



Magellan Autism ConnectionsSM Provider Training – Frequently Asked Questions June 2009

Does the \$36,000 coverage limit include co-payments, co-insurance and deductibles?

For both Independence Blue Cross (IBC) and Capital Blue Cross (CBC), the \$36,000 is based on the paid amount. Co-payments, deductibles and co-insurance do not accumulate to the coverage limit.

Will the Explanation of Benefits (EOB) include accumulators?

Neither IBC nor CBC will include the accumulated amount on the EOB.

Will the EOB state that benefits are exhausted or will it state that the autism benefits are exhausted?

The EOB message states: This member has now used the annual maximum dollar amount payable for these services under the contract.

Will the provider be notified when the \$36,000 has been reached?

Providers will be notified through the EOB message that states that the annual maximum dollar amount has been met under the contract.

Will the member/family be updated regarding the amount of money available from the \$36,000 limit?

For IBC, the member/family will be updated only if they call the member services department.

For CBC, the subscriber will be sent a letter when the dependent reaches \$25,000.

Will clinical guidelines determine how many sessions are approved at each request?

Care managers follow Magellan's medical necessity criteria and clinical practice guidelines for the initial authorizations and for concurrent review to determine how many sessions are authorized.

Does the person providing Magellan with the assessment information have to be a master's- or doctoral-level provider; or can he or she be the rendering/treating clinician?

The initial assessment and plan development must be conducted by a master's/doctoral-level provider who also will provide the assessment information to Magellan's care managers.



I have heard that parents may not be able take a child off their insurance policy; or if the parent takes the child off the insurance policy, DPW will pay the cost? Is this true?

Please raise this question to Department of Public Welfare (DPW).

During a training Webinar, I received information indicating that a provider can span the dates of services on a claim form. Is that correct for Magellan and/or IBC claims?

No, that information is incorrect. Providers may not submit claims for a span of dates. Each date of service must be billed separately.

Providers commented that Medicaid approves services at place of service-school, and this Act is to replicate services approved by Medicaid.

Both CBC and IBC exclude school as a place of service.

What place of service is covered under commercial insurance?

CBC will cover office, community, and home-based settings.

IBC will cover office, community mental health centers, and home-based settings.

If school, daycare, camps and after-school programs are not covered, will Pennsylvania HealthChoices pay these claims? If yes, will I be able to receive a non-authorization letter?

Please raise this question to Department of Public Welfare (DPW).

Is there a way to change the blocks of time authorized? The 15-minute blocks of time are most useful for the follow-up services.

Both H2019 and H2021 for Follow-up and Reassessment are paid in 30-minute increments. H2014 for Supervision also is paid in 30-minute increments. This mirrors the way Magellan reimburses our Pennsylvania HealthChoices providers.

Magellan's rates for follow-up services are lower than we are currently receiving from the Pennsylvania HealthChoices programs.

The rates reflected in Magellan's commercial reimbursement schedule for autism are our commercially approved standard rates and we will not be negotiating non-standard reimbursement rates for these services.



Does the contract renewal date for CHIP/Adult Basic always begin at the same time for everyone or is it by member?

It begins at the same time. The renewal date for CHIP is December 1, 2009. The renewal date for Adult Basic is October 1, 2009.

Will Navinet benefit information inform providers if the member has autism benefits?

Providers with access to the Navinet portal will be able to view information that specifically indicates the autism benefit information.

Providers commented that there have been mixed messages in the provider community on whether providers also will need to complete an autism assessment for Pennsylvania HealthChoices when they complete an assessment for commercial insurance.

The Department of Public Welfare (DPW) stated during a conference call that providers will need to complete an assessment for Pennsylvania HealthChoices when they complete one for commercial insurance. For further clarification, please contact the DPW.

Pennsylvania HealthChoices requires providers to complete an initial assessment (H0032) every year. For the commercial line of business will the initial assessment only occur once or will it have to be completed every year?

The *initial* assessment, H0032, would only occur for a new case. Reassessment, covered under H2019, would be done when clinically indicated.

Since IBC requires a review every 90 days, will Pennsylvania HealthChoices change their review period from 120 days to 90 days so all services can coincide with one another if the member has dual benefits?

Please raise this question to Department of Public Welfare (DPW).

Does the provider have to register the taxonomy code required for Personal Choice claims with NPPES?

Magellan and IBC do not require that the providers specifically register these taxonomy codes with NPPES. These codes were established to assist with processing of the claims as a result of providers' multiple contractual relationships with Magellan and multiple NPIs. The goal is to minimize rejections and improve claims payment accuracy.

Can a PhD supervise a master's-level clinician who is not credentialed or a board certified behavioral analyst for the Initial Assessment and Plan Development (H0032).

No, the initial assessment must be conducted by a doctoral-level or master's-level board certified behavior analyst.



Is there a special, designated autism team at each Magellan care management center?

Yes, Magellan has dedicated care managers—who have received training specific to autism spectrum disorders (ASD) and the behavioral treatment modalities used to treat ASDs—at each care management center.

What is the appeal process for autism determinations and what is the turnaround time for the appeals?

For CBC:

- Magellan is not delegated member appeals; CBC handles all member appeals.
- Standard appeals process: CBC will notify member of decision no later than 60 days after receipt of the appeal. If the member’s appeal involves a preauthorization denial and member has not yet received the medical services at issue, CBC will review the appeal and notify member of decision no later than 30 days after receipt of the appeal.
- Expedited internal: Investigation and notification of the decision will be completed within 48 hours of receipt of the request.
- Expedited external: Within 24 hours of the request, CBC will submit the review request to the Pennsylvania Insurance Department.

For IBC:

- Magellan is not delegated member appeals; IBC handles all member appeals.
- Standard appeals process: IBC will notify member of decision no later than 60 days after receipt of the appeal.
- Expedited appeals: Investigation and notification of the decision will be completed within 48 hours of receipt of the request (72 hours for PPO). Magellan is required to deliver the information to IBC within two hours for Act 62 member appeals.

Will Magellan consider multiple, different clinical modalities for treating members with autism or are they only recognizing specific modalities?

Magellan recognizes the types of treatments for autism spectrum disorders as those specifically delineated by Act 62 when such treatments are medically necessary and prescribed as set forth in the Act.

What is the frequency of updating our agency’s staff rosters, and is there is a way to do the updates online or electronically (e-mail spreadsheet)?

Please submit all staff roster edits on a quarterly basis by e-mail to LFYarbro@MagellanHealth.com. Currently, staff rosters for contracted autism service providers are not able to be updated using Magellan’s online tools.



What is the turnaround time for a decision once a provider submits a completed ATEC Tool and Autism Treatment Request?

Magellan should communicate the decision within two days, in accordance with existing Act 68 guidelines.