

**Magellan Behavioral Health Providers of Texas, Inc.**  
**Provider Handbook Supplement**  
**for Texas Medicaid (STAR) and CHIP Programs**

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## *Introduction*

Welcome to the Magellan Behavioral Health Providers of Texas, Inc. (Magellan) Provider Handbook Supplement for Texas Medicaid (STAR) and Children's Health Insurance Program (CHIP). This handbook addresses policies and procedures specific to Texas providers for the Medicaid and CHIP Programs. The Provider Handbook Supplement for Texas Medicaid and CHIP Programs is to be used in conjunction with the Magellan National Provider Handbook. When information in the Texas Medicaid and CHIP Programs Supplement conflicts with the national handbook, or when specific information in the Texas Medicaid and CHIP Programs does not appear in the national handbook, policies and procedures in the Texas Medicaid and CHIP Programs Supplement prevail.

In order to meet the behavioral health needs of their members, Aetna and UniCare have contracted with Magellan Health Services to provide a continuum of services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.

Magellan offers a variety of behavioral health services to Aetna State of Texas Access Reform (STAR), Medicaid and CHIP members in the Tarrant and Bexar Service Areas, and to UniCare CHIP members in the Dallas service area. These services include: assessment and treatment planning, psychiatric services, medication management, inpatient services, intensive outpatient services, case management services, outpatient therapy and substance abuse services. For more detail on the behavioral health benefits, both providers and members may contact the appropriate Magellan number for the plan in question:

Aetna Medicaid	1-800-327-9807
Aetna CHIP	1-800-424-5897
UniCare CHIP	1-800-473-2422

Members can change health plans by calling the Texas Medicaid Managed Care Program hotline at 1-800-964-2777. However, a member cannot change from one plan to another health plan during an inpatient hospital stay.

## **STAR Program**

STAR Services included under the HMO capitation payment for Behavioral Health include:

- Inpatient and outpatient mental health services for children (less than 21 years old )
- Residential rehabilitation services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services.

# **Section 1: Introduction**

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## **Children’s Health Insurance Program**

The Children’s Health Insurance Program (CHIP) is the Health and Human Services Commission (HHSC) program to help Texas families obtain affordable coverage for their uninsured children (aged 0 through 18). The principal objective of CHIP is to provide primary and preventative health care to low-income, uninsured children of Texas, including Children with Special Health Care Needs (CSHCN) who are not served by or eligible for other state-assisted health insurance programs.

CHIP Covered Services must meet the CHIP definition of “Medically Necessary Covered Services” as defined in Section 10, HHSC Uniformed Managed Care Contract Terms & Conditions.

## Section 3: Role of the Provider – Initiating Care

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<b>Our Philosophy</b>	Magellan joins with our members, providers and customers to make sure members receive the most appropriate services and experience the most desirable treatment outcomes for their benefit dollar.
<b>Our Policy</b>	We assist members in optimizing their benefits by reviewing and authorizing the most appropriate services to meet their behavioral health care needs, and members may self-refer without a referral from their primary care physician. We do not pay incentives to employees, peer reviewers (i.e., physician advisors), or providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-authorization or under-utilization of behavioral health care services.
<b>What You Need to Do</b>	<p>Your responsibility is to do the following when a member presents for care:</p> <ul style="list-style-type: none"><li>◆ Contact Magellan for an initial authorization, except in an emergency.</li><li>◆ Contact Magellan as soon as possible following the delivery of emergency services to coordinate care and discharge planning.</li><li>◆ Provide Magellan with a thorough assessment of the member, including, but not limited to the following:<ul style="list-style-type: none"><li>▪ Symptoms</li><li>▪ Precipitating event(s)</li><li>▪ Potential for harm to self or others</li><li>▪ Level of functioning and degree of impairment (as applicable)</li><li>▪ Clinical history, including medical, behavioral health, and alcohol and other drug conditions or treatments</li><li>▪ Current medications</li><li>▪ Plan of care</li><li>▪ Anticipated discharge and discharge plan (if appropriate).</li></ul></li></ul> <p>Call the Magellan Care Management Center if during the course of treatment you determine that services other than those authorized are required.</p>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"><li>◆ Contact you directly to arrange an appointment for members needing emergent or urgent care.</li><li>◆ Refer members based upon the member's identified needs and preferences.</li><li>◆ Authorize medically necessary care.</li><li>◆ Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services.</li></ul>

## **Section 3: Role of the Provider – Initiating Care**

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- ◆ Communicate the authorization determination by telephone, online and/or in writing to you and the member.
- ◆ Offer you the opportunity to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested services.
- ◆ Authorize a second opinion if appropriate.
- ◆ Conduct retrospective audits of selected medication management cases for quality of care purposes.

