

Magellan Behavioral Health of Pennsylvania, Inc. Provider Handbook Supplement for HealthChoices Program Providers for Bucks, Delaware, Lehigh, Montgomery and Northampton Counties Members

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Welcome to Magellan!

Welcome to Magellan Behavioral Health of Pennsylvania, Inc. (Magellan). This Provider Handbook Supplement is designed to give Magellan network providers specific information on the delivery of behavioral health care services to members of the HealthChoices Program in Bucks, Delaware, Lehigh, Montgomery and Northampton counties in Pennsylvania.

This handbook supplements the Magellan Health Services, Inc. National Provider Handbook, addressing policies and procedures specific to the HealthChoices Program for members in Bucks, Delaware, Lehigh, Montgomery and Northampton counties. It should be used in conjunction with the national handbook. When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in this supplement prevail.

It is important that providers review this supplement and follow its procedures when providing services to members in the HealthChoices Program. This supplement provides information from Magellan on authorization procedures, clinical and administrative systems, and documentation requirements. It is to be used with the:

- Magellan Mental Health Guidelines for HealthChoices (*Appendix D*)
- Department of Public Welfare's (DPW) Medical Necessity Criteria (*available at http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002381.pdf*)
- Pennsylvania Client Placement Criteria II for adults (*Appendix E*), and
- Adolescent Patient Placement Criteria of the American Society for Addiction Medicine, Second Edition (ASAM-PPC-2).

Provider Orientation

In addition, we encourage you to review a [provider orientation presentation](#) for the Pennsylvania HealthChoices program that we have posted online (www.MagellanHealth.com/provider, under Pennsylvania HealthChoices in the Plan-Specific area). We developed this orientation in collaboration with our providers. We designed it for providers who are new to Magellan, but it also has proven to be a helpful overview for more tenured providers who want to refresh their knowledge of Magellan's policies and procedures. We also encourage you to visit our Pennsylvania-specific website at www.MagellanoPA.com for additional information on Compliance, Training, and County specific information.

We look forward to working with you in the delivery of quality behavioral health care services to HealthChoices members in Bucks, Delaware, Lehigh, Montgomery and Northampton counties.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our website at www.MagellanHealth.com/provider. You can look up authorizations and verify the status of a claim online at this site, in addition to completing other key provider transactions. We

1. Introduction

have designed our website for you to have easy and quick access to information and answers to questions you may have about Magellan.

You can also reach us at the Magellan Newtown and Lehigh Valley Pennsylvania Care Management Centers at the following numbers:

Bucks and Montgomery County Provider Services Line: 1-877-769-9779

Delaware County Provider Services Line: 1-800-686-1356

Or Fax: 1-866-667-7744

Lehigh and Northampton Counties Provider Services Line: 1-866-780-3368

Members may contact Magellan at:

Bucks County Member Services Line

1-877-769-9784

1-877-769-9785 TDD

Delaware County Member Services Line

1-888-207-2911

1-888-207-2910 TDD

Lehigh County Member Services Line

1-866-238-2311

1-866-238-2313 TDD

Montgomery County Member Services Line

1-877-769-9782

1-877-769-9783 TDD

Northampton County Member Services Line

1-866-238-2312

1-866-780-3367 TDD

2. Network Participation

Contracted providers for the Pennsylvania HealthChoices network are required to maintain active Medical Assistance enrollment for their contracted provider type and specialty at the approved OMHSAS service location. If you anticipate moving a contracted service location, please notify your network coordinator immediately to discuss the appropriate actions that will need to be taken to transition your contract and MA enrollment.

Medical Assistance Enrollment Procedures

- To be eligible to enroll, providers must be licensed and currently registered by the appropriate state agency.
- To enroll, you must complete a provider enrollment application and any applicable addenda documents, dependent on the provider type, prior to serving HealthChoices members.
- Base Medicaid Applications are available at the www.dpw.state.pa.us website address.
- Supplemental Medicaid services must be approved by the Behavioral Health MCO (Magellan) and the appropriate county behavioral health office.
- If you **move** locations, you must complete a *new application* prior to starting services for the HealthChoices population.
- If you are **adding a new service** to an existing location, you must complete a *new application*.
- To **terminate association (fee assignment)** with a provider group by an individual, you must complete a *service location change request* form.
- To **add or terminate participation** with a Provider Eligibility Program (PEP), you must complete a *service location change request* form.
- See the State's website for instructions for the PROMISe™ Provider Service Location Change Request. (Note: this is for a location *change*, not for adding a new service location.) You must complete a new Provider Enrollment Application or New Service Location Application, as applicable, to add a new service location where recipient services are provided.

* Please be sure to follow these procedures to avoid any interruption in reimbursement from Magellan. For assistance with provider types and required applications you should submit, please contact your local Network Coordinator.

Contracting with Magellan

To be eligible for referrals of and reimbursement for covered services rendered to HealthChoices members, each provider, whether an organization, individual practitioner or group practice, must sign a Magellan Provider Participation Agreement agreeing to comply with Magellan's policies, procedures, and guidelines. In the event that you apply for network inclusion and are declined, Magellan will provide written notice of the reason for the decision.

2. Network Participation

Magellan does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Credentialing/Re-Credentialing

Magellan and its providers must adhere to credentialing requirements under the Pennsylvania Department of Health Regulations, Chapter 9, Managed Care Regulations, Subchapter G, Section 9.761 and 9.762. In establishing and maintaining the provider network, Magellan has established written credentialing and re-credentialing criteria for all participating provider types.

Magellan's credentialing policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Magellan utilizes accepted industry standards in the credentialing and re-credentialing processes for professionals. Magellan network providers are required to participate in Magellan's credentialing and re-credentialing processes, and must meet Magellan's credentialing criteria (*Refer to the [Magellan National Provider Handbook, Appendix B](#)*). Some organizations and agencies for the HealthChoices Program are credentialed pursuant to standards specific to the HealthChoices Program.

Hours of Operation

Network providers must offer hours of operation (to Pennsylvania HealthChoices members) that are no less than the hours of operation they offer to commercial members, or comparable to Medicaid fee-for-service if the provider serves only Medicaid members.

Prescribing Practitioner Data Collection Process

Magellan is required by the Office of Mental Health and Substance Abuse Services (OMHSAS) to collect information on providers in our network who prescribe medications. This information is compiled and reported on a quarterly basis to OMHSAS, and the information is shared with the HealthChoices Physical Health Maintenance Organizations (HMOs.) Providers must supply this information to Magellan on a quarterly basis, so that we can provide the most accurate information to OMHSAS and the HMOs. Your reports are due to Magellan by the first day of the month following the close of each quarter (January 1, April 1, July 1 and October 1). If the first of the month falls on a weekend or holiday, the report is due the next business day. This report is site-specific, so include your unique nine-digit Magellan MIS number on all submissions. If you are a provider that has a prescribing practitioner, you will receive an online survey to complete on a quarterly basis. Please submit your responses within the above timelines.

3. The Role of the Provider and Magellan

Authorization Process

*****Emergency Services Do Not Require Preauthorization by Magellan*****

MEMBER REFERRAL AND PREAUTHORIZATION PROCEDURES

Magellan must authorize all levels of care in order for it to be eligible for reimbursement, excluding emergency services, which do not require preauthorization, and excluding services outlined below as “unmanaged.” Magellan is available for authorization and referral information for providers and members 24 hours a day, seven days a week.

Magellan has established toll-free numbers for both members and providers to access care and obtain authorization for services.

Provider Services Toll-Free Numbers

Bucks and Montgomery County Provider Services Line: 1-877-769-9779

Delaware County Provider Services Line: 1-800-686-1356

Lehigh and Northampton Counties Provider Services Line: 1-866-780-3368

Care managers are available 24 hours a day, seven days a week. These numbers can also be used *after business hours* for members in crisis and for providers assisting members.

Magellan utilizes a telephonic interpreter service for those members who call for services but do not speak English. We also supply a list of providers who speak languages other than English (Bucks County *Appendix B1*, Delaware County *Appendix D1*, Lehigh and Northampton Counties *Appendix LN1*, Montgomery County *Appendix M1*). This list of providers is updated periodically and is subject to change. If you have any questions regarding this listing, please call customer service.

Member Toll-free Help Line Numbers

Bucks County Members Services Line

1-877-769-9784

1-877-769-9785 TDD

Delaware County Member Services Line

1-888-207-2911

1-888-207-2910 TDD

Lehigh County Member Services Line

1-866-238-2311

1-866-238-2313 TDD

Montgomery County Member Services Line

1-877-769-9782

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1-877-769-9783 TDD
Northampton County Member Services Line
1-866-238-2312
1-866-780-3367 TDD

ROUTINE OUTPATIENT CARE

Preauthorization

A member, family member, provider or advocate for the member can call the toll-free help line 24 hours a day, seven days a week to obtain a referral to a network provider.

Generally, the requirements for obtaining authorization for services and for reporting the Performance Outcome Management System (POMS) information has been reduced from multiple-page forms to a one-page Treatment Authorization Request Cover Sheet (*Appendix A*) and a two-page Treatment Authorization Request (*Appendix B*). Note that the provider is required to complete the POMS portion of the Treatment Authorization Cover Sheet during the initial visit and submit the form to Magellan for reporting to the State.

Partners in Care Program

The Partners in Care program is a collaboration between community provider agencies and Magellan to manage community-based behavioral health care services. The Partners in Care program replaced the traditional managed care authorization procedures with an active program of on-site program consultation. The Partners in Care programs are unique to each Magellan Care Management Center. Refer to the list below for level of care references. This program consultation model includes a review of management reports, treatment record reviews, case consultations, development of program improvement plans, and other quality management activities designed to improve member outcomes and program efficiencies. The objectives of the Partners in Care program are to:

- 1) Increase program efficiencies by reducing administrative requirements
- 2) Increase the quality and effectiveness of program services, including member outcomes
- 3) Develop and implement a payment system that pays for quality.

For our Partners in Care initiative, we eliminated the authorization requirement for routine outpatient mental health and drug and alcohol services (including individual therapy, group therapy, family therapy, psychiatric evaluation, and medication checks/medication management); Clozaril monitoring and support; methadone maintenance services; Psychiatric Rehabilitation (PRS); case management services and intensive outpatient services for HealthChoices members residing in Bucks, Delaware, and Montgomery counties. We also eliminated the authorization requirement for Community Treatment Team (CTT), Mobile Assessment Stabilization and Treatment Team (MAST), Assertive Community Treatment (ACT), Peer Support and Substance Abuse Partial Hospitalization programs for members in Bucks, Delaware and Montgomery counties. For routine outpatient mental health services (not drug and alcohol), you do still need to submit the POMS information, using the shorter form.

3. The Role of the Provider and Magellan

In Lehigh and Northampton Counties, outpatient providers are required to obtain prior authorization for 75-minute therapy sessions (90808) via telephonic reviews with a Magellan care manager. The Partners In Care initiative in Lehigh and Northampton Counties includes: routine outpatient mental health and drug and alcohol services (including individual therapy, group therapy, family therapy, psychiatric evaluation, and medication checks/ medication management); Clozaril monitoring and support; methadone maintenance services; and intensive outpatient services.

Magellan requires member eligibility verification through the Eligibility Verification System (EVS) and hard copies of the EVS printout are to be maintained in the member's medical record. Eligibility may change throughout a member's treatment history, so it is recommended that providers check eligibility on an ongoing basis.

ALL OTHER LEVELS OF CARE

Preauthorization

Preauthorization of services is required for the following levels of care:

- Psychological testing
- Family-based mental health services
- Behavioral health rehabilitation services for children and adolescents (BHRSCA)
- Multi-systemic therapy (MST)
- Functional family therapy (FFT)
- Family-focused, solution-based services (FFSBS)
- Mental health partial hospitalization
- Acute inpatient
- Residential facilities, including residential treatment facility (RTF), halfway house, drug and alcohol long- and short-term rehabilitation facilities
- Detoxification
- Multidimensional therapeutic foster care (MDTFC)
- Therapeutic foster care (CCR Host Home)
- Psychiatric rehabilitation (PRS) – Lehigh and Northampton only
- Peer support – Lehigh and Northampton only
- Outpatient – 75-minute therapy session (90808) - Lehigh and Northampton only
- Community Treatment Team and Assertive Community Treatment Team – Lehigh and Northampton only
- Intensive Case Management – Lehigh and Northampton only.

Preauthorization of substance abuse partial hospitalization, Community Treatment Team, Mobile Assessment and Stabilization Team, and Program for Assertive Community Treatment is required for Lehigh and Northampton counties members.

Call **the appropriate toll-free number** to obtain authorization for services:

- Bucks and Montgomery Counties Provider Services Line: 1-877-769-9779
- Delaware County Provider Services Line: 1-800-686-1356
- Lehigh and Northampton Counties Provider Services Line: 1-866-780-3368.

3. The Role of the Provider and Magellan

Concurrent Review

1. If you recommend that care be continued beyond the initial authorization, you must present clinical information to the assigned Magellan care manager. For concurrent review of 24-hour levels of care and acute partial hospital care, you must call the care manager; the review will be conducted telephonically. These telephonic reviews are to be conducted on the last authorized day. For concurrent review of non-routine outpatient services, refer to the Clinical Review Process (*Appendix C for Newtown, Appendix LN2 for Lehigh and Northampton counties*) for required documentation. For Lehigh and Northampton counties, concurrent reviews for partial hospitalization are to be submitted by paper on the Treatment Authorization Request form. School-based partials are required to complete telephonic reviews.
2. The member is to be placed in the most appropriate, least restrictive level of care necessary to meet his/her needs. The member's care is to be individualized and recovery/resiliency-focused, and the member is to be included in the treatment planning process. It is expected that all members will receive an integrated assessment to include assessment for co-occurring mental health and substance use issues.
3. The continued need for a level of care is based on medical necessity and is reviewed on a regular basis. Some reviews are based on paper documentation while other reviews are done telephonically.

