Magellan HEALTHCARE.

EAP Provider Orientation

November 2023

Magellan's Employee Assistance Program (EAP) helps individuals to resolve personal problems and address common work/life issues, while it also provides training, consultation, and other management services for employers. Agenda







Registering an EAP case

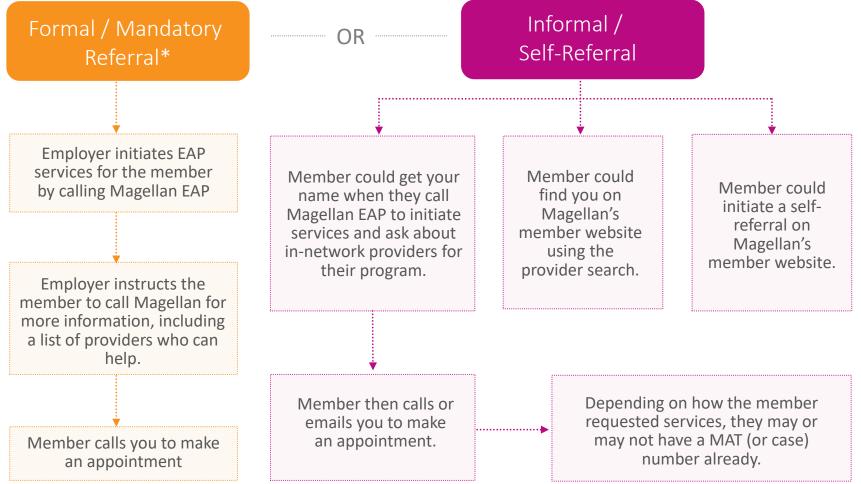
Obtaining an EAP registration packet

Submitting for reimbursement



EAP referral process





*Formal/mandatory referrals have special requirements.



EAP referral process, cont'd



When a member contacts you for EAP services:



Ask the member if this is a formal/ mandatory referral* or an informal/self-referral.



- Ask the member if they have a MAT number.
- YES: Proceed to step 3.
- NO: Call Magellan EAP. If the member doesn't have the phone number for their program, call 1-800-523-5668.
 - Be prepared to verify some information for the EAP member, including company name, member full name (and employee name if different), date of birth, and address.
 - Ask Magellan staff if there is already a case on file, or to create a case, and provide you with a MAT number.



Go online to **MagellanProvider.com** to register the case using the MAT number and member's last name.

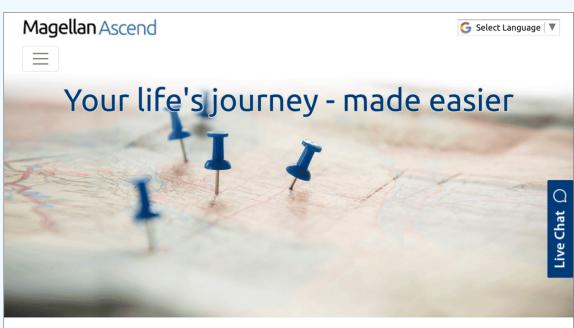


Member website overview: MagellanAscend.com*





EAP member logs in or creates a new account indicating the name of their company.



REACH YOUR GOALS

Welcome! You've come to the right place to find free, confidential services to help you and your household members manage everyday challenges and work on more complex issues.

- Explore the variety of services available
- Find a provider to meet your unique needs
- Search the Learning Center for relevant health information and tools

*Some EAP members may use a more current version of our member website, Member.MagellanHealthcare.com. Requesting an EAP self referral is basically the same process on either website.