## Role of the Provider—Concurrent Review

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- Our Philosophy** Magellan believes in supporting the most appropriate services to improve health care outcomes for members. We look to our providers to notify us if additional services beyond those initially authorized are needed, including a second opinion for complex cases.
- Our Policy** Concurrent utilization management review is required for all service, including but not limited to:
- ◆ Inpatient
  - ◆ Intermediate ambulatory services such as partial hospital programs (PHP) or intensive outpatient (IOP) programs, and
  - ◆ Office or clinic setting traditional outpatient services.
- What You Need to Do** If after evaluating and treating the member, you determine that additional services are necessary:
- ◆ Contact the designated Magellan care management team member at least one day before end of the authorization period by telephone for inpatient and intermediate ambulatory services.
  - ◆ Submit a Treatment Request Form (TRF)\*\* online or a state mandated form from the member's initial authorization for traditional outpatient services before authorization expiration date.
  - ◆ Be prepared to provide the Magellan care manager or physician advisor with an assessment of the member's clinical condition, including any changes since the previous clinical review.
  - ◆ Request a second opinion if you feel it would be clinically beneficial.
- What Magellan Will Do** Magellan's responsibility to you is to:
- ◆ Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for authorization of care.
  - ◆ Promptly review your request for additional days or visits in accordance with the applicable medical necessity criteria.
  - ◆ Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
  - ◆ Respond in a timely manner to your request, verbally and in writing, for additional days or visits.
  - ◆ Issue an adverse determination within two business days after receipt of the request for authorization of services; within one business day for concurrent hospitalization decisions; and within one hour for post-stabilization or life-threatening conditions (for emergency behavioral health conditions, no prior authorization is required).

## **Section 3: Role of the Provider – Claims Reconsideration and Appeals for Aetna Medicaid (STAR) and Aetna CHIP Members**

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**Our Philosophy** Magellan supports the right of the provider to request reconsideration for adverse claims determinations.

**Our Policy** We will notify the member and provider by mail with an explanation of benefits and procedures for requesting claim reconsideration.

**What You Need to Do** Your responsibility is to:

- ◆ File your appeal within 120 days from the date of the explanation of benefits.
- ◆ Include any documentation you would like considered in the reconsideration request, including any documentation or information that was not considered in the initial determination.
- ◆ Send the request for reconsideration to:  
Magellan Health Services  
Attn: Complaints Department  
10101 Alliance Road, Suite 201  
Cincinnati, OH 45242
- If you are not satisfied with the outcome of the reconsideration, you can file an appeal to Aetna at:  
Aetna Medicaid and CHIP Claims Appeal  
P.O. Box 981516  
El Paso, TX 79998-1516

**What Magellan Will Do** Magellan's responsibility to you is to:

- ◆ Acknowledge the reconsideration within five days of receipt.
- ◆ Complete reconsideration review within 30 calendar days of receipt.
- ◆ Provide written notification of the reconsideration decision no later than 30 calendar days after Magellan's receipt of the request.
- ◆ Refer you directly to Aetna if you are not satisfied with the reconsideration decision.

## Section 3: Role of the Provider – Appeals for Aetna Medicaid (STAR) and Aetna CHIP Members

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- Our Philosophy** Magellan complies with requirements of Aetna Medicaid and CHIP administrative and medical necessity appeals processes.
- Our Policy** To comply with our health plan delegation agreements and to inform Magellan-contracted providers of the processes by which to file appeals to adverse determinations.
- What You Need to Do** To comply with this policy your responsibility is to:
- ◆ Contact Aetna directly for *administrative and medical necessity appeals* at the following address:  
Aetna Medicaid and CHIP Services  
P.O. Box 569150  
Dallas, TX 75356-9150
- What Magellan Will Do** Magellan’s responsibility to you is to:
- ◆ Provide accurate information on how to appeal.