Refer to Appendix C or Appendix LN2 to determine if a concurrent review is to be conducted telephonically or on paper.

4. Continued stay reviews for mental health treatment are based on the Magellan Mental Health Guidelines for HealthChoices (*Appendix D*) and DPW Medical Necessity Criteria. Continued stay reviews for drug and alcohol treatment are based on the PCPC II Summary for Adults (available at www.dpw.state.pa.us) and the ASAM – PPC-2 for Adolescents. You must complete a PCPC-II Summary Form (*Appendix E*) for all PCPC levels of care and keep it in the member's record.

SECOND OPINION

Each member has the ***right to request a second opinion*** from a qualified health care professional within the network. Magellan ***must provide for a second opinion*** from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member.

EMERGENCY SERVICES

1. HealthChoices members may use ANY hospital or emergency service for emergency care.

3. The Role of the Provider and Magellan

2. Magellan may not deny payment for treatment obtained when a representative of Magellan instructs the member to seek emergency services.
3. Magellan may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
4. Magellan may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention:
 - Would not have placed the health of the individual in serious jeopardy
 - Would not have resulted in serious impairment to bodily functions
 - Would not have resulted in serious dysfunction of any bodily organ or part.
5. Magellan may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's behavioral health managed care organization of the member's screening and treatment within 10 calendar days of presentation for emergency services.
6. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Magellan.
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

RETROSPECTIVE REVIEW

A retrospective review is an evaluation of the medical necessity of treatment services after the treatment has been rendered without preauthorization. Retrospective reviews may be requested under the following circumstances:

1. **Emergency services:** Magellan performs retrospective reviews of emergency services performed without preauthorization. The review considers services performed from the time of the emergency until the member is in a safe setting. For services provided in an emergency situation, Magellan must receive a request for retrospective review within 120 days of the date services were provided. We will conduct the review using the emergency care definition as provided under Pennsylvania Act 68. Magellan may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.11(a) of the definition of emergency medical condition.
2. **HealthChoices eligibility is retroactively initiated:** Magellan will perform a retrospective review when services are provided to a member whose eligibility is retroactively initiated by HealthChoices. We will review services from the date of eligibility through the date that eligibility was initiated or reinstated. For retrospective review requests due to a member's retroactive enrollment in HealthChoices,

3. The Role of the Provider and Magellan

Magellan must receive the retrospective review request within 120 days after the service was performed, or within 120 days after the member's eligibility was established or reasonably discovered. Magellan will consider the services provided from the date that the member became eligible with HealthChoices up until the date that eligibility was established, or reasonably discovered. We will conduct the review using Magellan's Medical Necessity Criteria, or PCPC or ASAM criteria, as appropriate.

3. **Service was not covered by the member's primary insurer:** Magellan will consider the services provided for any dates of service for which the member's primary insurer was believed responsible for coverage. For requests for retrospective review based on the service not being covered by the member's primary insurer, Magellan must receive the **retrospective** review request within 120 days after the service was performed, or within 120 days of the primary insurer's final decision notice. We will conduct the review using Magellan's Medical Necessity Criteria, or PCPC or ASAM criteria, as appropriate.

Magellan will not consider network providers' retrospective review requests that are not submitted within the above timeframes. Magellan will consider, on a case-by-case basis, non-network providers' retrospective review requests that are not submitted within the above timeframes, since these providers may not be familiar with the above requirements.

To request a retrospective review, submit the following to Magellan:

1. A cover letter explaining why treatment was rendered without preauthorization.
2. Sufficient clinical information to establish medical necessity for the services provided. This may include information from the medical record, or PCPC or ASAM evaluations.
3. For retrospective review requests due to a member's retroactive enrollment in HealthChoices, provide evidence that HealthChoices eligibility was checked via Eligibility Verification System (EVS)/Pennsylvania Open Systems Network (POSNet) on each date of service (e.g., EVS printouts created during the period in which services were provided).
4. For requests for retrospective review based on the service not being covered by the member's primary insurer, include a copy of the Explanation of Benefit (EOB) form or final decision letter that demonstrates that the treatment rendered was not covered by the primary insurer.

Submit your request for retrospective review for Bucks, Delaware and Montgomery counties members to:

Magellan Behavioral Health of Pennsylvania, Inc.
105 Terry Drive
Suite 103
Newtown, PA 18940
Attention: Retrospective Review

Or for Lehigh and Northampton counties members to:

Magellan Behavioral Health of Pennsylvania, Inc.

3. The Role of the Provider and Magellan

3897 Adler Place, Building C
Bethlehem, PA 18017
Attn: Retrospective Review

Magellan will review your request and send notification of the decision within 30 days of receipt of all necessary information to render a determination. Requests for retrospective review may result in non-authorization of the requested services based on the above criteria. Appeal rights (provider complaints) are outlined in the decision notice if any portion of the requested services is not authorized.

Discharge Summary

1. A completed Discharge Summary (*Appendix F*) is required within 7 days after a member completes a mental health outpatient treatment episode.
2. For 24-hour levels of care, the care manager reviews the discharge plan telephonically with you on the day of discharge or within 24 hours of discharge.
3. You must notify the assigned Magellan care manager as soon as a treatment episode is complete or within 7 days, especially in the case of Against Medical Advice (AMA) discharge and in administrative discharges as there is a requirement to offer follow-up treatment. When you become aware of a potential AMA discharge, it is your responsibility to offer a discharge appointment to the member that is within the standard of seven calendar days of the date of discharge. Discharge planning is still important, even if the discharge is AMA.

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRSCA)

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRSCA) is a federally mandated program that applies to states that receive federal Medicaid funds. BHRSCA requires preventive health care or immediate remedial care for the prevention, correction or early control of abnormal medical or mental health conditions. BHRSCA is available to HealthChoices-eligible members ages birth to 21 years, based on medical necessity. These services cannot be limited based on amount, duration, or cost of services; nor can members be denied because they fall outside the scope of the benefits package, if the services prescribed are medically necessary.

PREAUTHORIZATION

1. With the exception of those providers participating in the Children's Quality Collaboration (CQC), all BHRSCA treatment requires preauthorization from Magellan.
2. To request BHRSCA services, a parent, legal guardian, legal custodian, child or adolescent (as appropriate), provider, or agency must contact Magellan. If the request is from a parent, legal guardian, legal custodian, child or adolescent, we will make a referral to at least two qualified network providers and authorize a mental health

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assessment/intake. We will provide a referral and authorization for a comprehensive evaluation for the child after the intake is completed.

3. If the service prescribed is BHRSCA, the evaluation must conform to the Child and Adolescent Services System Program (CASSP) Best Practices Guidelines and be performed by a psychiatrist or licensed psychologist.
4. Children who are diagnosed with an autism spectrum disorder also need a functional behavior assessment completed by a behavioral specialist consultant and require pre-authorization by Magellan in Lehigh and Northampton counties.
5. Upon recommendation of BHRSCA by the prescriber, you will need to arrange an Interagency Service Plan Team (ISPT) meeting in coordination with the family, child, and other team members' schedules. You are responsible for informing the team members of the date and time of the ISPT.

The purpose of the ISPT meeting is to:

- Serve as a conduit for coordinating existing services and community supports
- Produce a plan for implementing agreed-upon services and supports
- Coordinate how, when, and where services will be delivered to a child and family.

The ISPT will:

- Develop a plan of care summary
- Identify the type of services, and determine the frequency, intensity, duration and the provider of the services.

Participants at the ISPT are to include the child, if appropriate; the parents/guardian; a Magellan ISPT specialist; a representative of the County (CASSP, Juvenile Probation, Children and Youth, Office of Mental Retardation), when appropriate; and the providers involved in the child's care. If services are being recommended for the school setting, invite educational staff to the ISPT meeting.

- Magellan must be notified of all scheduled ISPT meetings for Bucks, Delaware and Montgomery counties members.
- Magellan will not make a treatment determination decision during the ISPT meetings. It is expected, however, that the prescribing provider advise Magellan of any provider preferences expressed by the parent or guardian.
- The provider serving as team leader at the ISPT meeting will coordinate preparation and submission of the BHRSCA request/packet to Magellan within five business days of the conclusion of the ISPT meeting. The packet must include the following:
 1. BHRS/RTF Treatment Authorization Request Cover Sheet (*Appendix G*)
 2. CQC Treatment Authorization Request for those providers participating in CQC (*Appendix B2 Bucks; Appendix D2 Delaware; Appendix M2 Montgomery*)
 3. MA 97 for Lehigh and Northampton counties

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4. Current psychological/psychiatric evaluation (within 45 days) including the information identified in the Life Domain Format (*Appendix H*)
5. Treatment Plan
6. Plan of Care Summary (*Appendix I*)
7. For Bucks County only, a Bucks County Comprehensive Interagency Service Plan (*See Appendix B3*) or Updated Comprehensive Interagency Service Plan (*Appendix B4*)
8. For Delaware County only, a Delaware County Interagency Team Form (*Appendix D3*)
9. ISPT Sign-In/Concurrence Form (*Appendix J*)
10. Mental Health Services in School Coordinator Form, if services are prescribed for school setting (*Appendix K; not applicable for Lehigh and Northampton counties*).

If the packet is missing any of the above documentation, you must make every effort to obtain the missing information. If information is missing, we will notify you of the missing information by fax within 48 hours. You must submit the required information to Magellan within two business days following notification. You must attach a BHRS/RTF Treatment Authorization Request Cover Sheet (*Appendix G*) to each request/packet.

- Upon receipt of the completed BHRSCA packet, a BHRSCA outpatient care manager will review the request, utilizing the medical necessity criteria approved by DPW.
- We will notify the parent/guardian and provider in writing of any denial or modification of the services requested. We also will notify the parent/guardian and provider in writing of the right to file a grievance of any denial of requested services with Magellan and DPW, and/or request a DPW Fair Hearing.

REAUTHORIZATION

A psychiatric or psychological re-evaluation must occur within 60 days prior to the expiration of the current authorization. Please forward the evaluation to Magellan prior to the Interagency Services Planning Team (ISPT) meeting, if Magellan will be in attendance. The authorization process described in the preauthorization section of this handbook supplement will then be followed. If the member is in two service systems or fewer, an ISPT meeting must occur, at a minimum, once per year. For members in three or more service systems, the ISPT meeting is to occur every 120 days, or upon expiration of the current authorization – whichever comes first. All ISPT meetings must occur within 21 calendar days of the date the evaluation is submitted to Magellan.

You are strongly encouraged to staff cases for which the provider agency performed an evaluation and wrote a prescription for BHRS. In the event that the prescribing agency cannot fulfill its prescription, the case may be referred to Magellan for a staffing search. You must have parental permission before referring a case back to Magellan for staffing.

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For Bucks, Delaware and Montgomery counties members, for an initial referral, the Referral for BHRS Services form (*Appendix L*) must be completed and attached to the packet, indicating that the case will not be staffed by the evaluating agency. We will then refer the case to other provider agencies for staffing. For ongoing cases, the Referral to Magellan for Staffing form needs to be faxed to Magellan when the prescribing agency advises that it cannot staff the prescribed services. This referral **must be resubmitted every two weeks**, if needed, in order for Magellan to continue the staff search. If we do not receive a resubmission within the two-week period, staffing of the case will again be the responsibility of the prescribing agency.

REDUCTION OF SERVICES DURING AN AUTHORIZATION PERIOD

The Interagency/Prescriber Collaboration Form (*Appendix M*) is utilized when the treatment team recommends a reduction in behavioral health rehabilitation services during the current authorization period. The provider completes the form, in collaboration with the family, and obtains the signature of the prescribing psychiatrist or psychologist who wrote the original prescription review. The Interagency/Prescriber Collaboration Form is then sent to the Magellan care manager who reviews it for clinical appropriateness and adjusts the authorization as needed. The authorization will be adjusted only for the remainder of the current authorization period. A new Plan of Care Summary is also required.

Note, the Interagency/Prescriber Collaboration Form cannot be utilized to increase services during an authorization period. If an increase in services is requested, the current process must be followed, and an addendum must be completed and sent to Magellan for review.

Extended Assessment Program – for Montgomery and Delaware Counties

The Extended Assessment program is available to children and families presenting with complex needs that are difficult to fully assess in the context of an office setting. The goal of this service is to determine the most appropriate level and intensity of care needed through a comprehensive evaluation of the child in all life domains. The Extended Assessment will be authorized for 24 hours of service to be provided in the child's home/school/community as needed. Throughout the Extended Assessment there will be ongoing assessment of the child's mental health needs and gathering of necessary data. An evaluation (psychiatric or psychological) will be scheduled, which will prescribe the necessary services based upon all of the information collected through the Extended Assessment. The Extended Assessment staff then assists the family in getting authorizations for these services, and the case remains open until the new services begin. All children seeking BHRS will be considered for referral to the Extended Assessment. This program is not utilized for children and adolescents diagnosed with autism spectrum disorder (see Functional Behavior Assessment).

Functional Behavior Assessment

The functional behavioral assessment (FBA) is a process used to determine the function or the reason(s) for a behavior or behaviors. During the process the team consisting of family, school staff, BHRS staff including a BSC trained in FBA process, as well as the child or adolescent with the behavioral issue if possible, look at the behavior in a systematic way. An

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FBA includes the gathering of information through interviews of those involved and direct observation and data analysis of when the behaviors occur and do not occur. Offer an FBA to all families with a child diagnosed with an autism spectrum disorder upon the initiation of BHRS services and when treatment plan adjustments seem indicated and the team needs additional information to make those changes. All practitioners that render an FBA need to have completed the state training and be registered with Magellan as an “FBA trained” BSC. For more information on upcoming FBA trainings or how to register your staff with Magellan, please contact a Network representative at: **1-877-769-9779**.

Family-Based Services for Children and Adolescents

PREAUTHORIZATION AND REAUTHORIZATION

All requests for family-based services are to be recommended by a psychiatrist or psychologist, and an evaluation must be completed.

