) send you an acknowledgement of receipt of your claim.

When you submit a provider dispute in accordance with the guidelines in [Appendix H](#) of this Handbook Supplement, we will acknowledge receipt within 15 business days of receipt and issue a written determination within 45 business days of our receipt of the dispute, or, if insufficient information is furnished, an amended dispute.

## Quality Assurance

<b>Our Philosophy</b>	We are committed to continuous quality improvement through a program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.
<b>Our Policy</b>	We conduct annual reviews of a random sample of provider treatment record documentation against standards for documentation and adherence to important elements of clinical practice guidelines. We also conduct annual reviews of a random sample of providers who self-identify as bi-lingual to confirm their language capabilities. We conduct our reviews in accordance with regulatory mandates and in a manner consistent with respecting federal and state health information privacy regulations.
<b>What You Need to Do</b>	To support this policy, your responsibility is to respond to our written request for treatment records within the time frame requested.
<b>What Magellan Will Do</b>	We will review your records, provide you with feedback on your individual results and review aggregate data to identify areas where we may improve our assistance to you in meeting our documentation standards and clinical practice guidelines.

## Language Assistance Services

<b>Our Philosophy</b>	We support the right of members with limited English Proficiency (LEP) to assistance that enhances their ability to understand and obtain needed services.
<b>Our Policy</b>	We maintain a formal language assistance program (LAP) to identify and assist members with LEP.
<b>What You Need to Do</b>	Please see the “What We Expect From You, Our Provider” section of <a href="#">Appendix I</a> , Language Assistance Services.
<b>What Magellan Will Do</b>	Please see <a href="#">Appendix I</a> , Language Assistance Services.