## Section 3: Role of the Provider- Appeals for UniCare CHIP Members

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**Our Philosophy** Magellan supports the right of the provider to appeal adverse clinical, claims and service determinations.

**Our Policy** We will notify the member and provider by mail with an adverse determination, explanation of benefits, and/or administrative non-authorization letter, and procedures for appeal.

**What You Need to Do** Your responsibility is to:

- ◆ File your appeal within 30 days from the date of the notice of action or adverse determination.
- ◆ Include any documentation you would like considered in the appeal request, including any documentation/information that was not considered in the initial non-authorization determination. If Magellan requests additional information in order to process the appeal, you must provide the requested information within 14 business days.
- ◆ Request an extension on behalf of the member, if appropriate.
- ◆ Send appeal information to:  
Magellan Health Services  
Attn: Appeals Department  
10101 Alliance Road, Suite 201  
Cincinnati, OH 45242

**What Magellan Will Do** Magellan's responsibility to you is to:

- ◆ Send an appeal acknowledgement letter within five days of receipt of appeal.
- ◆ Complete standard appeals within 30 calendar days of receipt.
- ◆ Notify member and provider of the process for expedited appeals.
- ◆ Make expedited appeal decisions within one business day of receipt of request and no later than three calendar days after review commences.
- ◆ Provide written notification of the appeal decision no later than 30 calendar days after Magellan's receipt of the appeal request.
- ◆ Provide notice that member is entitled to an appeal by an Independent Review Organization (IRO)\* if condition is life-threatening.
- ◆ Transfer the required information to the Independent Review Organization within the time frame designated by the Texas Department of Insurance (TDI) of three working days.

\*The IRO review is an external appeal process made available through the Texas Department of Insurance (TDI) and applies to adverse determinations based on lack of medical necessity or appropriateness of treatment.

## Section 3: Role of the Provider – Member Access to Care

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- Our Philosophy** Magellan believes that members are to have timely access to appropriate mental health and substance abuse services from an in-network provider 24 hours a day, seven days a week.
- Our Policy** We require in-network providers to be accessible within a time frame that reflects the clinical urgency of the member’s situation. Clinical urgency is categorized as Routine, Emergent and Urgent and defined by the State of Texas as follows:
- Routine**—When the member’s condition is considered to be sufficiently stable and not to have a negative impact on the member’s condition to allow for a face-to-face assessment to be available within 10 business days following the request for service.
- Emergent**—A medical situation that is not life threatening. Non-life threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member’s clinical state or condition. Gross impairment of functioning usually exists and is likely to result in compromise of the member’s safety.
- Urgent**—Health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician’s or a provider’s office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.
- What You Need to Do** Your responsibility is to:
- ◆ Provide access to services 24 hours a day, seven days a week.
  - ◆ Inform members of how to proceed, should they need services after business hours.
  - ◆ Provide coverage for your practice when you are not available, including, but not limited to an answering service with emergency contact information.
  - ◆ Respond to telephone messages in a timely manner.
  - ◆ Provide comprehensive screening and appropriate triage for members who present at your office or emergency room experiencing a life threatening emergency. (Pre-authorization is not required for these services.)
  - ◆ Provide services within six hours of referral in an emergent situation that is not life threatening. Non-life threatening emergency is a condition that requires rapid intervention to

## Section 3: Role of the Provider – Member Access to Care

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prevent acute deterioration of the member's condition.

- ◆ Provide services within 24 hours of referral in an urgent clinical situation.
- ◆ Provide services within 10 business days of referral for routine clinical situations.
- ◆ Provide services within seven days of a member's discharge from an inpatient stay.
- ◆ Contact Magellan immediately if member does not show for an appointment following an inpatient discharge so that Magellan can conduct appropriate follow up.
- ◆ Contact Magellan immediately if you are unable to see the member within the timeframes.

### What Magellan Will Do

Magellan's responsibility to you is to:

- ◆ Communicate the clinical urgency of the member's situation when making referrals.
- ◆ Assist with follow-up service coordination for members transitioning to another level of care.
- ◆ Contact members who seek emergent or urgent services and are follow-up treatment compliant.
- ◆ Contact members who miss appointments and work with them to reschedule.