Initial requests for family-based services require the Initial Referral for Family Based Services form (*Appendix N*). Fax this form to the BHRSCA outpatient department with the psychiatric/psychological evaluation. For members in Lehigh and Northampton counties, reauthorization requests are to be submitted on the Request for Reauthorization – Family Based Services form (*Appendix LN3*).

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRSCA) - Residential Treatment Facilities and Community Residential Rehabilitation (CRR)

PREAUTHORIZATION

All residential treatment services require preauthorization and may be requested by a parent, provider or agency by contacting Magellan.

When a parent, provider or agency requests residential treatment services, an initial face-to-face psychiatric evaluation for the child or adolescent member is needed. Magellan will assist in the referral process for the evaluation. If the evaluation indicates residential treatment and Magellan is participating in the ISPT meeting, forward the evaluation to Magellan. Additionally, for Lehigh and Northampton counties, forward the evaluation to the CASSP coordinator at the County.

For Bucks, Delaware and Montgomery counties, if residential treatment services are determined to be medically necessary, the requesting provider must call Magellan’s Children’s Unit to arrange an ISPT meeting. The ISPT meeting must occur within 21 days of the evaluation. The provider identified by the Children's Unit is responsible for completing and submitting the request package for Residential Treatment, which must include the following:

- Comprehensive Interagency Service Plan or Updated Comprehensive Interagency Service Plan, for Bucks County

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- Current psychiatric evaluation (within last 30 days for Joint Commission for Accreditation of Health Care Organizations [JCAHO] accredited facilities) or current psychological evaluations (within last 45 days for non-JCAHO accredited facilities)
- Treatment plan
- MA 325 (or MA 97), for Bucks, Lehigh, Northampton and Montgomery counties
- Plan of Care Summary (*Appendix I*); For Bucks County, Bucks County Mental Health/ Mental Retardation signatures must be present
- ISPT sign-in form
- Attachment 8 PA DPW Community-Based Mental Health Services - Alternatives to Residential Mental Health Form (*Appendix O*).

Submit these documents by mail to Magellan, along with a cover letter and BHRS/RTF Treatment Authorization Request Cover Sheet (*Appendix G*). For Lehigh and Northampton counties, fax county requests to 1-866-292-9469.

REAUTHORIZATION

A psychiatric or psychological re-evaluation must occur within 60 days prior to the expiration of the current evaluation. For members in Bucks, Delaware and Montgomery counties, the evaluation is to be forwarded to the Magellan care manager prior to reconvening the next meeting of the ISPT. The ISPT team leader will schedule the next team meeting within 21 days of the evaluation and notify Magellan of the date of the meeting. We may participate in the discussion and explore other services that may help address the family and child's needs; however the Magellan care manager will not make authorization decisions at ISPT meetings. The re-authorization packet needs to be submitted to Magellan within seven calendar days from the date of the meeting.

Act 62

The Pennsylvania Autism Insurance Act (Act 62) went into effect on July 1, 2009. For members who have the Act 62 benefit, HealthChoices is the secondary coverage for designated Behavioral Health Rehabilitation Services (BHRS). Specifically, requests for Mobile Therapy (MT), Behavioral Specialist Consultant (BSC) and Therapeutic Support Staff (TSS) must first be presented to the primary plan for approval. The exclusions to this are school-based BSC and TSS services, as well as Mobile Therapy-Mandatory Meeting which can be submitted directly to Magellan-HealthChoices without an accompanying denial letter from the primary carrier.

For all other services, HealthChoices will not be able to issue approval for BSC, MT, or TSS services without an approval/denial decision by the primary plan. It is required that written documentation of the primary decision be submitted with the HealthChoices request.

Packets must be sent to Magellan for HealthChoices authorization within two weeks of the primary's decision. For additional information on the process for seeking authorization and reimbursement from Magellan-HealthChoices, please reference previous Act 62 communications including Magellan's Retrospective Review Process. You may also contact your designated HealthChoices Network Coordinator.

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For more information on Act 62, please see www.PAInsurance.org.

PA Performance Outcomes Management System (POMS) Reporting

POMS is a tool the Department of Public Welfare (DPW) established to continuously evaluate the effectiveness of the HealthChoices program. POMS allows DPW to identify members with a serious illness or risk of illness; establishes a data baseline for member functioning at registration or entry into the HealthChoices system; updates member data as the course of treatment evolves; and finalizes member data at closure of treatment.

HealthChoices providers are **mandated** by DPW to collect priority population data and submit POMS data on every HealthChoices member receiving mental health services at certain points during treatment. These include the following:

- When you are seeing the member for the first time (initial registration)
- When you are seeing the member for the first time under HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to HealthChoices)
- When you are seeing the member for the last time (either termination from your care if the member is moving to another provider, or closure if the member is ending all mental health treatment)
- Whenever there is a change in **any** POMS element.

POMS registration, change and discharge are expected for all Mental Health Service providers. All levels of Mental Health Service including Inpatient, Residential and Community Based are required to follow the standards of the submission of POMS information. Providers do not have to register members receiving D&A ONLY levels of care.

Methods of Submission:

- Online product available through www.MagellanHealth.com/provider (Please contact your network coordinator if you need assistance)*
- POMS Form fax or mailed to Magellan of Pennsylvania

*Magellan now offers electronic POMS submission via secured website access. For information and technical assistance on electronic POMS submission, please contact your local Network Coordinator or call: **1-877-769-9779**.

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Court-Ordered Evaluation/Treatment

1. For a court-ordered evaluation or treatment, Magellan may authorize **up to**:
 - Five days for an initial inpatient stay for any Section 302 commitment
 - 20 days for a Section 303 court order
 - 90 days for a Section 304 court order
 - 180 days for a Section 305 court order.
2. All Section 306 orders are authorized according to the County's involuntary commitment procedures.
3. When a commitment is changed to voluntary status after a 302, Magellan will continue to conduct concurrent reviews and monitor progress.
4. Court-ordered treatments and evaluations will be considered upon receipt of notification from the provider. Other than an involuntary commitment (302), all court-ordered treatment must meet Medical Necessity Criteria, the Magellan Mental Health Guidelines for HealthChoices, in order to be authorized. Utilization reviews will be conducted for care monitoring and aftercare planning.

Note that preauthorization requirements apply to court-ordered treatment.

Electroconvulsive Therapy (ECT)

1. ECT treatment requires preauthorization by Magellan's medical director.
2. In the event that emergency ECT is required, immediate follow-up with Magellan's medical director is required for treatment authorization.
3. Most ECT episodes will begin in an inpatient setting; however, when clinically appropriate, movement to outpatient status is to occur.
4. To request authorization for ECT, you must complete the ECT Request Form (*Appendix P*), and mail or fax the form to the attention of the medical director at the address for the Magellan Newtown Care Management Center. The Magellan medical director and/or his/her designee will review requests for authorization of ECT treatment and make a determination.

Psychiatric Observation Periods

An inpatient observation period may be part of a level-of-care assessment. An observation period is used to gather additional data, to make a level-of-care recommendation and complete the disposition planning and arrangements for the member. All 23-hour observation requests must be pre-approved by Magellan.

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Twenty-three-hour observations are considered in situations including, but not limited to:

- A member is in an altered state (e.g., intoxicated, agitated) that is likely to significantly change after a period of rest or observation.
- A member is in an altered state (e.g., intoxicated, drugged) in which an evaluation cannot be completed and in which it is not prudent for the member to be placed in a lower level of care.
- The member's clinical needs are unclear due to lack of information. Further evaluation is needed to determine the member's needs.

Psychological Testing

Preauthorization is required for all psychological testing.

Any provider who wishes to refer a member for psychological testing must complete the Request for Psychological Testing Preauthorization Form (*Appendix Q*) and fax the completed form to Magellan at 1-866-667-7744 for Bucks, Delaware and Montgomery counties; and to 1-866-292-9469 for Lehigh and Northampton counties.

A licensed psychologist or psychiatrist will review the request.

Intensive Case Management (ICM)

Intensive Case Management (ICM) services are provided for adults with a serious and persistent mental illness along with a Global Assessment of Functioning (GAF) of 40 or below. ICM services also are provided for children who are multi-system involved. Maximum caseloads for ICM are 30 for adults and 15 for children. ICM must be available 24 hours a day, seven days a week. Minimum member contact is every 14 days.

Resource Coordination (RC)

Resource Coordination (RC) services are provided for adults with a serious and persistent mental illness and a GAF of 60 or below. RC services also are provided for children with DSM-IV diagnosis and a GAF of 60 or below. Caseloads range from 30 to 75 for adult members and 20 to 40 for children. Contact with the member must occur once per month. Face-to-face contact must occur at least once every two months for adults, and at least once a month for children.

Blended Case Management (BCM)

The Blended Case Management (BCM) model offers an opportunity to change how case management services are delivered to members. The distinction between ICM and RC is eliminated by allowing the case manager to adjust the level of intensity of services to the member. This improves continuity of care for the member and service provider. In July 2003, a pilot project was initiated by the Office of Mental Health and Substance Abuse Services (OMHSAS) to test the BCM model. The pilot found that consumers were satisfied

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with the service and that most individuals remained stable or improved as determined by scores on the Environmental Matrix. OMHSAS has encouraged County MH/MR programs and their case management providers to implement BCM. Magellan, in collaboration with its County partners and providers, are working together to pilot and implement this BCM model.

Intensive Support Network – Bucks and Delaware Counties IMPACT – Lehigh and Northampton Counties

ADULT INTENSIVE SUPPORT NETWORK

Magellan and its partner Counties have initiated an Intensive Support Network (ISN) program for adults, in which a plan is developed to organize treatment resources to better meet the needs of members with multiple needs. The purpose of the program is to identify and coordinate treatment services and other community supports so the member can have continuity of care, better address recovery goals, strive to achieve increased independence, and have better community integration. These goals are measured by increased community tenure of no hospitalizations for at least 90 days. Although the criteria for admission into ISN focuses mainly on the readmission of people with mental health disorders, people with co-occurring mental health and substance use disorders, and people with mental health and mental retardation, also are included.

The ISN program is designed for adults who meet the following criteria:

- Members with two or more admissions to an acute inpatient or residential level of treatment within 60 days with a diagnosis of schizophrenia or bipolar disorder
- Pregnant women who abuse substances
- Other, customer-specific criteria (see appendices).

Magellan and/or the County may identify additional members for consideration.

See *Appendix BD1* for Bucks and Delaware counties' ISN Program Description and customer-specific criteria. See *Appendix LN4* for specific criteria for the Lehigh and Northampton counties IMPACT program.

Components of the program include:

- More intensive care management involvement
- Development of a support plan and a crisis plan
- Intensive aftercare planning and follow-up
- Frequent interactions with the intensive case manager, resource coordinator or identified team leader
- Treatment Planning Conferences

The ISN Treatment Planning Conference is an important component of the program. The conferences allow all of those involved in the member's care to meet face-to-face to discuss the member's history and current treatment, and to brainstorm, along with the member, for their next steps toward recovery. Treatment

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providers have the opportunity to share information, and the member has the opportunity to openly voice his/her goals, treatment choices and preferences.

DELAWARE COUNTY CHILDREN'S INTENSIVE SUPPORT NETWORK

The Children's ISN program is designed to coordinate outpatient services and other community supports to enable the member to achieve increased functioning and community tenure in accordance with Child and Adolescent Services System Program (CASSP) principles.

The Delaware County ISN program is designed for children and adolescents who meet the following criteria:

- Members with two or more admissions to an acute inpatient or residential level of treatment within 60 days with a diagnosis of schizophrenia or bipolar disorder
- Children age 12 and under who are hospitalized
- Other, customer-specific criteria (see appendices).

See *Appendix BD1* for Delaware County ISN Program Description and customer-specific criteria. Face-to-face coordination and planning occurs either through an ISPT meeting or in a Treatment Planning Conference.

Access Standards and Initial Authorization Determination Timelines

Level of Urgency	Time Frame for Provider to Conduct Face-to-face Assessment	Time Frame for Magellan to Make a Determination
Emergent	Within 1 hour	Immediately
Urgent	Within 24 hours	Within 1 hour
Routine	Within 5 business days	Within 24 hours

Magellan requires members discharged from a 24-hour level of care to be seen by the aftercare provider within five business days of discharge.

You must notify Magellan of any circumstances that may affect your ability to meet required time/access standards. The Provider Access Form (*Appendix R*) must be faxed to the attention of the Network Department within one business day of your decrease in availability.

Clinical Assessments and Care Reviews

MENTAL HEALTH AND SUBSTANCE ABUSE

Magellan follows the Guidelines for Best Practice published by the Pennsylvania Department of Public Welfare, Office of Mental Health, Bureau of Children's Services, Comprehensive Assessment Components and Comprehensive Assessment Components for Priority Populations. Magellan also emphasizes strengths-based and co-occurring

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assessments. The information below is a general guide to some of the clinical information that is reviewed during the preauthorization and concurrent review processes:

- Current behaviors
- Precipitants to admission, “why now”
- Mental status and five-axis diagnosis
- Psychiatric and substance abuse treatment history and response
- Medical factors
- Medications, side effects, allergies, labs
- Risk factors related to functional impairment and dangerousness
- Treatment planning
- Discharge planning
- Barriers to member’s improvement
- Family and social supports
- Education and treatment when co-occurring issues are present
- Consideration of alternate levels of care.

Refer to the *Confidentiality* section of this handbook supplement (under Section 4) for information on limits of disclosure with substance abuse cases.

Drug and alcohol reviews include a discussion of ASAM and PCPC dimensions as outlined below:

1. Dimension 1 – Acute Intoxication or Withdrawal
2. Dimension 2 – Biomedical Conditions
3. Dimension 3 – Emotional/Behavioral (including assessment of mental health status)
4. Dimension 4 – Treatment Acceptance/Resistance (not required for detox levels)
5. Dimension 5 – Relapse Potential (not required for detox levels)
6. Dimension 6 – Recovery Environment (not required for detox levels).