Member website overview, cont'd **EAP self referral**



| Q |
|---|
|---|

Once on the website, the member selects the "Find Care" tab and chooses the provider list for the "Employee Assistance Program" to begin their provider search by location or provider info.

| Location Provider Info | Fields marked with an asterisk * are required. |
|---|--|
| Choose a Provider List:* Employee Assistance Program | |
| Search by Address Zip Code:* | Distance:* |
| | 5 Miles |
| | SEARCH |



Member website overview, cont'd **EAP self referral**





- A list of providers will populate, based on the member's search criteria.
- The member will select and confirm their choice.

| provider search | | |
|-------------------|--|--|
| | | |
| MSW Social Worker | Constitution in a | FAP Select Status |
| | Grief/Bereavement Marriage/Family Therapy | EAP Select Status MSW WASHINGTON UNIVERS 1976 Languages: English |
| NT LOUIS MO 63146 | Mental Health Post Traumatic Stress Disorder Substance Abuse | |
| | vate practice 2 NT LOUIS MO 63146 | Septing new patients: Yes Specializes in: VATE PRACTICE Grief/Bereavement Marriage/Family Therapy NT LOUIS MO 63146 Mental Health Post Traumatic Stress Disorder |



Member website overview, cont'd **Provider email**





- A member may initiate contact with you using the email address listed in your provider profile (instead of calling).
- If you do not use email to communicate with your clients, you should set up an auto-response notifying them of this policy.



Agenda









Registering an EAP case

Obtaining an EAP registration packet

Submitting for reimbursement



Registering an EAP case

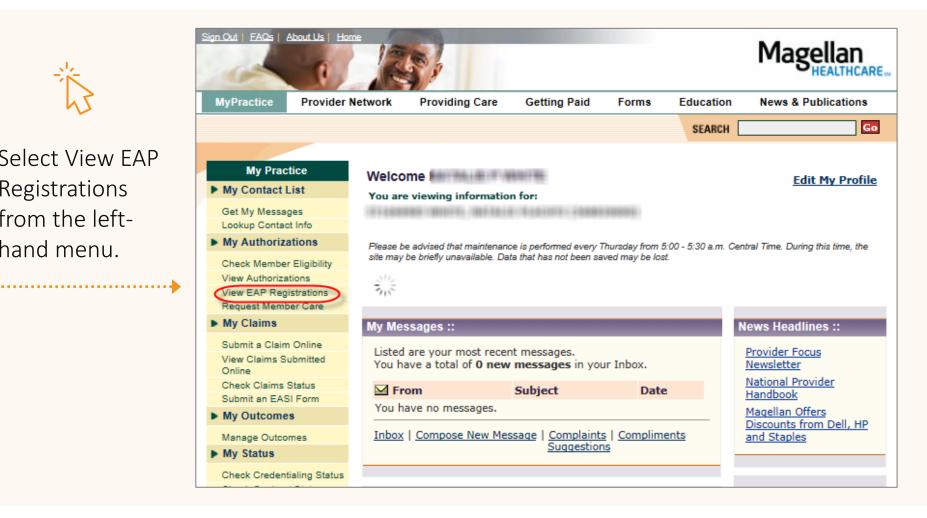








Select View FAP Registrations from the lefthand menu.