## **Section 3: Role of the Provider – Local Mental Health Authority**

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- Our Philosophy** Magellan will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities for treatment of members with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), as well as members committed by a court of law to a state psychiatric facility, to support and provide the most appropriate care.
- Our Policy** In coordination with the LMHA, Magellan will authorize additional behavioral health services for special populations, and will assist our providers in meeting with these requirements.
- What You Need to Do** Your responsibility is to:
- ◆ Understand federal Medicaid (STAR) standards applicable to providers.
  - ◆ Meet federal Medicaid (STAR) standards.
  - ◆ Refer members to LMHA as appropriate, and accept referrals from LMHA.
- What Magellan Will Do** Magellan’s responsibility to you is to:
- ◆ Operate a toll-free telephone hotline to respond to your questions, comments and inquiries.
  - ◆ Establish a multi-disciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
  - ◆ Provide covered services to members with SPMI/SED when medically necessary.
  - ◆ Coordinate treatment with all providers, including other behavioral health providers, medical providers and LMHAs as clinically appropriate.

## **Section 3: Role of the Provider – Coordination with Texas Department of Family Services**

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**Our Philosophy** Magellan will coordinate with all entities and stakeholders invested in the member’s care.

**Our Policy** Magellan collaborates with all state and legal entities involved in providing services to our members, including the Texas Department of Family and Protective Services (TDFPS)—formerly the Department of Protective and Regulatory Services.

Magellan will not deny, reduce or controvert the medical necessity of any behavioral health services included in a court order. Magellan may participate in the preparation of the medical and behavioral care plan prior to TDFPS submitting the health care plan to the Court. Any modification or termination of court-ordered services will be presented and approved by the court having jurisdiction over the matter.

**What You Need to Do** Your responsibility is to:

- ◆ Provide medical records to TDFPS.
- ◆ Schedule behavioral health service appointments within 14 days unless requested earlier by TDFPS.
- ◆ Contact TDFPS to report any suspected abuse or neglect.
- ◆ Coordinate with Magellan for services to members who have a TDFPS service plan.

**What Magellan Will Do** Magellan’s responsibility to you is to:

- ◆ Clearly communicate the intention of any court order and services required.
- ◆ Coordinate services for additional care that you recommend.
- ◆ Communicate with TDFPS to clearly understand the intent of the court order and services required.
- ◆ Communicate with TDFPS to clearly understand the intent of the court order and services required.
- ◆ Communicate with you, our provider, to ensure you understand the intent of the court order and the services you are to provide.
- ◆ Not deny, reduce or controvert the medical necessity of any behavioral health services included in a court order.
- ◆ Participate in the preparation of the medical and behavioral care plan with TDFPS prior to submitting to the court.

## **Section 3: Role of the Provider – Referrals from Primary Care Physicians**

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- Our Philosophy** Magellan believes that collaboration and communication among all providers participating in a member's treatment is essential for the delivery of integrated quality care.
- Our Policy** Magellan supports communication between behavioral health providers and primary care physicians (PCPs) providing behavioral health services within the scope of his or her practice.
- What You Need to Do** Your responsibility is to:
- ◆ Make a referral and/or collaborate with the member's PCP as clinically appropriate for on-going or complex mental health or substance abuse problems.
  - ◆ Talk directly to a Magellan care manager to facilitate care in an urgent situation.
  - ◆ Inform Magellan of on-going or complex mental health or substance abuse problems.
- What Magellan Will Do** Magellan's responsibility to you is to:
- ◆ Encourage PCPs to make referrals to behavioral health specialists, as appropriate.
  - ◆ Encourage behavioral health providers to communicate key health information with PCPs including:
    - Initial evaluation
    - Significant changes in treatment, medication or clinical status
    - Termination of treatment.
  - ◆ Encourage PCPs to obtain member authorization to communicate with behavioral health providers.
  - ◆ Work with treatment providers to quickly and effectively respond to urgent care situations.
  - ◆ Refer members with on-going or complex mental health or substance abuse problems to a network behavioral health provider.

## **Section 3: Role of the Provider – Advance Directives**

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**Our Philosophy** Magellan believes in a member’s right to self-determination in making health care decisions.

**Our Policy** As appropriate, Magellan will inform adult members 18 years of age or older about their rights to refuse, withhold or withdraw medical and/or mental health treatment through advance directives. Magellan supports the state and federal regulations, which provide for adherence to a member’s psychiatric advance directive.