Treatment Planning

FOCUSED TREATMENT

Magellan supports a targeted and focused approach to member care. Clinical and support needs are to be identified using behavioral descriptions that explain the reason a member requires treatment. All treatment is expected to have a clear direction toward one or more goals. Goals are to be concrete, specific, realistic, measurable, stage-of-change specific and based on the strengths of the member. Providers are encouraged to include recovery principles in the treatment planning process.

Magellan requires that treatment adhere to all applicable ethical standards.

DISCHARGE PLANNING

Discharge planning and aftercare monitoring are to be based on Child and Adolescent Services System Program (CASSP) and Community Support Program (CSP) intersystem

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guidelines, and Treatment Principles for Alcoholism and Other Drug Dependencies (AODD). These principles are key components in the successful treatment of members. Our care managers will work with you to coordinate discharge planning from all levels of care to continue treatment, care coordination and member satisfaction. We utilize the full continuum of care so that the appropriate, least-restrictive level of care is obtained. Effective discharge planning begins at admission.

Recovery and Resiliency

Magellan values individuals and families as partners in treatment, and believes that:

- All individuals and families have strengths
- Hope is encouraged when someone really listens
- Empowering is better than controlling.

Magellan is committed to the principles of recovery and resiliency for all members, and believes that a high level of functioning within the community is possible for all individuals, provided they have access to appropriate services and supports. We are committed to working together with providers, members, families and counties to achieve this reality. Our philosophy of care also recognizes that full participation of the member and/or family member in the treatment process maximizes the likelihood of a successful recovery intervention. Magellan care managers work together with providers and members to address both treatment and environmental factors impacting recovery.

Magellan supports providers in ensuring that treatment for all individuals is recovery- and/or resiliency-oriented, stage-of-change specific, strengths-based, and member/family-centered. For children, treatment will be family-focused, and for adults, will involve significant others to the extent desired by the member. Community-based treatment, using natural supports and extensive community support, will be standard. Additionally, treatment will be multi-systemic in nature; culturally competent; flexible and accountable; coordinated; provided in the most appropriate, least-restrictive and least-intrusive setting; evidence-based, and reflective of best practices. Magellan supports provider's efforts to foster resilience in children and their families through the promotion of protective factors and reduction of risk factors.

CASSP Principles

CHILD AND ADOLESCENT SERVICES SYSTEM PROGRAM (CASSP) PRINCIPLES

CASSP principles must be reflected in the care and coordination of treatment for children and adolescents. These principles are to be integrated into the interventions and practice, and evidenced by active participation of the member and family in treatment.

Child-Centered services are designed to meet the individual needs of the child. These services consider the child's family and community environment, are developmentally appropriate, child-specific, and build on the strengths of the child and family to meet the biopsychosocial physical needs of the child.

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Family-Focused services recognize that the family is the primary support system for the child. The family participates fully in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents, and other adults who are committed to the child.

Community-Based services (whenever possible) are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

Multi-System services draw on every child-serving system involved in the child's life. Representatives from all of these systems and the family collaborate to define the goals for the child, develop a service plan, including the necessary resources required to implement the plan, provide appropriate support to the child and family, and evaluate progress.

Culturally Competent services are provided by individuals with the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practice characteristics of the culture of a particular group of people.

Least-Restrictive/Least-Intrusive services take place in settings that are the most appropriate and natural for the child and family. They also are the least-restrictive and intrusive services available to meet the needs of the child and family.

Principles of Cultural Competence

1. The system is strengths-based, family friendly, culturally sensitive and clinically sound. Behavioral health care is provided by valuing and recognizing the role each person's culture plays in their health and well-being.
2. The system recognizes that ethnically diverse populations have unique needs that may present a unique set of mental health issues to which the system should be equipped to respond.
3. Individuals and families may make different choices based on cultural forces; these choices should be considered.
4. Inherent in cross-cultural interactions are dynamics that should be acknowledged, adjusted to, and accepted.
5. The system should sanction and, in some cases, mandate the incorporation of cultural knowledge into practice and policy making.
6. Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community (e.g., neighborhoods, churches, spiritual leaders, healers, etc.).

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7. Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture.
8. Community control of service delivery is essential to the development of effective services. This occurs through minority participation on boards of directors, administrative teams, program planning and evaluation committees.
9. An agency's staffing should reflect the makeup of the potential member population, adjusted for the degree of community need, and make every effort to deliver effective services.
10. Culturally competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the member population.

See *Appendix S* for a Cultural Competence Implementation Audit Tool.

Community Support Program in Pennsylvania

The Community Support Program (CSP) in Pennsylvania recognizes that people with mental illnesses are to be treated with dignity and respect. They have the same needs, rights, and responsibilities as other citizens and are to have access to the same opportunities, support, and mental health services.

In addition to traditional mental health services, services such as housing, vocational training and employment, income maintenance, medical care, and rehabilitation are essential to help people live successfully in the community.

Providers are expected to demonstrate that the CSP principles are incorporated into all aspects of professional practice. Community support services are to:

- Be based on the needs of the individual
- Empower members by encouraging them to have control over their lives by setting their own goals, deciding what services they will receive, and helping to plan and implement the delivery of services
- Be culturally competent, and available and acceptable to racial, ethnic, gender, and religious groups
- Be flexible enough for members to move in and out of the system, as needed
- Focus on strengths, and help members maintain a sense of identity, self-esteem, and dignity
- Assist members in making a successful transition from inpatient treatment to the community through natural supports in all aspects of living, working, learning, and leisure
- Assist members in developing their potential for growth and movement toward independence and recovery

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- Meet the special needs of members with mental illness who also are affected by old age, substance abuse addiction, physical disability, mental retardation, homelessness, and/or involvement in the criminal justice system
- Be accountable to the members who access their services – members and families should help plan, implement, deliver, monitor, and evaluate services
- Be coordinated through mandated linkages with members, families, and at the local and state levels – continuity of care for members discharged from hospitals to community-based services should be confirmed.

Bureau of Drug and Alcohol Programs Principles of Effective Treatment

PHILOSOPHY

Substance abuse and dependence are primary diseases, not symptoms of other underlying conditions. Substance use disorders can be diagnosed, are responsive to treatment and are complex behavioral disabilities usually having chronic medical, social and psychological components, which result in multiple negative consequences. Substance abuse and dependence-related problems affect not only the dependent individual, but other family members, particularly children. Denial is a central characteristic or symptom of substance abuse and dependence that complicates an individual's ability to acknowledge a problem.

PRINCIPLES

- **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
- **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace and society. Treatment interventions should be specific to the member's stage of change.
- **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must not only address the individual's drug use but any associated medical, psychological, social, vocational and legal problems.
- **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, persons presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder. Both disorders are considered primary.
- **Treatment should be member-specific** and guided by an individualized treatment plan based upon a face-to-face comprehensive biopsychosocial evaluation of the member and, when possible, a comprehensive evaluation of the family as well.

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- **Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, members address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.
- **Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and Double Trouble are essential adjuncts to the treatment process.** Attendance should be encouraged when appropriate.
- **Medications are an important element of treatment for many patients,** especially when combined with counseling and other behavioral therapies. Methadone and buprenorphine are effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone also is an effective medication for some patients addicted to opiates and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.
- **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases,** and counseling to help members modify or change behaviors that place themselves or others at risk of infection. Counseling can help members avoid high-risk behavior. Counseling also can help infected individuals manage their illness.
- **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that, for most patients, the threshold of significant improvement is reached at about three months of treatment. Treatment may include residential care followed by intensive outpatient care, or partial treatment followed by outpatient care, or any movement through the level-of-care continuum. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
- **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining long-term abstinence.
- **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates, and the success of drug treatment interventions.

3. The Role of the Provider and Magellan

- **Persons recovering from alcoholism or other drug dependencies are viewed as important resources in the statewide service system.** As representatives of the recovering community, persons in recovery serve as an inspiration to the addicted person. Practicing professionals provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for patient advocacy.

Mental Health Advance Directives

Pennsylvania Act 194 became effective on January 28, 2005, and allows for Mental Health Advance Directives. All Magellan providers are required to comply with Act 194, as stated in the provider contract.

Mental Health Advance Directives allow members to plan for their future mental health care in the event they can no longer make mental health care decisions on their own as a result of illness. This can be accomplished by creating a Mental Health Declaration or by appointing a Mental Health Power of Attorney, or both.

A Mental Health Declaration is a set of written instructions informing a provider of the member's:

- Treatment preference
- Treatment location preference
- Any specific treatment instructions.

A Mental Health Power of Attorney is a document that allows a member to name a person, in writing, to make mental health care decisions for the member if he or she is unable to make them on his or her own. The Mental Health Power of Attorney will make decisions about the member's mental health care based on the member's written instructions.

If a member would like to have a Mental Health Declaration or a Mental Health Power of Attorney, or both, they can contact an advocacy organization such as the Mental Health Association in Pennsylvania at 1-866-578-3659 or 717-346-0549; email: info@mhapa.org. They will provide the member with the forms and answer any questions. Encourage members to share their written Mental Health Advance Directives with you so that you can follow them.

If a member believes that their provider has not handled their Mental Health Advance Directives properly, or if they have any other complaints about Mental Health Advance Directives, members can follow the standard complaint process in their Member Handbook.

Contact with PCPs and Other Providers

HealthChoices members do not need referrals from their primary care physicians (PCPs) to receive mental health and drug and alcohol treatment; however, we do accept referrals from PCPs.

3. The Role of the Provider and Magellan

As a behavioral health provider, you are expected to coordinate treatment with the member's PCP and respective HMO to maximize the integration, quality-of-care and cost-effectiveness of the overall health care services provided. (See the *Pennsylvania Medicaid MCO Directory* at www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002108.pdf.)

After the member signs the Authorization to Use or Disclose Protected Health Information (PHI) (*Appendix T*), you are to notify the member's PCP of the initiation and progress of behavioral health care services by providing the following:

- Progress updates through the PCP Communication Form (*Appendix U*)
- A copy of the completed Discharge Summary.

Each HealthChoices HMO maintains a "special needs" division to coordinate and case manage medical and behavioral care. In addition, HealthChoices HMOs also maintain a special prenatal care case management program to encourage treatment compliance.

For members who have identified themselves as HIV-positive, you should coordinate treatment with the PCP and other health officials involved in the member's care in accordance with applicable Pennsylvania confidentiality law.

You also are expected to coordinate care with other behavioral health providers involved in the member's care and to actively participate in interagency team meetings.

Coordination of Care with Collateral Agencies/Interagency Team Meetings for Adults

Behavioral health providers or other service agencies are expected to coordinate care with other providers or other agencies involved in the member's care, including, but not limited to, the Office of Probation and Parole, Office of Mental Retardation, Area Agency on Aging, and Children and Youth Services.

Laboratory Services

Magellan does not require preauthorization for most laboratory services. However, you must refer members to an approved network laboratory for services as needed.

Transportation Services

Emergency transportation services are the responsibility of the member's HMO. When a member is in need of emergency ambulance transportation and Magellan is notified of the emergent need, we will follow procedures set forth by the member's HMO to arrange for the service. The Special Needs Unit (SNU) of the applicable PHMCO will facilitate the ambulance search.

3. The Role of the Provider and Magellan

Requests for non-emergency transportation can be made to the following agencies. For administrative issues with non-emergency transportation, call Magellan and we will assist the member.

Bucks County Transport:

Lower Bucks	1-215-741-0866
Central Bucks	1-215-343-4140
Upper Bucks	1-215-249-9626

Delaware County Transport:

Community Transit	1-610-490-3977
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Lehigh & Northampton Counties Transport

MA Transportation	1-610-432-3200
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Montgomery County Transport:

Transnet	1-215-542-7433
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When Magellan determines that there is a need to transport a member from one facility to another, we will follow the procedures set forth by the member's HMO to arrange the transportation.

Pharmacy Services

With the exception of methadone, most pharmacy services are covered by the member's physical health HMO, including drugs prescribed by Magellan network physicians. Magellan is responsible for methadone coverage.

As HMO plans vary, you will need to be knowledgeable about the member's prescription plan. **Members are eligible for up to 72 hours of medication** if the medication is not on the Formulary. This procedure is designed to provide the member the opportunity to appeal a denial for the medication. Encourage members to tell you if a prescription has been denied so the appropriate action can be taken. To appeal pharmacy denials, members and providers are to follow the grievance procedures outlined by the designated HMO. You may use the Medication Problem Report (*Appendix V*) to report problems with obtaining medications for members, **after** an attempt is made to resolve the issue with the HMO.

You can obtain specific formulary information through the HMO websites at:

- AmeriChoice – www.AmeriChoice.com
- AmeriHealth Mercy – www.amerihealthmercyhp.com
- Gateway Health Plan – www.gatewayhealthplan.com
- Health Partners – www.HealthPart.com
- Keystone Mercy Health Plan – www.kmhp.com
- Unison Health Plan – www.unisonhealthplan.com

You can reach the HMO Special Needs Units at:

- AmeriChoice – 1-215- 832-4571 (Special Needs Hotline)
- AmeriHealth Mercy – 1-888-991-7200

3. The Role of the Provider and Magellan

Gateway Health Plan – 1-800-642-3550
Health Partners – 1-215-991-4370 (Special Needs Hotline)
Keystone Mercy Health Plan – 1-800-573-4100
Unison Health Plan – 1-877-844-8844

Transfer of Care

When a member requests a transfer from one provider to another, he or she will be encouraged to discuss this request and the reason for it with his or her current provider. The care manager will inform a treating provider by telephone prior to transferring the member to another provider.

Member Rights and Responsibilities

You are expected to share with members their rights and responsibilities (below). Evidence that you have shared this information with members is expected to be in their record. Rights and Responsibilities also need to be posted in a visible area within your office.

