

Magellan Behavioral Health*

Provider Handbook Supplement for the Vermont Provider Network

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Welcome to Magellan

This Provider Handbook Supplement is designed to give Magellan network providers specific information on the delivery of behavioral health care services to members in Vermont.

This handbook supplements the [Magellan National Provider Handbook](#), addressing policies and procedures specific for Vermont providers. It should be used in conjunction with the National Provider Handbook. When information in this supplement conflicts with the National Provider Handbook, or when specific information does not appear in the National Provider Handbook, the 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 Vermont. This supplement provides information from Magellan pertaining to authorization procedures, clinical and administrative systems, and documentation requirements to which each provider should adhere.

We look forward to working with you in the delivery of quality behavioral health care services in Vermont.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our website at www.MagellanHealth.com/provider. We have designed our website for you to have easy and quick access to information and answers to questions you may have about Magellan.

You also can reach Magellan's Vermont Field Network Department at 1-800-231-7158.

2. Overview of Vermont Rule H-2009-03 Regulations

Quality Assurance Standards and Consumer Protection Guidelines for Managed Care Plans

The Vermont Rule 10 regulations became effective on September 20, 1997, and have been subsequently amended and are now known as H-2009-03. These regulations set forth quality assurance standards and consumer protection guidelines for managed care plans. Magellan is committed to meeting the quality assurance and consumer protection requirements of Rule H-2009-03.

Under the Magellan provider agreement, both parties agree to comply with applicable state and federal laws. This handbook section sets forth the requirements regarding certain rights and responsibilities required by Vermont Rule H-2009-03.

Protections of the Provider's Right to Communicate

1. The provider is not prohibited from disclosing to members or potential members information about Magellan's contract with the provider or the member's benefit plan that may pertain to the member's health or any decision regarding the member's health.
2. The provider is not prohibited from, nor penalized for, discussing treatment options with members, regardless of Magellan's position on the treatment options, or for advocating on behalf of members within Magellan's utilization review and/or grievance processes.
3. The provider is not penalized for reporting in good faith to state or federal authorities any act or practice by Magellan that jeopardizes member health or welfare.

Protections Against Inducing Providers to Forego Delivery of Medically Necessary Services

4. No provision in the agreement between Magellan and the provider is an inducement to the provider to forego providing medically necessary services to a member.

Requirements to Make Records Available

5. The provider is to make members' health records available to Magellan in order to monitor and evaluate the quality of care provided, to conduct medical and other health care evaluations, and to review the appropriateness of care provided to members. The provider and Magellan must keep members' health records confidential.
6. The provider is to make health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care provided or investigating grievances or complaints of members. The provider is also required to comply with all applicable state and federal laws related to the confidentiality of health and medical records, including but not limited to mental health and substance abuse treatment records.
7. Providers will give members access to their treatment records upon request during business hours. Providers may charge members for copies; however, charges are to be limited to the cost of copying.

2. Overview of Vermont Rule H-2009-03 Regulations

Requirement to Inform Providers of Covered Services

8. Magellan will inform the provider on an ongoing and current basis, through a quarterly newsletter, of the specific covered services for which the provider will be responsible, including any limitations or conditions on the services. In addition, providers may call Magellan for specific information on covered services.

Consumer Protections

9. Under the agreement between the provider and Magellan, the provider agrees that in no event, including non-payment by Magellan, insolvency of Magellan or breach of the agreement between provider and Magellan, will the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person acting on behalf of the member (other than Magellan) for services provided pursuant to the agreement. The contract does not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for non-covered services delivered on a fee-for-service basis to members.
10. Under the agreement between the provider and Magellan, provider agrees that in the event of Magellan's insolvency or other cessation of operations, covered services to a member will continue through the period of time for which a premium has been paid on behalf of the member, or until the member's discharge from an inpatient facility, whichever period of time is greater. Covered benefits for a member confined in an inpatient facility on the date of Magellan's insolvency or other cessation of operations will continue until the member's continued confinement in the facility is no longer medically necessary.
11. Under the agreement between the provider and Magellan, the provisions set forth in items #9 and #10 above will survive the termination of the contractual agreement regardless of the reason for termination, including the insolvency of Magellan, and shall supersede any oral or written contrary agreement between a provider and a member or member's representative.
12. If a provider terminates or is terminated from the network and the member has a life-threatening, disabling or degenerative condition, the member will be permitted to continue covered services with the provider for 60 days from date of termination or until the member is accepted by a new provider.