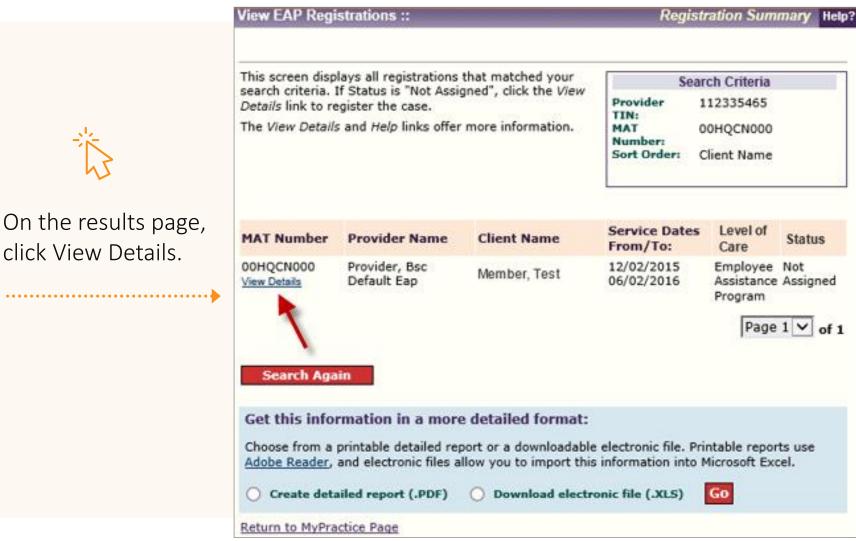




| To register a case (which will designate provider), search by MAT Number and t both are required fields. | , 0 | | | | | |
|---|---------------------------|--|--|--|--|--|
| View EAP Registrations :: | Registration Search Help? | | | | | |
| Enter data for ONE OR MORE of the following search option better narrow your results. | | | | | | |
| If you received a MAT number from the member, you must enter it in <i>Option 1</i> AND enter last name in <i>Option 2</i> below to register the member (designates you as the treating provider). | Ask a Specialist | | | | | |
| Option 1 MAT Number | letter O. | | | | | |
| Option 2 Member/Client Information | | | | | | |
| And Last Name: First Name: Me | ember No.: (Optional) | | | | | |













Select "Yes" and click the Submit button.

| View EAP Registration | Registration Details Help | | |
|---------------------------------|--------------------------------|---------------------|------------------|
| Do you want to regi | ster this case? •Yes | Submit | |
| MAT Number: 00HQ | CQ000 | 1 | |
| Member Name: | Member, Test | Member No.: | 123456789 |
| Member DOB: | 05/04/1978 | Subscriber Name: | Individual, Test |
| Company Name: | Test Company | | |
| Services | | | |
| Service Dates: | 12/02/2015 - 06/01/2016 | Services Available: | 3 |
| Primary/Secondary Diagnosis: | R69 | Outcome Code: | 600 - EAP |
| Level of Care: | Employee Assistance Program | | |



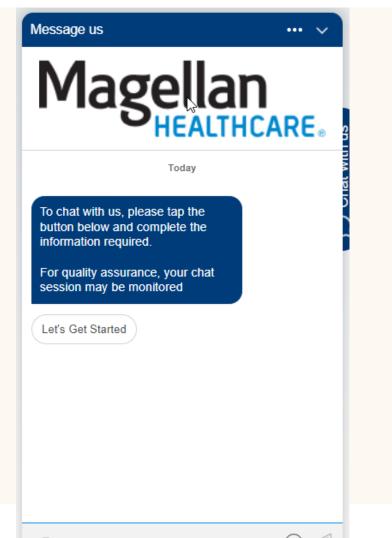
Connecting with us





If you have questions during the registration process, connect using our chat feature.

*If you have questions regarding a FOH member, please call the number on the member's benefit card as the Chat feature is NOT available for these members.



0 A



Agenda









Registering an EAP case

Obtaining an EAP registration packet

Submitting for reimbursement



EAP registration packet materials and associated forms



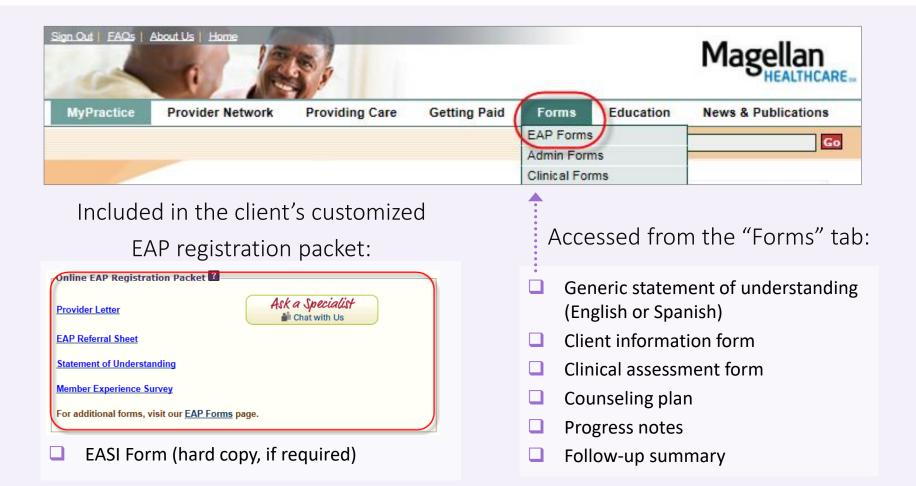
After you register the case, you can access the EAP registration packet materials at the bottom of the page. If you leave this page, search by Last Name and MAT Number to find it again.