Members have the right to get the care they need. They should expect to:

- Be treated with respect and with due consideration for dignity and privacy
- Receive fair treatment regardless of their race, religion, gender, ethnicity, age, disability, or source of payment
- Have their treatment and other member information kept private; only by law may records be released without member permission
- Have easy access to care in a timely fashion
- Share in developing their plan of care
- Receive information in a language they can understand
- Have a clear explanation of their condition
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand
- Participate in decisions regarding his or her health care, including the right to refuse treatment
- Get information about Magellan's services and role in the treatment process
- Know the clinical guidelines used in providing and managing their care
- Have access to information about provider work history and training
- Be able to provide input on Magellan policies and services
- Know about advocacy and community groups and prevention services
- Freely file a complaint, grievance or appeal and to learn how to do so
- Know about laws that relate to their rights and responsibilities

3. The Role of the Provider and Magellan

- Know of their rights and responsibilities in the treatment process
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request that their medical records be amended or corrected
- Freely exercise their rights, and the exercising of those rights will not adversely affect the way Magellan and our providers treat the member.

Members also have responsibilities to Magellan staff and their providers. They are as follows:

- Treat those giving them care with respect
- Help develop their treatment plan
- Take an active role in their care and follow their care plan
- Keep appointments and be on time, or call at least 24 hours before an appointment to cancel
- Seek care before they are in a crisis situation
- Ask his/her provider questions, so that he/she understands the care and instructions given
- Take any prescribed medicine as instructed
- Follow the complaint and grievance process if they are unhappy with their care, provider, or the Magellan program.

Reporting Requirements Under the Child Protective Service Law

Magellan providers are mandated reporters under the Pennsylvania Child Protective Services Law. Therefore, you are required to contact the Child Abuse Hotline (**1-800-932-0313**) and the County's Children and Youth Agency when members under age 18 are suspected of being subjected to child abuse or neglect pursuant to Title 23 Pa. Chapter 63 Section 6311.

Reporting Requirements for Elder Abuse

Magellan providers also are required to report suspected abuse, neglect, exploitation and/or abandonment of County residents who are age 60 or older. If you suspect elder abuse, you are required to contact the following agencies:

Bucks County Area Agency on Aging Protective Services - 1-800-243-3767

Delaware County Office of Services for the Aging - 1-800-416-4504

Lehigh County Aging and Adult Services - 1-610-782-3200 or 1-610-782-3034

Montgomery County Elder Abuse Hotline - 1-800-734-2020

Northampton County Aging and Adult Services - 1-610-252-9060.

3. The Role of the Provider and Magellan

When abuse is sexual, results in serious physical or bodily harm, or when a death is suspicious, call the above agencies, the local police or the Pennsylvania Department of Aging at 717-783-1550.

Filing a Provider Complaint

PROVIDER COMPLAINT PROCEDURE

Magellan provides a formal process for providers to express a complaint related to service provided by Magellan, to have their concerns or complaints investigated and resolved, and to receive a timely and professional response to those concerns.

Provider Complaint Definition:

A provider complaint is defined as any oral or written communication made by a provider to a Magellan employee expressing dissatisfaction with any aspect of Magellan operations, activities, or staff behavior. If the concern is on behalf of a specific member, it will be classified as a “member complaint” and the member complaint policy will be followed.

Issues of suspected fraud and abuse that involve payments made by Magellan or services authorized by Magellan are to be reported to Magellan’s Quality Improvement/Complaints and Grievance department.

To register a complaint, call the Provider Services Line at **1-877-769-9779** for Bucks, Delaware and Montgomery counties providers, and **1-866-780-3368** for Lehigh and Northampton counties providers. Ask to speak with a customer service representative, or you may submit your complaint in writing to:

Magellan Behavioral Health of Pennsylvania, Inc. Attn: Complaints and Grievances
105 Terry Drive, Suite 103
Newtown, PA 18940
or

Magellan Behavioral Health of Pennsylvania, Inc. Attn: Complaints Department
3897 Adler Place, Building C
Bethlehem, PA 18017

The provider complaint process has two levels:

FIRST LEVEL

A Magellan staff member documents that a complaint has been received. The complaint is investigated and resolved within 30 calendar days of receipt. A written response is mailed to the provider within five business days of resolution. The response may include the results of the investigation, action(s) taken, and recommendations for additional actions or follow-up, if needed.

3. The Role of the Provider and Magellan

All complaints involving potential harm to members or others are directed to the Magellan Care Management Center's clinical officer or medical director, or their respective designee, to determine an immediate course of action.

SECOND LEVEL

If the provider is unsatisfied with the first-level resolution, he or she may request a second-level hearing. The provider is notified in the first-level resolution letter of the right to request a second-level hearing. To request a second-level hearing, the provider must file a second-level complaint within 45 days of receiving Magellan's first-level decision.

The second-level complaint review will be conducted by the County through which the provider is contracted. The second-level complaint committee will include, at minimum, three persons – at least one County staff member, a Magellan representative, and, at the County's discretion, a representative from a network provider entity. No representative from Magellan previously involved with the issue will serve on the second-level complaint committee.

The County will notify the provider of the right to appear before the second-level complaint committee. The provider may have other representation to assist in the presentation of the complaint.

The second-level complaint committee must conduct the review within 30 days of receipt of the second-level complaint. We will send the provider the results of the second-level complaint decision in writing within five business days following the second-level complaint review. The decision of the second-level complaint committee is final.

Member Complaints and Grievances

The following Sections of this Provider Handbook Supplement on Member Complaints and Grievances processes are taken from the HealthChoices Member Handbook and are included here for your information.

Complaints

What is a complaint?

A complaint is when you tell us you are unhappy with Magellan or your provider or you do not agree with a decision made by Magellan.

These are some examples of a complaint:

- *You are unhappy with the care you are getting.*
- *You are unhappy that you cannot get the service you want because it is not a covered service.*
- *You are unhappy that you have not received services that you have been approved to get. (If a treatment plan is approved, services must be provided according to the prescribed treatment plan. See **Access Standards** in this section for delivery of care requirements.)*

3. The Role of the Provider and Magellan

What should I do if I have a complaint?

To file a complaint, you can call Magellan at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311 for Lehigh County members, 1-877-769-9782 for Montgomery County members, and 1-866-238-2312 for Northampton County members;

Or write down your complaint and send it to:

For Bucks, Delaware, and Montgomery County:

Magellan Behavioral Health of Pennsylvania, Inc.
P.O. Box 1261
Newtown, PA 18940-0873
Attention: Complaints and Grievances

Or

For Lehigh or Northampton County:
Magellan Behavioral Health of Pennsylvania, Inc.
3897 Adler Pl., Building C
Bethlehem, PA 18017

This is called a **first-level** complaint.

When should I file a first-level complaint?

You must file a complaint **within 45 days of getting a letter** telling you that:

- You cannot get a service you want because it is not a covered service.
- Magellan will not pay a provider for a service you received.
- Magellan did not decide a first-level complaint or grievance within 30 days of when you filed it.

You must file a complaint **within 45 days of the date you should have received a service**, if your provider did not give you the service. You may file all other complaints at any time.

What happens after I file a first-level complaint?

Magellan will send you a letter to let you know we received your complaint. The letter will tell you about the first-level complaint process.

You may ask Magellan to see any information they have about your complaint. You may also send Magellan any information that may help with your complaint.

If you filed a complaint because of one of the reasons listed below, you can be included in the first-level complaint review. You must call Magellan within 10 days of the date on the letter to tell us that you want to be included:

- You are unhappy that you have not received services that you have been approved to get.
- You are unhappy that you cannot get a service you want because it is not a covered service.
- You are unhappy that Magellan will not pay a provider for a service you received.

3. The Role of the Provider and Magellan

- *You are unhappy that a decision was not made about your first-level complaint or grievance within 30 days.*

You can come to our offices or be included by phone. You do not have to attend if you do not want to. If you do not attend, it will not affect our decision.

One or more Magellan staff, who has not been involved in the issue you filed your complaint about, will make a decision on your complaint. Your complaint will be decided no more than 30 days after we received it.

A letter will be mailed to you no more than five business days after Magellan makes its decision. This letter will tell you the reason(s) for the decision. It will also tell you how to file a second-level complaint, if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are not covered, the services will continue until a decision is made.

Second-level Complaint

What if I do not like the decision?

*If you are not happy with the first-level complaint decision, you may file a **second-level** complaint with Magellan.*

When should I file a second-level complaint?

You must file your second-level complaint within 45 days of the date you get the first level complaint decision letter. Use the same address or phone number you used to file your first-level complaint.

What happens after I file a second-level complaint?

Magellan will send you a letter to let you know we received your complaint. The letter will tell you about the second-level complaint process.

You may ask Magellan to see any information they have about your complaint. You may also send information that may help with your complaint.

You can come to a meeting of the second-level complaint committee or be included by phone. The county in which the member is eligible will conduct the second-level hearing. You will be notified in writing once the time and place have been scheduled. You can attend the hearing in person or participate by telephone. If you do not attend or participate, it will not affect the decision.

The second-level complaint review committee will consist of representatives from the county, a representative from Magellan (for Bucks, Delaware, Lehigh and Northampton counties), and either a HealthChoices member who has received behavioral health services, or the parent of a member who has received services. The members of the committee will not have been involved in the issue you filed your complaint about. The committee will make a decision within 30 days from the date Magellan received your second-level complaint.

3. The Role of the Provider and Magellan

A letter will be mailed to you within five business days after the committee makes its decision. This letter will tell you the reason for the decision. It will also tell you how to ask for an external complaint review if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a second-level complaint that is hand-delivered or postmarked within 10 days of the date on the first-level complaint decision letter (notice), the services will continue until a decision is made.

External Complaint Review (AS SET FORTH IN THE MEMBER HANDBOOK FOR INFORMATIONAL PURPOSES.)

What if I still don't like the decision?

If you are not happy with Magellan's second-level complaint decision, you may ask for a review of your complaint by the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Magellan's policies and procedures.

*You must ask for an external review within 15 days of the date you receive the second-level complaint decision letter. **If you ask, the Department of Health will help you put your complaint in writing.***

You must send your request for external review in writing to either:

<i>Pennsylvania Department of Health Division of Managed Care Attention: Complaint Appeals 912 Health & Welfare Building Harrisburg, PA 17120 1-888-466-2787</i>	<i>Pennsylvania Insurance Department Bureau of Consumer Services 1321 Strawberry Square Harrisburg, Pennsylvania 17120 1-877-881-6388</i>
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If you send your request for external review to the wrong department, it will be sent to the correct department. The Department of Health or the Insurance Department will get your file from Magellan. You may also send them any other information that may help with the external review of your complaint. You may be represented by an attorney or another person during the external review. A decision letter will be sent to you after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services will continue until a decision is made.

3. The Role of the Provider and Magellan

Grievances

What is a grievance?

A grievance is what you file when you do not agree with Magellan's decision that a service you or your provider asked for is not medically necessary. You can file a grievance if Magellan does one of the following:

- *Denies a service,*
- *Approves less than what was asked for, or*
- *Approves a different service from the one that was requested.*

First-level Grievance

What should I do if I have a grievance?

*If Magellan does not completely approve a service for you, we will tell you in a letter. The letter will tell you how to file a grievance. **You have 45 days from the date you receive this letter to file a grievance.***

To file a grievance, you can call Magellan at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311 for Lehigh County members, 1-877-769-9782 for Montgomery County members, and 1-866-238-2312 for Northampton County members;

Or

Write down your grievance and send it to

For Bucks, Delaware, and Montgomery County:

*Magellan Behavioral Health of Pennsylvania, Inc.
P.O. Box 1261
Nentown, PA 18940-0873
Attention: Complaints and Grievances*

Or

For Lehigh or Northampton County:

*Magellan Behavioral Health of Pennsylvania, Inc.
3897 Adler Pl., Building C
Bethlehem, PA 18017*

Or

Your provider can file a grievance for you, if you give the provider your consent in writing.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

What happens after I file a first-level grievance?

Magellan will send you a letter to let you know we received your grievance. The letter will tell you about the first-level grievance process.

3. The Role of the Provider and Magellan

You may ask Magellan to see any information they have about your grievance. You may also send any information that may help with your grievance to Magellan.

If you want to be included in the first-level grievance review, you must call us within 10 days of the date on the letter which lets you know we received your grievance. You can come to our offices or be included by phone. You don't have to attend if you do not want to. If you do not attend, it will not affect our decision.

A committee of one or more Magellan staff members, including a doctor or licensed psychologist, who has not been involved in the issue you filed your grievance about, will make a decision about your first-level grievance. Your grievance will be decided within 30 days after we received it.

A letter will be mailed to you no more than five business days after Magellan makes its decision. This letter will tell you the reason for the decision. It will also tell you how to file a second-level grievance if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are being reduced, changed or stopped, the services will continue until a decision is made.

Second-level Grievance

What if I do not like the decision?

If you are not happy with the first-level grievance decision, you may file a second-level grievance with Magellan.

When should I file a second-level grievance?

You must file your second-level grievance within 45 days of the date you get the first level grievance decision letter. Use the same address or phone number you used to file your first-level grievance.

What happens after I file a second-level grievance?

Magellan will send you a letter to let you know we received your grievance. The letter will tell you about the second-level grievance process.

You may ask Magellan to see any information they have about your grievance. You may also send any information that may help with your grievance to Magellan.

You can come to a meeting of the second-level grievance committee or be included by phone. The county in which the member is eligible will conduct the second-level hearing. You will be notified in writing once the time and place have been scheduled. You can attend the hearing in person, or participate by telephone. If you do not attend or participate, it will not affect the decision.

The second-level grievance review committee will consist of a representative from the county, a representative from Magellan (for Bucks, Delaware Lehigh and Northampton counties), and either a HealthChoices member who has received behavioral health services, or the parent of a member who has received services. A doctor or licensed psychologist will be on the committee. The members of the committee will not have been involved in the issue you filed your grievance about. The committee will make a decision no more than 30 days from the date Magellan received your second-level grievance.