**What You Need to Do** Your responsibility is to:

- ◆ Understand and meet federal Medicaid standards regarding advance directives.
- ◆ Understand and meet state Medicaid (STAR) standards regarding psychiatric advance directives.
- ◆ Maintain a copy of the psychiatric advance directive in the member’s file, if applicable.
- ◆ Understand and follow a member’s declaration of preferences or instructions regarding mental health treatment.
- ◆ Use professional judgment to provide care believed to be in the best interest of the member.

**What Magellan Will Do** Magellan’s responsibility to you is to:

- ◆ Meet state of Texas and federal advance directive laws.
- ◆ Document the execution of a member’s psychiatric advance directive.
- ◆ Not discriminate against a member based on whether the member has executed an advance directive.
- ◆ Provide information regarding advance directives to the member’s family or surrogate if the member is incapacitated and unable to articulate whether or not an advance directive has been executed.
- ◆ Follow-up with the member to provide advance directives information once the member is no longer incapacitated.

## **Section 3: Role of the Provider – Medical Necessity Review Guidelines**

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**Our Philosophy** Magellan is committed to the philosophy of promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member's biopsychosocial needs. Medical necessity review is applied based on the member's individual needs including, but not limited to, clinical features and available behavioral health care services.

**Our Policy** Magellan uses the criteria as set forth by the Department of Insurance in the rules and regulations for Cost Control and Utilization Review for Chemical Dependency Treatment Centers by the Texas Commission on Alcohol and Drug Abuse, for all substance abuse treatment determinations. In addition, Magellan follows the Utilization Management Guidelines as those prescribed for use by Local Mental Health Authorities by Mental Health Mental Retardation (MHMR), for members receiving services from local community mental health centers.

**What You Need to Do** Your responsibility is to:

- ◆ Be familiar with the medical necessity guidelines appropriate for the member's condition.

**What Magellan Will Do** Magellan's responsibility to you is to:

- ◆ Communicate the specific guideline(s) used in rendering a determination.
- ◆ Make the guidelines available to you.
- ◆ Provide you with a specific clinical rationale and appeal procedures for any non-authorization determination.

## **Section 3: Role of the Provider – Members with Special Needs**

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- Our Philosophy** Magellan believes that members with Special Health Care Needs (MSHCN) should have direct access to in-network behavioral health specialists as appropriate to their condition and identified needs.
- Our Policy** Magellan maintains systems and procedures for identifying MSHCN, including people with chronic or complex behavioral health conditions. For Children with Special Health Care Needs (CSHCN), Magellan refers to providers with expertise in treating children. It is our policy to review the request for services using Magellan Medical Necessity Criteria or Texas Council on Alcohol and Drug Abuse Criteria for substance abuse services.
- What You Need to Do** Your responsibility is to:
- ◆ Coordinate with Magellan and/or the comprehensive treatment team if you are providing services to an MSHCN or CSHCN.
  - ◆ Collaborate with Magellan and/or the appropriate community agencies involved in the member's care.
- What Magellan Will Do** Magellan's responsibility to you is to:
- ◆ Coordinate with those providing services to an MSHCN or CSHCN.
  - ◆ Collaborate with you and/or the appropriate community agencies involved in the member's care.
  - ◆ Provide appropriate care management to assure the individual's needs are being met.

## Section 3: Role of the Provider- Texas Fraud and Abuse

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- Our Philosophy** Magellan fully supports all state and federal laws and regulations to fraud, abuse, waste in health care and will cooperate with enforcement of these laws and regulations.
- Our Policy** Magellan will fully cooperate and assist HHSC and any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. Magellan will provide records and information, as requested.
- What You Need to Do** Your responsibility is to:
- ◆ Report any members you suspect of committing Medicaid (STAR)/CHIP abuse, waste or fraud to:
    - Magellan
    - The Attorney General's Office, or
    - Office of Inspector General.
  
  - ◆ Cooperate with the Inspector General for the Texas Health and Human Services System or its authorized agent(s), the Centers for Medicare and Medicaid (STAR) Services, the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, TDI, or other units of state government free of charge by providing all requested information and access to premises.
- What Magellan Will Do** Magellan's responsibility to you is to:
- ◆ Provide you with contact information, or file the information for you with the appropriate regulatory body.