Plan and Provider Requirements Regarding Contract Termination and Disputes

13. Under the agreement between the provider and Magellan, either party may terminate the contract, without cause, with at least 90 days' written notice to the other party.

Prohibition against Transfer of Liability to the Provider

14. The contractual agreement between Magellan and the provider will not transfer to the provider, by indemnification or otherwise, any liability related to activities, actions or omissions of Magellan.

3. Magellan's Vermont Provider Network

Credentialing and Re-Credentialing

Contracting with Magellan

To be eligible for referrals of and reimbursement for covered services rendered to covered members in Vermont, 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.

Our Philosophy

Magellan is committed to promoting quality care for its members. In support of this commitment, practitioners must meet a minimum set of credentialing criteria in order to provide services to our members.

Our Policy

Magellan and its providers must adhere to credentialing requirements under applicable Vermont laws and regulations including Rule H-2009-03. Vermont law requires the use of the Council for Affordable Quality Healthcare (CAQH) credentialing application form for the initial application, and for applications for re-credentialing.

- ◆ 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](#)).
- ◆ The initial verification of credentials or provisional credentialing must be completed before entering into a contractual relationship.
- ◆ Full credentialing must be completed before Magellan can include the provider in any provider list, provider directory, or any other member materials.
- ◆ Any provider of mental health or substance abuse services not currently under contract with Magellan that is willing to meet the terms and conditions for participation may apply for contracted status and may become contracted after successful completion of credentialing.

To be eligible for referrals, Magellan network providers are required

3. Magellan's Vermont Provider Network

to successfully complete the credentialing review process prior to acceptance as a network provider. See the National Provider Handbook Appendix B for criteria. Vermont Licensed Psychologist-Masters are credentialed as Masters Prepared Therapists.

What You Need to Do

To comply with this policy your responsibility is to:

- ◆ Follow credentialing procedures described in the National Provider Handbook.

What Magellan Will Do

Magellan's responsibility to you is to:

- ◆ Maintain confidentiality of credentialing information.
- ◆ Make credentialing information available to providers for the purpose of correcting inaccurate information.
- ◆ Develop and maintain credentialing criteria to be used in evaluating each provider application consistent with the requirements of VT H-2009-03. These criteria, and the Magellan's credentialing verification policies and procedures, shall be made available to contracted providers and provider applicants upon written request.
- ◆ Ensure that no provider remains in provisionally credentialed status for more than 60 days. Establish a mechanism for informing each contracted provider on an ongoing and current basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on the services.
- ◆ Maintain credentialing information for a minimum of three years.
- ◆ Communicate appeal processes to providers who have been denied participation with Magellan, or reducing, suspending, or terminating the privileges of contracted provider participation or continuing participation with Magellan.
- ◆ Establish a procedure that permits health care providers to review their own results on performance measures intended for public reporting in advance of their release. The procedure shall include a reasonable opportunity for a provider to request correction of any inaccuracies prior to publication of the data and reasonable procedures and time limits for resolving any related disputes. If the performance measures are derived from claims data without any medical record review, Magellan, if requested by the provider, shall confirm those results with a review of medical records prior to public reporting. Magellan shall promptly correct inaccuracies where warranted.

3. Magellan's Vermont Provider Network

- ◆ Accept provider inquires at the following address:
Magellan Health Services
Attn: Field Network Department
65 Broadway, Ste. 904
New York, NY 10006

4. The Role of the Provider and Magellan

Appointment Access Standards

Our Philosophy

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

Our Policy

Our access-to-care standards allow members to obtain behavioral health services from an in-network provider within a timeframe that reflects the clinical urgency of their situation. Magellan provides assistance 24 hours a day, seven days a week.