| Online EAP Registration Packet | |
|--|----------------------------------|
| Provider Letter | Ask a Specialist Chat with Us |
| EAP Referral Sheet | |
| Statement of Understanding | |
| Member Experience Survey | |
| For additional forms, visit our <u>EAP For</u> | r <u>ms</u> page. |



EAP registration packet materials and associated forms







EAP registration packet: Provider letter and EAP 📃 🕨 🕨 referral sheet



| 14100 Magellan Piaza Maryland Heights, MO 63043 | | These documents include informatic about the member/client and their |
|---|---|---|
| Date <practitioner name=""> <practitioner attention="" name=""></practitioner></practitioner> | Case: <case number=""> Re: <first name=""> <last name=""></last></first></case> | specific EAP. |
| <practitioner 1="" address="" line=""> <practitioner 2="" address="" line=""> <practitioner 3="" address="" line=""></practitioner></practitioner></practitioner> | | Month Name DD, YYYYY MAGELLAN HEALTHCARE, INC. EAP Referral Sheet |
| Dear EAP Provider: | | Case#/MAT#: <mat#></mat#> |
| Thank you for serving the Magellan* mem Program (EAP). The following information | ber listed above through the Employee Assistance is included in the referral packet: | Client: <last name="">, <first name=""> Client SSN: XXX-XX-9999-00 Gender: Male</first></last> |
| | sheet includes information regarding the member's | Telephone: <phone #="">Ext. <ext> Can be called (Y/N)?: Y Message (Y/N)?: N</ext></phone> |
| | zation and the member's EAP benefit. | Organization: Memorial Sloan Kettering Organization No.: 012545-00 |
| Statement of Understanding – Eac EAP services. This form may be cu the member's referral packet. | ch member must sign this document prior to receiving stomer-specific, so please use only the form included with | Demographic Information: |
| Workplace Outcomes Suite (WOS | S) – We will email or text the five-question WOS directly | ALCOHOL SCREEN 001 Random DRUG SCREEN 001 Random PRESENTING PROBLEM 001 Alcohol METHOD OF ACCESS 183 Website |
| to each member at the beginning of WOS, please see <u>www.eapresearch</u> | EAP and at final billing. For more information on the com. | Presenting Risk Level: Routine (Does not print for FOH.) |
| | rmation (EASI) Form – The EASI form is required to This is the ONLY form that is accepted for billing. are not accepted for EAP services. | EAP Consultant: <consultant name=""> <phone number=""> <ext></ext></phone></consultant> |
| | the last session or at case closure, share the "Tell us nember. They can complete the survey digitally, ering a short URL. | Care Requested: EAP 99/99/9999 99/99/9999 9 |
| For more information about Magellan EAP website at <u>www.MagellanProvider.com/EA</u> | services, or to access clinical forms, visit our provider <u>P</u> . | This program allows self-referrals. If you self-refer you must have the client sign a self-referral waiver form. See your EAP addendum. Find EAP forms online at www.MagellanProvider.com/EAP . |

EAP registration packet: member experience survey and statement of understanding



Magellan

STATEMENT OF UNDERSTANDING

You have chosen to receive employee assistance program ("EAP") services which are provided through Magellan Healthcare ("Magellan"). EAP services may include assessment and referral or brief counseling. The EAP counselor will work with you to clarify the problem, identify choices, and develop an action plan. Magellan customer service associates and EAP consultants are available to respond to your call 24 hours a day, 365 days a year.