## Section 3: Role of the Provider-Court-Ordered Commitments

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### Our Philosophy

Magellan is subject to all state and federal laws and regulations relating to court-ordered commitments, and will provide services to CHIP and STAR members within regulatory requirements.

### Our Policy

Magellan will provide inpatient psychiatric services to members less than 21 years of age, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction, under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities.

### What You Need to Do

To comply with this policy, your responsibility is to:

- ◆ Contact the designated Magellan care management teammember by telephone if you are aware of a court-ordered commitment.
- ◆ Be prepared to provide the Magellan care manager or physician advisor with an assessment of the member's clinical condition.

### What Magellan Will Do

Magellan's responsibility is to:

- ◆ Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for authorization of care.
- ◆ Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
- ◆ Respond in a timely manner verbally and in writing to your request:
  - Within two business days after receipt of the request for authorization of services
  - Within one business day for concurrent hospitalization decisions
  - Within two business days after receipt of the request for authorization of services, and
  - Within one hour for post-stabilization or life-threatening conditions (for Emergency Behavioral Health Conditions, no prior authorization is required).
- ◆ Not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided, pursuant to court-ordered commitments for members less than 21 years of age.

## **Section 4: Quality Partnership– Complaint and Appeal Process for Members and Providers**

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<b>Our Philosophy</b>	Magellan believes that members and providers have the right to express comments related to care, service or confidentiality, to have those concerns thoroughly investigated, to receive a timely, comprehensive and professional response to concerns, and to have the right to appeal a complaint determination.
<b>Our Policy</b>	Our policy is to follow all regulations for Medicaid (STAR) and CHIP member services.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>◆ Refer to and follow the specific procedures for filing a complaint or complaint appeal as directed in the adverse determination letter.</li><li>◆ Contact Magellan by telephone, e-mail or U.S. Mail to file a complaint.</li></ul>
<b>What Magellan Will Do</b>	Magellan’s responsibility to you is to: <ul style="list-style-type: none"><li>◆ Provide a toll-free number to use to file a complaint.</li><li>◆ Provide assistance in the filing process, if needed.</li><li>◆ Acknowledge a complaint within five business days of receipt.</li><li>◆ Resolve complaints within 30 calendar days.</li><li>◆ Resolve complaints for emergencies or denials of continued stay within one business day.</li></ul>

### **Complaint Appeals**

Magellan follows all Medicaid (STAR) and CHIP requirements in responding to complaint appeals. This includes the following:

1. The member must submit a complaint appeal within 30 days of the date of the notice of action/adverse determination letter. Instructions for the appeal process are included in this letter.
2. A complaint form will be included in the acknowledgment of a verbal complaint.
3. For CHIP members only, complaint appeals are resolved by a Complaint Appeal Committee consisting of equal numbers of Magellan staff, providers and members not involved in the previous decision.

## Section 5: Texas Provider Reimbursement – Professional Services

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**Our Philosophy** Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.

**Our Policy** Magellan reimburses mental health and substance abuse treatment providers using current procedural terminology (CPT) fee schedules for professional services. Magellan will deny claims not received within applicable state mandated or contractually required timely filing limits.

**What You Need to Do** In addition to your responsibilities outlined in the National Provider Handbook, you need to:

- ◆ Collect applicable co-payments from STAR and CHIP members.
- ◆ Submit your claim for reimbursement promptly after the date of service or discharge (must be within 95 days).
- ◆ Submit complete and accurate data elements on your claims (See *Appendix F* of the *Magellan National Provider Handbook* located at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) to review the elements of a clean claim.)
  - Include Texas Provider Identification Number on the claims, otherwise claims will be denied.
  - Submit claims with the **license-level** modifier that represents the treating provider’s license level if you are an organizational provider or an individual provider submitting professional service claims (CPT code related services) as part of an organization (using the organization’s Taxpayer Identification Number).
  - Use the appropriate modifier associated with the degree level of the individual providing the service. (Magellan processes claims using the organization’s record, and the license-level modifier provided on the claim communicates the correct rate for reimbursement.)

For your reference, we have included a table below defining the modifiers by degree/license level.