What You Need to Do

To comply with this policy your responsibility is to:

- ◆ Provide services within 24 hours of a referral in an urgent clinical situation. “Urgently needed care” or “urgent care” means those health care services that are necessary to treat a condition or illness of an individual that if not provided promptly (within 24 hours or a timeframe consistent with the medical exigencies of the case) presents a serious risk of harm.
- ◆ Follow other standards outlined in the National Provider Handbook, Section 3.
- ◆ Call 1-800-395-1356 for prior authorization, to speak with a care manager or to ask any questions.
- ◆ Request routine outpatient treatments via Magellan’s website, www.MagellanHealth.com/provider, or mail or fax Treatment Request Forms to:

Magellan Health Services
199 Pomeroy Rd
Parsippany, NJ 07054
Fax: 877-551-8302.

What Magellan Will Do

Refer to the National Provider Handbook, Section 3, for an overview of Magellan’s responsibilities to you.

4. The Role of the Provider and Magellan

Authorization Process

Our Philosophy

Through the authorization process, we assist members in optimizing their benefits by reviewing and authorizing appropriate services to meet their behavioral health care needs.

Our Policy

Magellan maintains policies for member referral and preauthorization, urgent and emergency care, concurrent review and post-service review. This handbook section describes the procedures and timeframes involved in all aspects of the authorization process.

What You Need to Do

Your responsibility is to:

- ◆ Participate in the utilization management processes, often necessary **before** beginning care, and at intervals during treatment, as required by the member's benefit plan.
- ◆ Contact Magellan at the number on the member's benefit card or online at www.MagellanHealth.com/provider to request an initial authorization, when necessary, or concurrent review authorization of care, as required by the member's benefit plan.

What You Need to Know

Magellan has a registered nurse or physician and a qualified licensed mental health care provider readily available by telephone seven days a week, 24 hours a day, to render utilization review determinations to members and treating providers.

All determinations to deny, limit, reduce, terminate or modify an admission, service, procedure or extension of stay are **rendered by a physician under the direction of the medical director** responsible for medical services provided to members, except when the denial is based on eligibility for coverage or is a denial of a service that is clearly excluded from coverage and that could not in any way be considered an appealable decision pursuant to any Vermont laws or rules regarding independent external review.

Except in cases where there was material misrepresentation or fraud, Magellan will not retroactively deny or limit reimbursement for the services described below.

- ◆ A covered service Magellan determines, either upon receipt of the claim or upon grievance review, to have been medically necessary but the member failed to fulfill the member's obligation to obtain prior authorization. If Magellan chooses to issue an initial administrative denial when a member fails to obtain prior authorization, Magellan shall also provide the

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member with clear notice that coverage will be provided if Magellan finds the service to be covered and medically necessary during grievance review. This subsection does not apply to a provider's obligation. Nothing in this subsection shall be construed to relieve contracted providers from their obligation to comply with Magellan's utilization management mechanisms or to relieve contracted providers of the consequences for failure to comply with such mechanisms;

- ◆ Any covered service provided to an eligible member by a provider who relied upon the written or oral authorization of Magellan or its agents prior to providing the service to the member; or
- ◆ A covered service provided to a member by his or her primary care provider or another contracted provider who relied upon the written or oral referral of the primary care provider when the health benefit plan requires primary care physician referrals for members to use specialists.

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

The following reviews will be treated as urgent:

1. All pre-service requests related to mental health and substance abuse conditions, unless the member or treating provider informs Magellan that the request is not urgent;
2. All pre-service pharmacy benefit determinations, unless the member or treating provider informs Magellan that the request is not urgent;
3. All pre-service requests related to whether use of a prescription drug for the treatment of cancer is medically necessary or is an experimental or investigational use; and
4. All requests designated as urgent by a member's health care provider or by the member.

Member Referral and Preauthorization Procedures

Magellan must authorize all levels of care in order for the services to be eligible for payment, 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

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week.

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

Authorization Toll-Free Number

1-800-395-1356

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. This list of providers is updated periodically and is subject to change. If you have any questions regarding this listing, please call Magellan customer service.