3. The Role of the Provider and Magellan

A letter will be mailed to you within five business days after the committee makes its decision. This letter will tell you the reason for the decision. It will also tell you how to ask for an external grievance review if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and you file a second-level grievance that is hand-delivered or postmarked within 10 days of the date on the first-level grievance decision letter, the services will continue until a decision is made.

External Grievance Review (AS SET FORTH IN THE MEMBER HANDBOOK. FOR INFORMATIONAL PURPOSES.)

What if I still don't like the decision?

If you are not happy with Magellan's second-level grievance decision, you can ask for an external grievance review.

You must call or send a letter to Magellan asking for an external grievance review within 15 days of the date you received the second-level grievance decision letter. Use the same address and phone number you used to file your first-level grievance. We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer's name, address and phone number. You will also be given information about the external review process.

Magellan will send your grievance file to the reviewer. You may provide the reviewer additional information that may help with the external review of your grievance, within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services will continue until a decision is made.

If you need help or have questions about complaints and grievances, you may call Magellan at the toll-free telephone number at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311 for Lehigh County members, 1-877-769-9782 for Montgomery County members, and 1-866-238-2312 for Northampton County members.

You can also contact Legal Aid of Southeastern Pennsylvania at 1-877-429-5994, Legal Aid for Lehigh Valley at 1-800-322-7572, or the Pennsylvania Health Law Project at 1-800-274-3258.

3. The Role of the Provider and Magellan

Expedited Complaints and Grievances

What can I do if my health is at immediate risk?

If your doctor believes that the usual timeframes for deciding your complaint or grievance will harm your health, you or your doctor can call Magellan and ask that your complaint or grievance be decided faster.

*You will need to have a letter from your doctor faxed to Magellan at **1-215-579-4514** for Bucks, Delaware or Montgomery counties members, and **1-610-814-8048** for Lehigh or Northampton counties members, explaining how the usual timeframe of 30 days for deciding your complaint or grievance will harm your health.*

*If your doctor **does not** fax Magellan this letter, your complaint or grievance will be decided within the usual timeframes.*

Expedited Complaint

The expedited complaint will be decided by a doctor who has not been involved in the issue you filed your complaint about.

Magellan will call you within three business days of when we receive your request for an expedited (faster) complaint review with our decision. You will also receive a letter telling you the reason(s) for the decision and how to file a second-level complaint, if you don't like the decision. For information on how to file a second-level complaint, see above.

An expedited complaint decision may not be requested after a first-level complaint decision has been made on the same issue.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a doctor and at least one Magellan member, will review your grievance. The doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

Magellan will call you within three business days of when we receive your request for an expedited (faster) grievance review with the decision. You will also receive a letter telling you the reason for the decision. It will also tell you how to ask for an expedited external grievance review, if you don't like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call Magellan at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311 for Lehigh County members, 1-877-769-9782 for Montgomery County members, and 1-866-238-2312 for Northampton County members within two business days of the date you get the expedited grievance decision letter. Magellan will send your request to the Department of Health within 24 hours after receiving it.

An expedited grievance decision may not be requested after a second-level grievance decision has been made on the same issue.

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What kind of help can I have with the complaint and grievance processes?

If you need help filing your complaint or grievance, a Magellan staff member will help you. This person can also assist you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance, you can contact Legal Aid of Southeastern Pennsylvania at 1-877-429-5994 or Legal Aid at 1-800-238-2311 for Lehigh and Northampton counties members.

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell Magellan, in writing, the name of that person and how we can reach him or her. You, or the person you choose to represent you, may ask Magellan to see any information they have about your complaint or grievance.

Persons whose primary language is not English

If you ask for language interpreter services, Magellan will provide the services at no cost to you.

Persons with Disabilities

Magellan will provide persons with disabilities the following help, if needed, in presenting complaints or grievances at no cost:

- *Sign language interpreters;*
- *Provide information submitted by Magellan at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review; and*
- *Someone to help copy and present information.*

NOTE: For some issues, you can request a fair hearing from the Department of Public Welfare in addition to, or instead of, filing a complaint or grievance with Magellan. See below for the reasons you can request a fair hearing.

DEPARTMENT OF PUBLIC WELFARE FAIR HEARINGS (AS SET FORTH IN THE MEMBER HANDBOOK. FOR INFORMATIONAL PURPOSES.)

In some cases you can ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something Magellan did or did not do. These hearings are called "fair hearings." You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after the first- or second-level complaint or grievance decision.

What kind of things can I request a fair hearing about, and when do I have to ask for a fair hearing?

If you are unhappy because...

A service was denied because it is not covered;

You must ask for a fair hearing...

*Within 30 days of getting a letter telling you of this decision **or** within 30 days of getting a letter telling you the decision after you filed a complaint*

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about this issue.

Magellan decided not to pay a provider for a service you received AND the provider can bill you for the service;

*Within 30 days of getting a letter from Magellan telling you of this decision **or** within 30 days of getting a letter telling you the decision after you filed a complaint about this issue.*

A decision was not made about your first-level complaint or grievance within 30 days of when you filed it;

Within 30 days of getting a letter from Magellan telling you that a decision was not made about your complaint or grievance within the time it was supposed to.

Your service was denied or decreased, or a different service was approved than the service your provider requested because it was not medically necessary;

*Within 30 days of getting a letter telling you of this decision **or** within 30 days of getting a letter telling you the decision after you filed a grievance about this issue.*

Your provider did not give you a service by the time you should have received it.

*Within 30 days from the date you should have received the service **or** within 30 days of getting a letter telling you the decision after you filed a complaint about this issue.*

How do I ask for a fair hearing?

You must ask for a fair hearing in writing and send it to:

*Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32, 2nd Floor
P.O. Box 2675
Harrisburg, PA 17105-2675*

Your request for a fair hearing should include the following information:

- The member's name;*
- The member's social security number and date of birth;*
- A telephone number where you can be reached during the day;*
- If you want to have the fair hearing in person or by telephone; and*
- Any letter you may have received about the issue you are requesting your fair hearing for.*

What happens after I ask for a fair hearing?

You will get a letter from the Department of Public Welfare's Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

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Magellan will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, Magellan must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?

If you ask for a fair hearing after a first-level complaint or grievance decision, the fair hearing will be decided no more than 60 days from when the Department of Public Welfare gets your request.

If you ask for a fair hearing and did not file a first-level complaint or grievance, or if you ask for a fair hearing after a second-level complaint or grievance decision, the fair hearing will be decided within 90 days of when the Department of Public Welfare gets your request.

A letter will be sent to you after the decision is made. This letter will tell you the reasons for the decision. It will tell you what to do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter telling you that your services have been reduced, changed or stopped, or telling you the decision about your first- or second-level complaint or grievance, your services will continue until a decision is made.

Expedited Fair Hearing

What can I do if my health is at immediate risk?

*If your doctor believes that using the usual timeframes to decide your fair hearing will harm your health, you, or your doctor or licensed psychologist, can call the Department of Public Welfare at **1-877-356-5355** and ask that your fair hearing be decided faster. This is called an expedited fair hearing.*

*You will need to have a letter from your doctor faxed to **717-772-7827** explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor does not send a written statement, your doctor may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.*

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The hearing will be held by telephone within three business days after you ask for the fair hearing.

*If your doctor **does not** send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled and decided within 90 days.*

If your doctor sends a written statement or testifies at the expedited fair hearing, the decision will be made within three business days after you asked for the expedited fair hearing.

If you need help or have questions about fair hearings, you may call Legal Aid of Southeastern Pennsylvania at 1-877-429-5994, or 1-800-322-7572 for Lehigh and Northampton counties members, or the Pennsylvania Health Law Project at 1-800-274-3258, or Magellan's toll-free telephone number at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311

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for Lehigh County members, 1-877-769-9782 for Montgomery County members and 1-866-238-2312 for Northampton County members.

NOTE: To ask for help or to request more details about the complaint, grievance and fair hearing processes, call Magellan's toll-free telephone number at 1-877-769-9784 for Bucks County members, 1-888-207-2911 for Delaware County members, 1-866-238-2311 for Lehigh County members, 1-877-769-9782 for Montgomery County members, and 1-866-238-2312 for Northampton County members.

Provider Responsibility in the Event of a Denial

In the event that a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

If the level of care being denied is inpatient, hospital staff is expected to communicate with the member, and the member's family if appropriate, on the same day that the non-authorization is issued. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Provider-Initiated Grievances

Consistent with 28 PA Code 9.603, with the member's written consent a provider may initiate a grievance on behalf of the member within 45 days from the date of denial notification. The following information must be included on the written consent:

- The name and address of the member, the member's date of birth, and identification number
- The name, address, and plan identification number of the provider to whom the member is providing consent
- The name and address of the plan to which the grievance will be submitted (Magellan – HealthChoices)
- An explanation of the specific service for which coverage was provided or denied to the member, to which the consent will apply
- The following statement: “The member or the member's representative may not submit a grievance concerning the services listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or member's representative has the right to rescind consent at any time during the grievance process.”

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- The member's signature. If the member is a minor, or is legally incompetent, the name, address, and relationship to the member of the person who signed the consent.

You may file your provider-initiated grievance by calling Magellan at 1-800-686-1356, or writing to:

Magellan Behavioral Health of Pennsylvania, Inc.
105 Terry Drive, Suite 103
Newtown, PA 18940
Attention: Complaints and Grievances
Fax: 1-866-667-7744

Upon receipt of acceptable member consent, Magellan will conduct the grievance review as outlined under the "Member Complaint and Grievance" procedures.

For more information regarding provider-initiated grievances, you may access the Pennsylvania Department of Health Technical Advisory regarding provider-initiated grievances on the Pennsylvania Department of Health website at:

http://www.dsf.health.state.pa.us/health/lib/health/managedcare/technical_advisory.doc.

You may also access a sample acceptable member consent form on the Pennsylvania Department of Health website at:

http://www.dsf.health.state.pa.us/health/lib/health/managedcare/enrollee_consent_form.doc

Reminder: Per your provider contract with Magellan, members are not responsible for payment for services provided during the provider-initiated grievance.

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Network Provider Participation

Magellan has collaborated with the Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices members. Magellan has implemented processes and procedures to gather information that is used to improve the quality of care. When we collect and evaluate information specific to you we will communicate the findings to you. Our Quality Improvement Program includes the following:

Evaluation of quality of care through:

- Treatment record reviews
- Site visits
- Review of quality indicators (complaints and adverse incidents)
- Specific quality studies.

Utilization of resources through:

- Utilization reports for all levels of care
- Monitoring readmission rates to 24-hour levels of care
- Custom reports to compare utilization to provider history and other providers.

Outcomes of care through:

- The use of standardized measurement tools
- Satisfaction surveys
- Special outcomes studies
- Performance improvement plans.

Administrative procedures through:

- Assessment of compliance with credentialing, quality and utilization program requirements
- Adherence to service standards, such as member's timely access to care.

Selective consultation through:

- Provider profiles
- Selection and implementation of clinical practice guidelines
- Analysis of member and provider satisfaction survey results
- Activities to improve care and service delivery.

If improvement is indicated as the result of our findings, we will collaborate with you to develop action plans geared toward improving the areas where deficiencies are identified.

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This feedback, action and follow-up process is key to improving care and the services for HealthChoices members.

Adverse Incidents

In accordance with the OMHSAS Community Incident Management & Report System Bulletin of 2006 (OMHSAS-06-04), providers are required to notify Magellan within 24 hours of the occurrence of a reportable incident involving a HealthChoices member. Included in this handbook are the definition and instructions for reporting adverse incidents (*Appendix W*) and the form to be faxed to Magellan to report the incident (*Appendix X*). This information is used to monitor and follow-up on serious incidents, and is included in quarterly trending reports and annual Provider Profiles.

Provider Performance Inquiry and Review (Quality of Care) Concerns

Magellan's Quality Improvement Program maintains a Provider Performance Inquiry and Review process for addressing potential concerns with a provider's actions. This may include provider performance concerns (quality of care concerns), action plans, site visits and other collaborative performance improvement activities.

Accreditation and External Review of Quality

The Magellan Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities. Reviewers for these accrediting bodies focus on compliance with standards and policies, as well as the effectiveness of our Quality Improvement Program in overseeing compliance with these standards.

NCQA's accreditation standards for managed behavioral health care organizations (MBHO) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver as well as the direct care you provide, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Strong emphasis also is placed on clear communication with members about:

- Their rights and responsibilities
- Key components of the MBHO program, such as utilization review criteria and practice guidelines
- Member and provider involvement in the MBHO's quality improvement program.

We have developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices requirements. Specific activities include:

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- Assessing accessibility to care for initial appointments, aftercare and specialty care
- Conducting site visits and treatment record reviews for assessment of quality of care and adequacy of the service site
- Credentialing and re-credentialing requirements for individual providers and organizations
- With appropriate authorization from the member, communicating and coordinating care with PCPs and other providers
- Developing preventive behavioral health care programs
- Conducting member satisfaction surveys
- Facilitating complaint and grievance procedures
- Reporting serious provider quality deficiencies to the appropriate authorities.

As part of our effort to provide timely access to members, you are asked to document the following:

- First appointment time offered to a member
- First appointment time kept by a member
- Appointments that are canceled or missed
- Attempts to contact members who terminate treatment without notification.

Site Visits

The Magellan Quality Improvement Program includes site visits to programs and facilities, in order to assess the quality of care and services delivered. Our staff conducts both administrative and clinical reviews. Licensed clinicians conduct all clinical aspects of the site visit.

Site visits may be conducted at minimum:

- During initial credentialing for participation in the network
- At re-credentialing, which occurs every two years for individual providers and every three years for organizations
- On other occasions when Magellan determines it is necessary, including, but not limited to, clinical reasons.

We evaluate site visit findings and send a written report to the provider. The report includes the following information:

- The findings from the site visit

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- Recommendations for improvement, if needed
- A request for a corrective action plan to improve care or services, if indicated.