<i>What modifier should I use for my claims? Degree/Licensure</i>	<i>HIPAA Modifier</i>
Psychiatrist	AF
Physician	AG
Psychologist	AH, HP
Social Worker	AJ
Master’s Level Counselor	HO
Clinical Nurse Specialist	SA, TD

## Section 5: Texas Provider Reimbursement for Professional Services

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NCAC (National Certified Addictions Counselor) or state substance abuse counseling certification	HF	Substance Abuse Pr
Bachelor's degree level counselors	HN	Bachelor's degree le
Less than bachelor's degree level counselors	HM	Less than bachelor's level

For more information on reimbursement coding requirements, visit our provider website at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) and go to *Getting Paid/HIPAA*.

Submit claims to:

**Aetna:** Aetna Texas, P.O. Box 1029, Maryland Heights, MO 63043

**UniCare:** UniCare, P.O. Box 1447, Maryland Heights, MO 63043

For questions, contact:

Aetna Medicaid/STAR 1-800-327-9807

Aetna CHIP 1-800-424-5897

UniCare CHIP 1-800-473-2422

### What Magellan Will Do

In addition to the responsibilities outlined in the National Provider Handbook, Magellan's responsibility to you is to:

- ◆ Review our reimbursement schedules periodically in consideration of industry standard reimbursement rates and revise them when indicated (Appendix B).
- ◆ Provide a toll-free number for you to call for provider assistance. That number is 1-800-430-0535, option #4.



## Appendix A - CHIP/STAR Behavioral Health Services Comparison

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit
Inpatient Mental Health Services	<ul style="list-style-type: none"> <li>• Medically necessary services including, but not limited to mental health services furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities.</li> <li>• Medically necessary inpatient mental health services are unlimited.</li> <li>• Includes inpatient psychiatric services, up to a 12-month period limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities.</li> <li>• Does not require primary care physician (PCP) referral.</li> <li>• Neurological testing is covered under inpatient and outpatient services.</li> </ul>	<ul style="list-style-type: none"> <li>• Medically necessary services for the treatment of mental, emotional or substance use disorders.</li> <li>• Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid (STAR) Program and are subject to utilization review requirements.</li> <li>• Includes inpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities.</li> <li>• Admissions for chronic diagnoses such as mental retardation (MR), organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.</li> </ul>
Outpatient Mental Health Services	<ul style="list-style-type: none"> <li>• Medically necessary services include, but are not limited to mental health services provided on an outpatient basis.</li> <li>• The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.</li> <li>• Includes outpatient psychiatric services, up to a 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code.</li> <li>• Does not require PCP referral.</li> </ul>	<ul style="list-style-type: none"> <li>• Medically necessary services for the treatment of mental, emotional or substance use disorders.</li> <li>• Outpatient behavioral health services are limited to 30 visits per member, per calendar year. (Additional visits can be allowed if authorization is requested prior to the 25<sup>th</sup> visit).</li> <li>• Includes outpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code.</li> <li>• Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapist</li> </ul>

## Appendix A - CHIP/STAR Behavioral Health Services Comparison

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit
	<ul style="list-style-type: none"> <li>• Outpatient visits are unlimited, including medication management visits.</li> <li>• Neurological testing is covered under inpatient and outpatient services.</li> <li>• A Qualified Mental Health Professional (QMHP) must be working under the authority of a Department of State Health Service (DSHS) entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services provided are within the scope of the services typically provided by QMHPs. These services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.</li> </ul>	<p>(LMFT).</p> <ul style="list-style-type: none"> <li>• Covered services are a benefit for members suffering from a mental psychoneurotic or personality disorder when provided in the office, home, skilled nursing facility, outpatient hospital, nursing home or other outpatient setting.</li> <li>• Does not require a PCP referral.</li> <li>• Medication management visits do not count against outpatient visit limit.</li> <li>• Psychological and neuropsychological testing are covered for specific diagnoses. Testing is limited to four hours per day per member (any provider).</li> <li>• Psychological testing is limited to eight hours of testing per member, per calendar year (any provider).</li> <li>• Neuropsych test battery is limited to eight hours per member, per calendar year (any provider).</li> <li>• Testing does count toward the 30 visit limit.</li> <li>• Additional services such as mental health screenings are covered under the Texas Health Steps Consumer Choice program.</li> <li>• For members 21 years of age or older: counseling by LPCs, LCSWs, LMFPs and psychologists. Limit of 30 visits per calendar year. If additional visits are required, they must be prior authorized.</li> </ul>
Inpatient Substance Abuse Treatment Services	<ul style="list-style-type: none"> <li>• Medically Necessary services include, but are not limited to, inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.</li> </ul>