Member Toll-free Help Line Number

1-800-395-1356

Emergency Services

- A. Members may use ANY hospital or emergency service for emergency care.
- B. Magellan may not deny payment for treatment obtained when a representative of Magellan instructs the member to seek emergency services.
- C. Members can receive emergency services 24 hours per day, seven days per week within the health benefit plan's service area, and members can also receive emergency services whether the member is inside or outside the health benefit plan's usual service area at the time such services are needed.
- D. If a prudent layperson or provider would have believed that an emergency medical condition existed, Magellan will cover emergency services provided in a hospital or other medically appropriate setting necessary to evaluate, stabilize and provide medically necessary emergency transport for a member.
- E. Magellan does not require prior authorization of such emergency services or the use of contracted providers.

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- F. Magellan also covers emergency services if Magellan, acting through a contracted provider or through any other authorized representative, has authorized the provision of emergency services. In the event such authorization has been given or obtained, Magellan will not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on the authorization, unless the authorization was based on a material misrepresentation about the member's health condition made by the member or by the provider of emergency services.
- G. Coverage of emergency services is subject to applicable copayments, coinsurance and deductibles.
- H. Magellan will ensure that its members have access to urgently needed care as defined in this handbook pursuant to Rule H-2009-03 inside the health benefit plan's service area, and coverage for such services whether the member is inside or outside the health benefit plan's usual service area at the time such services are needed.

What Magellan Will Do

Magellan's responsibility is to:

- ◆ Provide timely access to appropriate staff to conduct utilization management reviews.
- ◆ Manage care with the least amount of intrusion into the care experience.
- ◆ Process referrals and complete the utilization management process in a timely manner.
- ◆ Manage care in accordance with the requirements, allowances and limitations of the member's benefit plan.
- ◆ Conduct utilization management reviews and make determinations in accordance with [Magellan's Medical Necessity Criteria](#) or other state- or customer-required clinical criteria based on the assessment information provided.
- ◆ Require Magellan employees to attend company compliance training regarding Magellan's policy to not provide incentives for non-authorization or under-utilization of care.

What You Need to Know

Urgent, Pre-Service Review

For urgent pre-service review determinations, Magellan will notify the member and treating provider (if known) in writing of its benefit determination (whether adverse or not) as soon as possible consistent

4. The Role of the Provider and Magellan

with the medical exigencies of the case, but not later than 72 hours after receipt of the request.

This period may be extended by not less than 48 hours by Magellan if such extension is necessary due to a failure of the member or provider to submit the information necessary to decide the request. Oral and written notification of the need for additional information will be provided to the member and the treating provider (if known) as soon as possible, but not later than 24 hours after receipt of the request.

Magellan will notify the treating provider (if known) and member of the determination orally as soon as the determination has been made. Written (either hard copy, or if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination will be sent to the treating provider (if known) and the member within 24 hours of the oral notification.

Non-Urgent, Pre-Service Review

For non-urgent, pre-service review determinations, Magellan will notify the member and treating provider (if known) of its benefit determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than 15 calendar days after receipt of the request. Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination will be sent to the treating provider (if known) and the member.

This period may be extended one time by Magellan for up to 15 calendar days, provided that Magellan both determines that such an extension is necessary due to matters beyond its control and notifies the treating provider (if known) and member prior to the expiration of the initial 15-calendar-day period, of the circumstances requiring the extension of time and the date by which Magellan expects to render a decision. If such an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension will specifically describe the required information, and the member or treating provider will be afforded at least 45 calendar days from receipt of the notice within which to provide the specified information.

What Magellan Will Do

Magellan's responsibility is to:

- ◆ Contact you directly to arrange an appointment for members needing emergent or urgent care. *Note: those needing emergent care are referred to network facility providers as appropriate.*
- ◆ Identify appropriate referrals based on information submitted by

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- our providers through the credentialing process.
- ◆ Make an authorization determination based upon the information provided by the member and/or the provider.
 - ◆ Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination.
 - ◆ Communicate the authorization determination by telephone, online and/or in writing to you as required by regulation and/or contract.
 - ◆ Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested services based on the medical necessity criteria review.