FEES

These services are provided at no direct cost to employees and family members. The employee's company pays for the services. However, if you need longer-term counseling or a specialized service, Magellan will assist in locating a resource or service in the community. It is your responsibility to pay for services provided by any resources outside the EAP. (Your benefit plan may cover some of the cost. Check with your benefits representative <u>before</u> services are provided by outside resources.)

CONFIDENTIALITY

Magellan and the EAP counselor will maintain confidential records of your contact with the EAP and the services provided to you in order to provide continuity and coordination of your care.

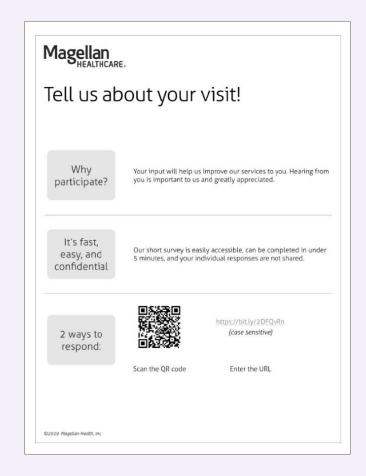
No one will reveal information concerning your use of the EAP to anyone outside the program except as follows: (1) you consent in writing; or (2) life or safety is seriously threatened; or (3) disclosure is required by law; or (4) your counselor refers you to benefitscovered treatment and the claims payor requires information. In addition, your counselor will disclose information and records to Magellan as needed for coordination of EAP services, quality assurance, or payment. Professional auditors (not employed by the employee's company) may also examine your file to evaluate the services. Depending on the privacy policy of the employer, the employee's privacy official might have access to information in connection with the employer's obligations in the Privacy Rule under HIPAA (the Health Insurance Portability and Accountability Act). Check the employer's privacy policy to see if the privacy official or anyone else will have access to information.

In order to provide the best service to customers, members and providers, Magellan Health (including its subsidiaries) ("Magellan") may monitor and/or record incoming calls for quality purposes. As a result of this ongoing practice, Magellan staff notifies callers of the potential for monitoring and/or recording for in-bound and out-bound calls made from their direct line.

IF YOU HAVE BEEN REFERRED TO THE PROGRAM DUE TO A WORK PERFORMANCE PROBLEM:

Under your employer's policy,

1) Magellan is expected to confidentially advise the referral source whether you are participating in the EAP and





Agenda







- Registering an EAP case
- Obtaining an EAP registration packet

Submitting for reimbursement



Submitting for reimbursement: Employee Assistance Service Information (EASI) Form





- 1. Go to MagellanProvider.com and sign in.
- 2. Select Submit an EASI Form from the left-hand menu.
- 3. Submit the online EASI Form for most EAP clients.*
- 4. You must submit the EASI Form within 90 days of the end date indicated on the referral sheet, found in the EAP member registration packet for each specific case.





Subm



On the Client Information screen, indicate if this is an Interim Bill or Final Bill.

You can also indicate the date the member first contacted you. This helps with our quality reporting.

Employee Assistance Service Information (EASI) Form

In order to receive payment for EAP services rendered, you must complete the information requested on the Employee Assistance Service Information (EASI) Form. The EASI Form must be submitted within 90 days of the end of the date indicated on the EAP referral sheet, found in the EAP registration packet for each specific case. Please refer to the client's original EAP registration packet for the specific billing address.