## Appendix A - CHIP/STAR Behavioral Health Services Comparison

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit
	<ul style="list-style-type: none"> <li>• Thirty days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost.</li> <li>• Does not require PCP referral.</li> <li>• Medically necessary detoxification/ stabilization services, limited</li> <li>• 24-hour residential rehabilitation programs, or the equivalent, are unlimited per 12-month period.</li> </ul>	<ul style="list-style-type: none"> <li>• Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.</li> <li>• Detoxification (inpatient and residential) is limited to 21 days a year and prior authorization is required.</li> <li>• Residential Treatment: Rehabilitation is limited to 35 days per episode and prior authorization is required. (Includes two episodes of care per rolling six-month period and four episodes per rolling year.) Specialized female (including pregnant women and women with children) up to 90 days per episode. Members aged 20 and younger are eligible for additional days with prior authorization.</li> </ul>
Outpatient Substance Abuse Treatment Services	<ul style="list-style-type: none"> <li>• Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by a physician and non-physician providers, such as screening, assessment and referral for substance use disorders.</li> <li>• Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services and life skills training, which consist of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day.</li> <li>• Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.</li> <li>• Does not require PCP referral.</li> <li>• Outpatient treatment services are unlimited.</li> </ul>	<ul style="list-style-type: none"> <li>• Substance use disorder treatment services are age appropriate medical and psychotherapeutic services designed to treat a client's substance disorder and restore function.</li> <li>• Group counseling is limited to 135 hours per member, per calendar year.</li> <li>• Individual counseling is limited to 26 hours per member per calendar year.</li> <li>• Additional counseling services may be considered for aged 20 and younger based upon medical necessity</li> <li>• Assessment for substance abuse disorder may be covered once per episode of care when provided using a standardized screening and assessment tool.</li> <li>• Medication Assisted Therapy (MAT) In Person is limited to once per day and prior authorization is required</li> </ul>

## Appendix A - CHIP/STAR Behavioral Health Services Comparison

Type of Benefit	CHIP Description of Benefit	Medicaid (STAR) Description of Benefit
	○	<ul style="list-style-type: none"> <li>• Medication Assisted Therapy (MAT) Take Home is limited to once per day up to 30 doses and prior authorization is required.</li> <li>• Ambulatory (Outpatient) Detoxification Services may be covered for a medically appropriate duration of care based on treatment needs for up to 21 days. (Clients aged 20 and younger may receive additional days of treatment with prior authorization.)</li> <li>• Inpatients residing in a DSHS facility are not eligible for outpatient services.</li> <li>• Does not require a PCP referral.</li> </ul>

## **Appendix B - CHIP/STAR Value-Added Services**

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### **CHIP and STAR Value-Added Services**

Magellan provides value-added services to Texas Medicaid CHIP and STAR members:

#### **STAR members**

- ◆ Outpatient individual and family therapy in non-traditional settings (member homes, juvenile justice offices, school counseling offices, etc.), for members who cannot travel to a traditional provider setting or whose needs are better serviced in an alternative setting.

#### **STAR and CHIP members**

- ◆ **In-home individual and family crisis intervention**
  - Mobile crises services quickly address needs.
  - Reduce the need for inpatient services.
- ◆ **Intensive care management for high-risk members**
  - Additional planning and support for members with complex needs and/or co-morbid illness.
- ◆ **Partial hospitalization**
  - Addresses needs of members stepping down from inpatient services.
  - Addresses needs of members requiring services more intensive than outpatient, but do not need 24-hour supervision and treatment.
- ◆ **Intensive outpatient services**
  - For members requiring services more intensive than weekly outpatient, but do not require 24-hour supervision and treatment.
- ◆ **23-hour observation bed services**
  - Allows facilities to monitor a member in crisis without a full admission to inpatient services.
  - Allows time for the crisis situation to abate and for a more thorough assessment of the level of care most appropriate to the member's needs.
  - Allows a brief time for a crisis to resolve prior to a full hospital admission.
- ◆ **Group psychotherapy**
  - Members with similar needs focus on learning and sharing coping skills and increased functioning.
  - Most often used in substance abuse treatment settings.
  - Often delivered concurrently with individual psychotherapy.