What You Need to Know

Concurrent Review

If an ongoing course of treatment has been approved, a decision by Magellan to deny, limit, reduce, modify or terminate coverage or payment for such course of treatment, or to deny a request by or on behalf of a member to extend the course of treatment, in whole or in part, will constitute an adverse benefit determination.

A request to continue or extend a facility stay or other ongoing course of treatment as described in this handbook will be decided as soon as possible consistent with the medical exigencies of the case. Magellan will notify the member and treating provider (if known) in writing of its benefit determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than 24 hours after receipt of the request.

In the case of an adverse concurrent review benefit determination regarding a facility stay or other ongoing course of treatment as described in this handbook, when the grievance is requested and conducted consistent with the guidelines below under the **Continuation of Services During the Internal Appeal and/or the External Appeals Process**, neither the member nor the provider will be liable for any services provided before notification to the member of the adverse benefit determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with Magellan when it has been offered at a time in a manner reasonably convenient for the provider, in which case the provider and not the member will be liable for any services provided.

Magellan will notify the treating provider and member of the determination orally as soon as the determination has been made.

4. The Role of the Provider and Magellan

Written (either hard copy, or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination will be sent to the treating provider and the member within 24 hours of the oral notification.

What Magellan Will Do

Magellan's responsibility is to:

- ◆ Promptly conduct clinical review of your request for additional days or visits in accordance with applicable federal and state requirements;
- ◆ Respond in a timely manner verbally and in writing to your request for additional days or visits;
- ◆ Call you directly if additional clinical information is needed;
- ◆ Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested services based on clinical criteria;
- ◆ Conduct retrospective audits of selected cases for quality of care purposes.

Post-Service Review

For post-service review determinations, Magellan will notify the member and treating provider (if known), of its benefit determination (whether adverse or not) within a reasonable period of time, but not later than 30 calendar days after receipt of the request. Magellan will send written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the benefit determination to the treating provider (if known) and the member.

This period may be extended one time by Magellan for up to 15 calendar days, provided that Magellan both determines that such an extension is necessary due to matters beyond its control and notifies the member and treating provider (if known), prior to the expiration of the initial 30-calendar-day period, of the circumstances requiring the extension of time and the date by which Magellan expects to render a decision. If such an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension will specifically describe the required information, and the member or treating provider will be afforded at least 45 calendar days from receipt of the notice within which to provide the specified information.

Continuity, Coordination and Collaboration

What You

Need to Know

Coordination and Continuity of Care

“Coordination and continuity of care” means that a member’s health care services are managed by Magellan in a manner that facilitates collaborative and effective treatment of a condition, illness or other medical condition, including but not limited to ensuring that Magellan:

1. Manages the benefits available for treatment of mental health and substance abuse conditions in a manner that allows for the effective provision of medically necessary care in urgent, medically complex, and unique situations, including but not limited to situations involving children and adolescents; and
2. Has authorized covered benefits necessary for a medically safe and appropriate discharge or transition plan developed after consultation with the treating health care provider or the provider’s designee before Magellan renders a decision that will result in discharge or transfer from a facility; and collaborates with health care providers to monitor and improve coordination of mental health and other health care services.

4. The Role of the Provider and Magellan

Grievance Procedures

Our Philosophy

We support the right of members and their providers acting on the member's behalf to appeal adverse benefit determinations.

Our Policy

Client requirements and applicable federal and state laws impact the appeals process; therefore, the procedure for appealing determinations is state-specific. The procedure is outlined in the non-authorization notification letter.

Mental Health and Substance Abuse Customer Service Complaint (or Inquiry)

Magellan handles mental health and substance abuse complaints or inquiries. If you have a complaint about mental health or substance abuse care that was denied, please call Magellan's customer service department at 1-800-395-1356. The customer service team can solve most problems. You also may file an appeal, as described below.