Site visit findings are reviewed by County representatives and the applicable Magellan Regional Network and Credentialing Committee (RNCC) as part of the provider's credentialing and re-credentialing process.

Member Satisfaction Surveys

Magellan utilizes a number of methods to assess the satisfaction of the members we serve. We may supplement the annual member satisfaction survey with a member office visit questionnaire administered to members who receive care from high-volume providers and organizations.

Provider Satisfaction Surveys

Our relationship with you, our providers, is crucial to the delivery of quality behavioral health care to our members. Therefore, Magellan also conducts an annual provider satisfaction survey. The survey findings are used to identify areas we need to work on and to develop and implement actions for improvement. This mail-out, mail-back survey is administered to network providers at least once a year. We strongly encourage you to participate.

Confidentiality

Under the Pennsylvania HealthChoices program, Bucks, Delaware, Lehigh, Montgomery and Northampton counties, DPW and Magellan have access to all medical assistance member records. The following information addresses the maintenance, confidentiality and release of member records to persons or entities other than the Counties, DPW and Magellan.

GENERAL GUIDELINES

Confidentiality of **all** information about a member receiving mental health and/or substance abuse treatment service is of paramount importance. Confidentiality is an ethical obligation of all treatment professionals, and a legal right for every member, regardless of the source or the format of the information. As a Magellan network provider, you are responsible for maintaining the confidentiality of all member information. You must be knowledgeable of all applicable state and federal laws, including HIPAA, regarding confidentiality or having an impact upon a member's right to confidentiality. This also includes any applicable reporting requirements for child or elder abuse, and the common law or statutory duty-to-warn.

Any requirements under applicable federal and state laws regarding confidentiality must be followed regarding release of information with or without patient authorization.

INFORMED DISCLOSURE

During the first therapeutic communication, whether by telephone or in person, you must inform members of their right to confidentiality and the limits of those rights so that the

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member may make an informed decision as to what he or she chooses to disclose to you. You will need to document in the member's medical record that a discussion regarding confidentiality took place, and the member's response to this information.

You also must inform members that information will be shared with Magellan, DPW, and the County, and obtain the member's Authorization to Disclose Protected Health Information to document that the member consents to such disclosures. The reasons you may need to share information with Magellan, DPW or the County may include the following:

- Medicaid program audits and evaluations
- Utilization review or claims review
- Investigation of complaints and grievances.

Disclosure of substance abuse records to Magellan, DPW or the County, even with the authorization of the member, is limited to the following, for the purpose of obtaining benefits under the HealthChoices program for the treatment of drug or alcohol abuse or dependence:

- Whether or not the member is in treatment
- The prognosis of the member
- The nature of the services being provided
- A brief description of the progress of the member
- A short statement as to whether the member has relapsed into drug or alcohol abuse, and the frequency of relapse.

Proper coordination of care under the HealthChoices program requires that a member's PCP be kept informed of any mental health or substance abuse services received through Magellan. This coordination of care is to be conducted in the member's best interest. Therefore, you must inform members of the need to communicate with their PCP and obtain authorization to release information to the PCP.

Finally, you are to inform the member of circumstances under which confidential information may be disclosed without his or her consent. These instances include:

- Medical emergencies
- Responses to court orders
- Reporting requirements (such as abuse and duty-to-warn).

GUIDELINES FOR ESTABLISHING OFFICE PROTOCOL ON CONFIDENTIALITY

You are expected to establish an office protocol, including processes, procedures and systems, to maintain member confidentiality. The following are suggested guidelines for establishing an office protocol on confidentiality.

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COMMUNICATION WITH MEMBERS

In addition to informing each member of his or her right to confidentiality, and any limits on those rights, you should also explain to members your procedures regarding telephone contact. These would include obtaining phone numbers where the member may be reached and names of those with whom you may leave messages. When leaving messages, leave only your name and phone number. The purpose of the call must never be revealed. The procedures for phone contact should be noted in sufficient detail in the member's record.

MEMBER RECORDS

You must maintain each member's record in a separate file. Include the member's identifying information, such as the case number and HMO, in the file. Keep member charts in a locked file when not in use. Your office must also be locked when you are not on the premises. Only you and authorized staff employed by you are to have access to member medical records.

Your office staff must be informed of the protocol for confidentiality and made aware of their responsibility to maintain the confidentiality of members. Your staff may not talk about members or give out any information to anyone (including the member's spouse) without the member's explicit written authorization. They may not acknowledge, by telephone, in person, or in writing, that an individual is or was in treatment or is in the office. In fact, it is a good idea to instruct your staff not to release any verbal or written information before they check with you, even with a signed authorization on file.

A system for keeping members' telephone calls and messages confidential should be established and your staff is to be informed of these procedures. Office staff should be sensitive to the need for maintaining confidentiality during phone conversations when others are in the reception area. Appointment books are to be treated as confidential and kept in a locked file when not in use. Separate entrances and exits, while not required, may help the effort to maintain confidentiality.

When mailing confidential information, label the document as confidential.

RECORDS OF DISCLOSURES

All disclosures of member information by you or your staff must be documented in the member's clinical record. The documentation must indicate to whom disclosure was made, date of disclosure, purpose of disclosure and the information disclosed. The member is to be informed of any disclosures that are made.

NOTE: You are responsible for knowing, understanding and following all applicable laws regarding confidential patient information. In providing the information in this handbook supplement regarding confidentiality, Magellan is not furnishing legal advice. If legal or other professional advice is required, you are responsible for seeking the services of a professional.

Fraud, Waste and Abuse

Magellan takes provider fraud, waste and abuse very seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. We have made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law. For definitions, corporate policies and more information, see the Fraud, Waste and Abuse section of our [National Provider Handbook](#).

Magellan providers are expected to develop, implement, and maintain a written Compliance Plan which adheres to applicable federal and Pennsylvania state law and any applicable guidance on such plans issued by the United States Office of Health and Human Services Office of the Inspector General (“HHS-OIG”) or the Pennsylvania Department of Public Welfare’s (DPW) Bureau of Program Integrity (BPI). All persons employed by or contracted with a Magellan-contracted provider will be governed under that provider’s Compliance Plan, and the provider is responsible for the individuals’ actions.

The Pennsylvania HealthChoices Behavioral Health Program Standards and Requirements (PSR) definitions are as follows.

Abuse:

Abuse is defined as any practices in a capitated Managed Care Organization (MCO), Primary Care Case Management (PCCM) program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medical Assistance Program (MA) or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of your contract, and requirements of state or federal regulations) for health care in the managed care setting. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, MA beneficiary or MA managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the MA Program or MCO, contractor, subcontractor, or provider. A provider can be described as any individual or entity that receives MA funds in exchange for providing a service (MCO, contractor or subcontractor).

Fraud:

Fraud is defined as knowingly and intentionally executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program. It is an intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself or some other responsible person in a managed care setting. It includes any act that constitutes fraud under applicable federal or state law.

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Waste:

Waste means over-utilization of services, or other practices that result in unnecessary costs.

We encourage you to visit the Pennsylvania Department of Public Welfare (DPW) website. The mission of the Office of Medical Assistance (MA) Program's Bureau of Program Integrity (BPI) is to ensure that:

- The Medical Assistance Program is protected from provider fraud, abuse, and waste;
- Medical Assistance recipients receive quality medical services;
- Medical Assistance recipients do not abuse their use of medical services; and
- Feedback is provided to the Department to enhance program performance.

The DPW - BPI has a wealth of information about fraud, waste, and abuse on its website (www.dpw.state.pa.us/learnaboutdpw/fraudandabuse) including general information on fraud, waste, and abuse; information about the Medical Assistance Provider Self Audit Protocol; and information on how to report fraud, waste, and abuse.

PROGRAM EXCLUSION

Under Pennsylvania law, providers whose provider agreements have been terminated by the DPW or a sub-agency thereof, or who have been excluded from the Medicare program or any other state's Medicaid program, are not eligible to participate in this Commonwealth's Medical Assistance Program during the period of their termination. The Pennsylvania Medicare List identifies providers, individuals, and other entities that are precluded from participation in the Pennsylvania Medical Assistance (MA) Program. (See <http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/index.htm>.)

THE EFFECT OF AN EXCLUSION

The Pennsylvania Medical Assistance (MA) HealthChoices Behavioral Health Program is funded by the State and the federal government. An exclusion from participation in state- or federally funded contracts and programs means the excluded individual or entity cannot participate in any federally or state-funded health care program. It also means that:

1. "No payment will be made by any state or federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity;
2. No payment will be made by any state or federal health care program for any administrative or management services provided by excluded individuals/entities;
3. Federally funded health care programs like Medicaid, Medicare, Medicare Advantage and other federal health care programs cannot pay excluded individuals/entities, or anyone who employs or contracts with excluded entities/individuals; and
4. Individuals and entities who are enrolled to participate in federally funded health care programs like Medicaid, Medicare, Medicare Advantage, and SCHIP, are prohibited from knowingly having a director, officer, partner, or person with a

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beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, or excluded.”

Under Pennsylvania law, the DPW and managed care organizations *will not* pay for any services prescribed, ordered, or rendered by the providers or individuals listed on the Medichcek List, including services performed in an inpatient hospital or long-term care setting. In addition, subsequent to the effective date of the termination or preclusion, any entity of which 5 percent or more is owned by a sanctioned provider or individual will not be reimbursed for any items or services rendered to MA recipients.

Providers are required to disclose to Magellan any update regarding the information below within 10 days from when the provider becomes aware of the information. Disclosure includes the following information:

- a. Identity of *any person* or entity having an ownership or control interest in the provider, and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
- b. Identity of any person who is managing employee of the provider and who has been convicted of a crime related to federal health care programs.
- c. Identity of any person who is an agent of the provider and who has been convicted of a crime related to federal health care programs.

PENNSYLVANIA LAW

Under Pennsylvania law (55 Pa. Code § 1101.75), an enrolled provider may not, either directly or indirectly, do any of the following acts:

1. Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.
2. Knowingly submit false information to obtain authorization to furnish services or items under MA.
3. Solicit, receive, offer or pay a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.
4. Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

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5. Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.
6. Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.
7. Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.
8. Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.
9. Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.
10. Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.
11. Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.
12. Enter into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.
13. Make a false statement in the application for enrollment or reenrollment in the program.
14. Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

Please note that a provider or person who commits a prohibited act specified above, except paragraph (11) above, is subject to the penalties specified in §§ 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department; and restitution and repayment).

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PROCEDURES RELATING TO PROVIDER EXCLUSION FROM FEDERALLY OR STATE-FUNDED PROGRAMS

Your responsibilities as required by the Centers for Medicare and Medicaid Services (CMS), further protects against payments for items and services furnished or ordered by excluded parties. If you participate in federally funded health care programs, you must take the following steps to determine whether your employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the HHS-OIG LEIE website at <http://www.oig.hhs.gov/> to capture exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Check the Pennsylvania Medichex List, a database maintained by the Department that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program (http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichexprecludedproviderslist/S_001152). If an individual's resume indicates that he/she has worked in another state, providers should also check that state's individual list.
- Immediately report to the respective state Medicaid Agency any exclusion information discovered.

In addition, to comply with Magellan's fraud, waste and abuse programs, your responsibility is to:

- Check each month to ensure that you, your employees, directors, officers, partners or owners with a 5 percent or more controlling interest and subcontractors are not debarred, suspended or otherwise excluded under the HHS-OIG LEIE at <http://www.oig.hhs.gov/>, the EPLS at <http://www.epls.gov/> or any applicable state exclusion list where the services are rendered or delivered; and
- Immediately notify Magellan in writing of the debarment, suspension or exclusion of you, your employees, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.

HOW TO REPORT SUSPECTED CASES OF FRAUD, WASTE AND ABUSE

1. Reports made to Magellan can be submitted via one of the following methods:
 - Special Investigations Unit Hotline: 1-800-755-0850
 - Special Investigations Unit Email: SIU@MagellanHealth.com
 - Corporate Compliance Hotline: 1-800-915-2108
 - Compliance Unit Email: Compliance@MagellanHealth.com

4. The Quality Partnership

2. Report suspected cases of fraud, waste, and abuse to the Medical Assistance (MA) Provider Compliance Hotline: 1-866-DPW-TIPS (1-866-379-8477).

The MA Provider Compliance Hotline, established by and located in the DPW [Bureau of Program Integrity](#), is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in fee-for-service and managed care within the Pennsylvania MA Program. The hotline is staffed with medical professionals who are available from 8:30 a.m. to 3:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-English speaking interpreter services are available to provide assistance to callers, and TTY services for persons with hearing impairment are also available. Additional instructions:

- Callers to the hotline are not required to identify themselves.
- If a caller does not wish to speak to a hotline representative directly, he or she should leave a message outside the regular hours of operation.
- Individuals can report suspected fraudulent and abusive practices through the DPW website without disclosing their identity by completing and submitting the MA Provider Compliance Hotline: Response Form.

Please have the following information when you call:

- Provider's name and address
- Description of the suspected fraudulent and abusive activity, including the time period, frequency of the events, recipient name, and recipient ID number
- Telephone number where you can be reached, in the event that you want to be contacted.

CONTACT INFORMATION FOR FRAUD AND ABUSE REPORTING

If you have knowledge of suspected MA provider noncompliance, or of substandard quality of care for services paid for under the Pennsylvania Medical Assistance Program, please contact the MA Provider Compliance Hotline by:

- Telephone (includes TTY service): **1-866-DPW-TIPS** (1-866-379-8477)
- Fax: **(717) 772-4655** – Attention: MA Provider Compliance Hotline
- Electronically submitting the [MA Provider Compliance Hotline Response Form](http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotline1866dpwtips/S_001149) at: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotline1866dpwtips/S_001149
- U.S. Mail: **Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675**

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COUNTY HEALTHCHOICES FRAUD AND ABUSE HOTLINE

You also can report fraud, waste, and abuse directly to your County's HealthChoices Fraud and Abuse Hotline, listed below:

- **Bucks County:** 1-866-379-8477
- **Delaware County:** 1-866-379-8477
- **Lehigh County:** 610-782-3440
- **Montgomery County:** 1-866-379-8477
- **Northampton County:** 1-877-235-3164

5. Provider Reimbursement

Submission of Claims

In accordance with applicable law, Magellan will pay clean claims within 45 days of the date of receipt. Interest of 10 percent per year, or the amount required by applicable law, will be paid on **clean claims** not paid within the 45-day timeframe. Interest is calculated beginning the day after the required payment date and ending on the date the claim is paid. In accordance with applicable law, Magellan will not pay any interest calculated to be less than \$2. Clean claims are defined as claims that can be processed without obtaining any additional information from the provider or from a third party.