Client Information ? * - Required MIS#: Case#/MAT#: 724741000 001035000 Clinician: TIN/SSN: 203451445 Address: Agency/Organization: ABINGDON VA 24210-9447 Magellan's Client Organization/ Client Name: Company Providing EAP Benefits: A PORT OF A PORT PROPERTY AND A PORT **Registration Start Date: Registration End Date:** 09/15/2017 12/31/2017 Number of Certified Sessions: 5 Bill Type:* Date Member Contacted You For First Session: ○ Interim Bill ○ Final Bill Continue Cancel





On the Encounter Information screen, record session details, including the Session Type (either In-Person or Telehealth).

| Encounter | Informatior | า 🔳 | | | | | | ? |
|--|----------------------------|---------------------|----------------|-----------|------------------|----------|--------------------|-----------------|
| * - Required | | | | | | | | |
| ICD-10 Assessment: Primary:* F06.4 | | | | | | | | |
| | ormation Re AA Guidelin | | Session | Informat | tion/Atte | endees F | Present | |
| Session Date*? | Time Seen* ? | Start Time* ? | Emp- loyee* | Spouse* | Depen- dents* | Other* | Session Type* ? | Voucher Date |
| | | Sess | ions ava | ilable to | enter | | | |
| 1. 10/01/20 | 17 30 | 14:00 | Yes 🗸 | Yes 🗸 | 0 🗸 | 0 🗸 | (InPe | |
| 2. | | | ✓ | ~ | ✓ | ✓ | ~ | |
| 3. | | | ~ | ~ | ~ | ~ | ~ | |
| 4. | | | ~ | ~ | ~ | ~ | ~ | |
| 5. | | | ~ | ~ | ~ | ~ | ~ | |
| Continue | Cancel | | | | | | | |







Enter Additional Information about the case.

.....

| * - Required | | |
|--------------------------------|---|------------------------------|
| Assessed Problem(s): | | |
| Primary Problem:* | | Alcohol 🗸 |
| Secondary Problem: | | Other 🗸 |
| Referred To:* ? | | |
| Substance Abuse: Detox. | | |
| Substance Abuse: Inpatient | ^ | |
| Substance Abuse: Residential | | |
| Substance Abuse: Day Treatment | | |
| Substance Abuse: Outpat Prog | | You have selected: |
| Behavioral Health: Inpatient | | Substance Abuse: Outpat Prog |
| Psychiatric: Residential | | |
| Psychiatric: Day Treatment | | |
| Behavioral Health: Outpatient | | |
| Psychiatric: Psychiatrist | × | |
| Statement of Understanding:* | | Client Signed |
| Member Experience Survey:* | | Given to Client |





Complete the Questionnaire Information screen for a Final Bill only.

| Questionnaire Informa | tion 📙 | | ? | | | |
|--|--|--|---|--|--|--|
| * - Required | | | | | | |
| In the past 4 weeks of | f EAP counseling | | | | | |
| | What percentage of improvement did the employee experience in routine work | | | | | |
| What percentage of imp daily living?* | provement did the employee | experience in activities of 25 | | | | |
| How many days might h had this EAP counseling | ave been missed from work ?* 👔 | t if the employee had not 3 | | | | |
| Alcohol/Other Drug (AO Child under 12?* | D) screening completed?* | Yes 🗸 | | | | |
| Risk of Harm | | | | | | |
| Threat of Violence (TOV) Level:* | 2-Possible threat mention | ed, no current danger 🔽 | | | | |
| Duty to Warn Issues?* | | No 🗸 | | | | |
| Risk of Workplace Viole | nce?* | No 🗸 | | | | |
| EAP Questionnaire | tioning prior to the first see | reion could best be described as | _ | | | |
| Overall | Social | ssion could best be described as Work | | | | |
| Poor V | Poor V | Poor | | | | |
| | | | | | | |
| Overall | Social | on could best be described as: Work | | | | |
| Below Average 🗸 | Below Average 🗸 | Below Average 🗸 | | | | |
| | | | | | | |





The Attestation screen requires that you attest to the accuracy of information you enter on the form before you submit.

Choose "Print Preview" to view a PDF of the information before agreeing and continuing from this screen.

Attestation Information

* - Required

- I hereby certify that all information I have submitted is correct and complete. I understand that any information I provide to Magellan Healthcare or its subsidiaries or affiliates that subsequently is found to be false could result in termination of any contact I may have with Magellan Healthcare or its subsidiaries or affiliates. In California, Magellan administers EAP programs through affiliates Human Affairs International of California and Magellan Health Services of California, Inc. -Employer Services.