Mental Health and Substance Abuse Appeal (Grievance)

Mental health and substance abuse appeals also are handled by Magellan. A provider may file a grievance after a customer service complaint (described above). Or a provider may promptly file an appeal. (We suggest that a member make a complaint to the Magellan customer service department first; this may save time.) A member also has the right to obtain copies of all information related to his or her appeal.

Expedited Appeals

Appeals requested when the member is in a higher level of care and the facility/provider is acting on behalf of the member are treated as expedited appeals. Any initial review handled as urgent will be handled as an expedited appeal.

Oral and written notice of the determination (whether adverse or not) will be made to the provider not later than 72 hours after receipt of the grievance for Urgent, Pre-service (Expedited) Grievances.

Oral notice of the determination (whether adverse or not) will be made to the provider not later than 24 hours after receipt of the grievance for Urgent, Pre-service Concurrent (Expedited) grievances followed by written notice within 24 hours.

4. The Role of the Provider and Magellan

Standard Appeals

For other appeals regarding mental health or substance abuse health care, we will send a notice of our decision in writing within 30 calendar days of receiving a request.

Submission Timeframe

A provider must submit his or her appeal within 180 days of receiving our denial. A provider may submit an appeal in writing or by phone. Please send written appeals to:

Magellan Health Services
199 Pomeroy Road
Parsippany, NJ 07054

Providers may call 1-800-395-1356 to submit an appeal by phone or if they need help in submitting an appeal.

Note: The State of Vermont has a Health Care Ombudsman's office. If a provider has a problem, this office may be able to assist. Call 1-800-917-7787 or 1-802-863-2316.

Voluntary Appeal of First-Level Mental Health or Substance Abuse Grievance Decision

You can request a second review of your appeal if you are not satisfied with the initial decision. To arrange for this review, write to:

Blue Cross and Blue Shield of Vermont
Mental Health Second-Level Appeals
P.O. Box 186
Montpelier, VT 05601-0186

If you have an emergency medical condition, you will be notified of the decision on your appeal within 24 hours. For all other appeals, you will be sent a decision within 30 calendar days of receipt of your request.

Independent Review

If, after the first review, you are dissatisfied with either of our internal reviews for medical necessity or experimental/investigational treatment decisions, you have the right to ask the state's Independent Panel of Mental Health Providers to review your case. The panel is not connected to BCBSVT/TVHP. Or, if your request has gone through our second level of review and you are still not satisfied, you can call the Independent Panel at that time and ask for a review. For more information about the

4. The Role of the Provider and Magellan

Independent Panel, or to ask for a review, call 1-800-631-7788 or 1-802-828-2900.

Continuation of Services During the Internal Appeal and/or the External Appeals Process

If services that require prior authorization have been authorized and the services are either currently being provided to a member in a health care facility or are another type of ongoing course of treatment, and the treating provider has determined that it is medically necessary for the ongoing course of treatment to continue without disruption or delay, the services will continue to be covered until:

- a. The exhaustion of all internal expedited grievances, if requested within 24 hours of receipt of the denial(s); or until the independent external review decision is issued, if expedited independent external review is requested within 24 hours of the receipt of the final grievance decision and notice of appeal rights by the member and is conducted in accordance with the timeframes specified by law; and
- b. Magellan has authorized coverage for a medically safe and appropriate discharge or transition plan developed after consultation with the member's treating health care provider or the treating health care provider's designee. A treating health care provider may select a hospital discharge planner as his or her designee.

If the denial is upheld by an independent external review conducted pursuant to Vermont law, Magellan is not responsible for payment for the services that were subject to the independent external review beyond the date the independent external review decision is issued. If the member nonetheless elects to continue the current level of treatment, Magellan requires that the member or treating provider contact Magellan in advance of discharge for the purpose of initiating utilization management regarding the discharge plan described in Subsection b. above.

What You Need to Do

To comply with this policy your responsibility is to:

- ◆ Refer to the non-authorization notification letter, which outlines the procedure.

4. The Role of the Provider and Magellan

What Magellan Will Do

Magellan's responsibility to you is to:

- ◆ Notify you in writing of a non-authorization determination and the appeal process.
- ◆ Notify you of the appeal decision if Magellan conducts the appeal and any further appeal rights.