We strongly encourage all providers to submit claims to Magellan electronically via our provider website, in bulk through EDI Direct Submit, or by enrolling with one of the claims clearinghouse vendors designated by Magellan. Call the Magellan Provider line at 1-877-769-9779 or 1-800-686-1356 for more information, or visit the [Electronic Transactions/Claims](#) section of the Magellan provider website.

For filing on paper, send claims to:

Magellan Health Services, Inc.
PAHC – **Bucks County**
P.O. Box **1715**
Maryland Heights, MO 63043

Magellan Health Services, Inc.
PAHC – **Delaware County**
P.O. Box **2037**
Maryland Heights, MO 63043

Magellan Health Services, Inc.
PAHC – **Lehigh County**
P.O. Box **2127**
Maryland Heights, MO 63043

Magellan Health Services, Inc.
PAHC – **Montgomery County**
P.O. Box **2277**
Maryland Heights, MO 63043

Magellan Health Services, Inc.
PAHC – **Northampton County**
P.O. Box **2065**
Maryland Heights, MO 63043

5. Provider Reimbursement

Third Party Liability

Medicaid is always the last payer; therefore providers must exhaust all other insurance benefits first, before pursuing payment through Magellan HealthChoices.

Claims for services provided to HealthChoices members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an explanation of benefits (EOB). HealthChoices will not make payments if the full obligations of the primary insurer are not met.

As a Magellan provider, you are required to hold HealthChoices members harmless and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.

Resubmitting Claims

Claims with *provider* billing errors are called “Resubmissions.” Resubmitted claims must be received by Magellan within 60 days of the date on Magellan’s explanation of benefits.

Resubmitted claims can be sent electronically via an 837 file. There is a specific indicator for an adjusted claim (please consult Magellan’s companion guide or the EDI hotline for assistance). When re-submitting on paper, the claim must be stamped “resubmission” (or otherwise noted on box 22 of Form CMS-1500), and include:

- The date of the original submission
- The original claim number if applicable

Corrections can also be made to claims submitted on Magellan’s website on the same day prior to 3 p.m. CST. Click *View Claims Submitted Online* and “Edit” by the appropriate claim. For claims corrections on a different day than submitted or after 3 p.m. CST, the following fields can be amended: Place of Service, Billed Amount; or Number of Units. This functionality is **only** available for claims with a status of *Received/Accepted*. Corrections to claims other than Place of Service, Billed Amount or Units can be submitted on hard copy corrected claim via postal mail as noted above.

Timely Claims Submission

All claims for covered services provided to HealthChoices members must be received by Magellan in accordance with the following timelines, **within 60 days from date of service for most levels of care, except as provided below:**

- Within 60 days from date of discharge for 24-hour levels of care
- Within 60 days of the last day of the month or the discharge date, whichever is earlier, when billing monthly for longer-treatment episodes of care at a 24-hour level facility
- Within 60 days of the claim settlement for third-party claims. This date is based on the date of the other carrier’s EOB, which must be attached to the claim you submit to Magellan.

If Magellan does not receive a claim within these timeframes, the claim will be denied for payment.

5. Provider Reimbursement

Alternative Payment Arrangements

When appropriate and approved by the State, there is a procedure Magellan uses to contract with providers outside of the traditional Fee-for-Service unit definition defined by the State. In order to participate in this arrangement, you must:

- Submit all treatment encounters per the assigned procedure/modifier combination as outlined in your contract
- Apply a dollar amount to zero paid claims to ensure timely processing
- Ensure that treatment encounter claims have been submitted before sending your invoice for consideration.

Magellan will process all invoices for the submitted treatment month once the encounters have been verified.

Proper Claims Forms and Codes

For the proper procedure code and/or modifier(s) to use for claims, consult your Magellan agreement and reimbursement schedules. Form CMS-1500 or UB-04 (formerly UB-92) should be used if submitting claims on paper. Please see “Elements of a Clean Claim” which is available on Magellan’s provider website:

https://www.magellanprovider.com/MHS/MGL/about/handbooks/appendices/f_cleanclaim.pdf.

Claims Review

Upon receipt of a claim, Magellan reviews the documentation and makes a payment determination. As a result of this determination, a remittance advice, known as an Explanation of Payment (EOP) is sent to you. The EOP includes details of payment or the denial. It is important that you review all EOPs promptly. If you have questions about EOPs or claims submitted for HealthChoices members, contact Magellan at **1-877-769-9779**.

Claims Resolution

The following suggestions will help expedite the processing of your claims:

- Use the appropriate billing revenue codes, procedure codes, and modifiers provided on the HealthChoices reimbursement schedules to your Magellan agreement. This also applies to third-party liability (TPL) claims submitted to Magellan.
- Submit claims in a timely manner (see “Timely Claims Submission”).
- If submitting on paper, use the appropriate claim form (UB-04 [formerly UB-92] or CMS-1500).
- Complete *all* required data on the form, including the Tax ID/ SS number and NPI number.
- Use the unit of service indicated on your Magellan contract.
- Submit the Usual and Customary Charges for the service (preferred).

The following are common claims errors that may result in a denial. Check all claims prior to submission to avoid delays due to these errors:

5. Provider Reimbursement

- Authorized units do not match billed units
- More than one month of service is billed on one claim form
- The recipient's Medical Assistance ID number is incorrect or not utilized
- The recipient's date of birth is missing
- Itemized charges are not provided when a date span is used for billing
- EOB is not attached to a third-party claim form
- Revenue code, procedure code and/or modifier(s) are incorrect
- Duplicate claim submissions are not identified as "duplicate"
- The diagnosis code is not an accepted code
- Service and/or diagnosis billed is not permitted under the provider's license.

Claims that providers believe were denied *incorrectly* are labeled as "Appeals." If you receive a claim denial, you have **sixty (60) days from the date of receipt to file a written appeal.** Your appeal must include supporting documentation that refutes the reason for the denial. Upon receipt of your written appeal, Magellan will investigate the information presented and respond within 30 days.

If supporting documentation is not available but a claims denial requires further understanding or research, providers may contact the Magellan provider line at 877-769-9779 or 800-686-1356 and speak to a customer service representative. At this time, a Service Request Application (SRA) may be submitted to Magellan's Claims Resolution Department for further investigation. An SRA is an electronic claims inquiry for a claim to be reviewed; it is not a guarantee of payment.

Eligibility Verification System

Authorization for service is based on eligibility at the time of the treatment request and does not guarantee payment. Providers are responsible for verifying a member's eligibility for HealthChoices coverage through the PA Medical Assistance (MA) PROMISE™ Eligibility Verification System:

- Prior to the first appointment,
- Throughout the course of treatment, and
- Prior to submitting claims

For information regarding the different options for checking EVS, go to the following DPW website address: (<https://promise.dpw.state.pa.us/>) or call # 1-800-766-5387 for interactive (real-time) eligibility verification (24 hours a day, seven days a week).

You may also check eligibility on www.MagellanHealth.com/provider (please be advised that this is not real-time eligibility) or by calling Magellan's customer service department. When applicable, hard copies of the EVS printout should be maintained in the member's medical record.

5. Provider Reimbursement

National Provider Identifier (NPI) Numbers

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions as of May 23, 2008. NPIs replaced all separately issued identifiers, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI was put in place so that each provider has one unique, government-issued identifier to be used in transactions with all health plans with which the provider conducts business. An NPI does not replace a provider's TIN. TINs continue to be required on all claims – paper and electronic. The NPI is for identification purposes, while the TIN is for tax purposes. **Important: claims that do not include a TIN will be rejected.**

There are two different types of NPI numbers: Type 1 is for health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. An individual is eligible for only one NPI; Type 2 NPIs are for health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

Organizations can choose to enumerate subparts by taxonomy/specialty, TIN or site address; however if you are an organization with a single-site address and multiple TINs, we prefer that you enumerate subparts at the TIN level. If you are an organization with multiple site addresses, we prefer that you enumerate subparts at the site address level. In other words, organizations should have one unique NPI for each rendering service location for billing purposes. An individual practitioner is assigned only one NPI (Type 1) regardless of the number of places where he/she may practice.

To apply for an NPI number, there are two different options:

- For the most efficient application processing and the fastest receipt of an NPI, use the web-based NPI application process. Log on to the National Plan and Provider Enumeration System (NPPES) and apply online at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>
- Or you may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) by contacting the Enumerator by phone at 1-800-465-3203 (TTY 1-800-692-2326); email customerservice@npienumerator.com; or mail at NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

Providers should submit their NPI to Magellan by signing in with your secure username and password on this website (www.MagellanHealth.com/provider), selecting *Display/Edit Practice Information*, and completing the NPI request field. You can also submit your NPI by mail or fax, by sending us a copy of your NPI notification letter or email from NPPES: Magellan Health Services, Attn: Data Management, 14100 Magellan Plaza, Maryland Heights, MO 63043, Fax number: 314-387-5584.

5. Provider Reimbursement

The following are claims submission procedures specific to the NPI:

- For claims submitted via the ASC X12N 837 professional health care claim transaction, place the Type 2 NPI in the provider billing segment, loop 2010AA; and the Type 1 NPI in loop 2310B.
- On the CMS-1500 paper form (version 08/05), insert the main or billing Type 2 NPI number in Box 33a. Insert the service facility Type 2 NPI (if different from main or billing NPI) in Box 32a. Group providers only must also insert Type 1 NPIs for rendering providers in Box 24J.
- On the UB-04 form, insert the main Type 2 NPI number in Box 56.
- For claims submitted to Magellan's website via Claims Courier: Organizations/ Facilities should complete the "Billing/ Pay-To Provider Information" section using the NPI number associated with the rendering service location. Individual providers should complete the "Billing/ Pay-To Provider Information" section with their own type 1 NPI number. The individual's NPI number should be entered in that section only. Group providers should complete the "Billing/ Pay-To Provider Information" section with the Group's type 2 NPI number. The "Rendering Provider Information" section should be completed using the rendering provider's type 1 NPI.

HealthChoices-Specific Website

Magellan Behavioral Health of Pennsylvania, Inc. has a website specific to HealthChoices accounts in Bucks, Delaware, Lehigh, Montgomery and Northampton counties: www.MagellanofPA.com. Here, providers can find all the resources they need to provide care through the Pennsylvania HealthChoices Program. At this Internet location is everything providers need to stay current about Magellan of Pennsylvania, including the latest updates, practice guidelines and training links, as well as county-specific information. Providers and members also can search for a provider by ZIP code, or search by level of care. The MagellanofPA website also enables the provider to link to our provider website to complete transactions such as checking member eligibility and submitting claims electronically.

MagellanHealth.com/Provider Website

The www.MagellanHealth.com/provider site is Magellan's provider-specific Internet portal. It offers Magellan providers the powerful tools and information they need to provide high-quality care to our members. The following resources and features are available on www.MagellanHealth.com/provider:

- Magellan's National Provider Handbook
- Pennsylvania HealthChoices Provider Handbook Supplement
- Website User Guide
- *Provider Focus* Newsletter
- Check Member Eligibility
- View Authorizations
- Check Claims Status
- Claims Courier (Magellan's web-based claims submission tool)
- Electronic Claim Submission Orientation
- Electronic Data Interchange (EDI) Testing Center
- Check Credentialing Status
- Group Roster
- Edit Practice Information
- Submit a W-9
- Manage Outcomes
- CEU Trainings
- Forms (Appendices).

Helpful hints for using www.MagellanHealth.com/provider:

- MagellanHealth.com/provider is optimized for use with Microsoft Internet Explorer 6.0 versions and above. Other versions and different browsers can still access our website, but the viewing experience and functionality may be reduced. If using Internet Explorer 8.0, users may need to adjust their Compatibility View Settings (Tool Menu) to add both www.MagellanHealth.com and www.MagellanHealth.com/provider.
- The Administrator is the user who is responsible for managing website access for an Entity. This person creates logins for staff who need to access [MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) for an individual practice, group, or facility. At a group or a facility, this may be an office manager, IT manager, etc. For an individual

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practice, the practitioner is automatically the Administrator. There is only one Administrator per Entity.

- Each user needs to have a unique login and password. The website Administrator for each provider can add new users and also grant them specific permission levels. Based on their job functions, all users may not require access to the same functions.
- Logins become “deactivated” after six or more months of non-use. A user may also forget their login or password, or they may lock themselves out after three or more unsuccessful login attempts. Users can regain access to the website by following the link “Forgot Password” underneath the Provider Sign-in on the MagellanHealth.com/provider home page. If a user runs into trouble re-setting their password or gaining access to the website, they should contact their Administrator.
- When signing up to use the website, users will select a “challenge” question. It is recommended that the answer be a simple, one-word response.
- Any field with an asterisk (*) is a required field.
- When searching for a member in Eligibility, you must fill in the three fields with the asterisk (Last Name, First Name and State). The next two fields are optional (Date of Birth and Member Number) and can be utilized with common names and searches that return many members with the same name. Be sure to spell the member’s name exactly as it appears on the member’s insurance card or EVS eligibility screen.
- Each user who needs to access Outcome Tools must have the following permissions: Check Member Eligibility, Outcomes, and PA Outcomes Measurement (a specific tool to complete POMS).