5. Provider Reimbursement

Claims Filing Procedures

Please refer to www.bcbsvt.com for information regarding claims submission.

Claims Processing for Services Provided to BCBS Members

For Blue Cross/Blue Shield of Vermont (BCBS) members, claims are processed by BCBS. Please submit your claims to:

BCBS
P.O. Box 186
Montpelier, VT 05602

If you have any questions regarding claims processing, you may contact the local BCBS customer service office at 1-800-247-2583 or the Magellan office at 1-800-395-1356.

Appendix A
Blue Cross Blue Shield of Vermont Fact Sheet



Blue Cross Blue Shield of Vermont Referral and Authorization Fact Sheet

Medically necessary outpatient mental health and substance abuse services

REFERRALS

Outpatient benefits are administered on a per member per calendar year basis. Coverage determinations are based on member eligibility, member benefit plan and medical necessity, subject to applicable state and federal laws.

Blue Cross Blue Shield of Vermont The Vermont Health Plan

PREAUTHORIZATION IS REQUIRED AFTER VISIT 10. Members may access mental health and/or substance abuse services through any of the three options listed below:

1. The member contacts Magellan directly at 1-800-395-1356 to determine network providers and request an authorization.
2. Participating provider may contact Magellan to request an authorization.
3. If the member has out-of-network benefits, he/she may self-refer to a provider who is not participating in the Magellan network.

To limit their out-of-pocket expense, members should be encouraged to seek services from a Magellan participating provider. If a member chooses to obtain services from a non-participating provider, the member may have higher co-payment/co-insurance amounts depending on the terms of his/her benefit plan.

AUTHORIZATION

No authorization will be required for the first 10 routine outpatient mental health sessions per calendar year for most BCBSVT benefit plans. The 10 authorization pass-through applies to services provided to the member under the same provider *tax identification number*. Providers do NOT need to request authorization for any medication management sessions (90862).

Please note the following important program provisions:

For members enrolled in BCBSVT plans, preauthorization is no longer required for the first 10 routine outpatient visits. For members who are part of the Federal Employee Program (FEP) plan, effective January 1, 2011 it is no longer required to obtain prior approval before providing outpatient professional or outpatient facility care for mental health and substance abuse treatment. Previously, prior approval was required. However, this does not eliminate the need for your office/agency to verify member enrollment and benefits. Additionally, effective January 1, 2011, the BCBSVT FEP no longer covers behavioral health services provided by Residential Treatment Centers or programs.

◆ Authorization is still required for:

- All psychological testing, and
- All higher levels of care regardless of diagnosis, such as intensive outpatient, partial hospitalization services, residential and inpatient admissions.

EXTENDED OUTPATIENT TREATMENT (CONCURRENT REVIEW)

Extended mental health and substance abuse treatment is available beyond the member's initial benefit when authorized, based upon medical necessity and the terms of member's benefit plan. Please consult the Magellan Provider Handbook at www.MagellanHealth.com/provider for a comprehensive overview of Magellan's Medical Necessity Criteria. Practitioners are to complete a treatment request form (TRF) prior to exhausting the initial benefit and fax it to Magellan's Clinical Department at 1-877-551-8302.

Please note: The medically necessary outpatient visits and benefits authorized are reimbursed at the applicable Magellan rates, less the applicable co-payment. **All providers are required to hold the member harmless and cannot bill the member for the difference between Magellan's reimbursement rate and the provider's standard rate. (No balance-billing.)**

Medically necessary inpatient/alternative levels of care

AUTHORIZATION

In most cases, members must have a face-to-face evaluation to determine the appropriate level of care. Providers are to contact Magellan at 1-800-395-1356 to arrange for these services prior to admission to the following levels of care:

- Inpatient Mental Health
- Crisis Stabilization Units (CSUs)
- Partial Hospitalization
- Intensive Outpatient
- Structured Outpatient Addiction Program
- Emergency services

OTHER SERVICES REQUIRING PRIOR AUTHORIZATION

For ALL members, the following additional services require prior authorization from Magellan:

- Psychological Testing
- Day Treatment Services
- Out-of-Plan Providers
- Extended Outpatient Benefits

Billing procedures

- An authorization number is required for mental health and substance abuse treatment beyond the member's initial benefit.
- **All claims must be submitted to:**
Blue Cross Blue Shield VT
PO Box 186
Montpelier, VT 05601
- **For further information about claims go to www.bcbsvt.com.**

For more information

- Non-clinical questions are to be directed to Magellan's Provider Services Line at 1-800-788-4005.
- Clinical questions are to be directed to 1-800-395-1356.
- Claims questions are to be directed to 1-800-395-1356.
- Consult our [National Provider Handbook](#) at www.MagellanHealth.com/provider.

Appendix B

Definitions

Definitions

- A. “Adverse benefit determination” means a denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including but not limited to:
1. A denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a health benefit plan;
 2. A denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and
 3. Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.
- B. “Clinical peer” means a health care provider in a specialty that typically provides the same procedure or treatment, or diagnoses or manages the medical condition under review and who holds a non-restricted license in a state of the United States.
- C. “Clinical review criteria” means the written screening procedures, clinical protocols, practice guidelines and utilization management and review guidelines used by the managed care organization to determine the necessity and appropriateness of health care services.
- D. “Concurrent review” means utilization review conducted during a member’s stay in a hospital or other facility, or other ongoing course of treatment.
- E. “Credentialing verification” or “credentialing re-verification” means the process of obtaining and verifying information about a health care provider and evaluating that health care provider relative to the managed care organization’s standards when that health care provider applies to become or remain a contracted provider with the managed care organization.
- F. “Discharge plan” means the plan that results from the formal process for determining, before discharge from a health care facility, the coordination and management of the care that a member will receive following the discharge.
- G. “Emergency medical condition” means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:
1. Placing the member’s physical or mental health in serious jeopardy; or
 2. Serious impairment to bodily functions; or
 3. Serious dysfunction of any bodily organ or part.

- H. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.
- I. “Grievance” means a complaint submitted by or on behalf of a member regarding the:
1. Adverse benefit determination;
 2. Availability, delivery or quality of health care services;
 3. Claims payment, handling or reimbursement for health care services; or
 4. Matters relating to the contractual relationship between a member and a managed care organization or the health insurer offering the health benefit plan.
- J. “Medically necessary care” means health care services, including diagnostic testing, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the member’s diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and
1. Help restore or maintain the member’s health; or
 2. Prevent deterioration of or palliate the member’s condition; or
 3. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
- K. “Post-service Review” means review of any claim for a benefit that is not a pre-service or concurrent review claim as defined by this rule.
- L. “Pre-service Review” means review of any claim for a benefit with respect to which the terms of coverage condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care.
- M. “Primary care provider” means a health care provider who, within that provider’s scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a primary care provider by a managed care organization.
- N. “Primary care services” include services provided by providers specifically trained for and skilled in first-contact and continuing care for persons with undiagnosed signs, symptoms or health concerns, not limited by problem origin (biological, behavioral or social), organ system or diagnosis. Primary care services include health promotion, disease prevention, health maintenance, counseling, patient education, self-management support, care planning and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

- O. “Service area” means the geographic region in or for which a health benefit plan subject to Part 5 or 6 of this rule is, consistent with applicable law, marketed, sold, intended by the issuer and described in the policy and certificate as the region in which the travel and waiting time standards in Section 5.1 of this rule are met and in which certificate holders are expected to and are able to access all or most of the covered benefits at the benefit level most advantageous to the member. That a health benefit plan subject to Part 5 or 6 of this rule may be required to authorize coverage for services for individual members in a location outside of the service area at the benefit level most advantageous to the member does not subject that location to the travel and waiting time requirements of this rule.

- P. “Urgently needed care” or “urgent care” means those health care services that are necessary to treat a condition or illness of an individual that if not provided promptly (within 24 hours or a timeframe consistent with the medical exigencies of the case) presents a serious risk of harm.