🗌 I Agree *

Enter your legal name & primary business phone number as part of the submission attestation.

| Legal Last Name * | Legal First Name * |
|-------------------------------|---------------------------|
| | |
| Primary Business Phone #: * 💡 | Primary Business Fax #: * |
| | |
| Continue Cancel Print Preview | |



Submitting for reimbursement: EASI Form (hard copy)



| Employee Assistance Service Information Form (EASI Form) Please confirm all information before submitting. If you have any questions, call Magelian LifeResources at 1-866-266-2376. Instructions: In order to receive payment for this case, you must complete the information requested on both pages of this form. Mail the completed form within 90 days of the end date on the Magelian referral sheet. Mail this customized form to: Magelian LifeResources - CONFIDENTIAL P.O. Box 6800, Columbia, MD 21046. To ensure privacy, please DO NOT add client names or SSNs this customized form, as the client is a Magelian employee or family member of an employee. MIS# | Magellan | submit th | grams require that you e two-page hard copy n by fax or mail. |
|--|--|--|---|
| City:State: ZIP Code | | | |
| Case#/MAT#:Magellan's Client Organization: Magellan LifeResources | ſ | | |
| Date member contacted you for the first session: 1. Please enter "Time Seen" in minutes if the session was beyond the standard. Standard payment is based on a 45-55 minute | 5. Referred to: (select all that apply) | Case # / MAT #: | _ |
| session. Sessions beyond the standard MUST be preauthorized. | 002 O Substance Abuse: Inpatient C | 7. Member Experience Survey | 11. The client's level of functioning prior to the first session could best be described as: |
| Section Date(c) Time Seen Start Time Appt Number Attendees Session Administration MMIDD/YY (minutes) (24 hr olook) Present Employee Spouse Dependents Other in Person Telehealth | UD4 () Substance Abuse. Outpatient | 001 O Given to client 002 O Not given to client | Overall Overall Poor Below average Good Above average Excellent Social Overall Below average Good Above average Excellent |
| | 200 O Substance Abuse: Alternative | 003 O Not applicable (under 16) | Work O Poor O Below average O Good O Above average O Excellent O NA |
| | 005 ○ Behavloral Health: Inpatient C 007 ○ Behavloral Health: Outpatient 201 ○ Behavloral Health: Alternative 019 ○ Financial Services 113 ○ Child Care Referral | 8. In the past 4 weeks as a result of EAP counseling: Employee only (if employed by organization providing Magellan EAP): What percentage of improvement did the employee experience in routine | Work Poor Below average Good Above average Excellent Work Poor Below average Good Above average Excellent |
| | 114 O Elder Care Referral | work capacity? +/- | 12. ICD-10 Assessment |
| | 020 O Legal Services 021 O Medical/Physical | % | |
| | 021 Community Social Services 202 Twelve-Step Programs 087 Educational Services | What percentage of improvement did the employee experience in activities of daily living? +/% | Primary Dx Secondary Dx |
| Complete the following by filling the circle (or square) that corresponds with the appropriate answer. 2 Is this bill: O an interim bill? O a that bill? 3. Racelethnicity of client: (select only one) O cauceain O Antrica American O Hispanic O Astan O Native American O Other O Declined | 045 O Career Counseling 023 O No Referral Made 075 O Declined Referral | How many days might have been missed from work if the employee had not had this EAP counseling? (specify 0-28) day(s) | 13. The information above accurately reflects the services I delivered. |
| 4. Assessed problem: (Mark ^O for primary assessed problem, in for secondary problem [optional]) | 6. Statement of Understanding | Dependent, retiree or other household members only: | |
| 01 ○ □Alcohol 82 ○ □Depression 251 ○ □Trauma 13 ○ □Work Performance 25 ○ □llicit Drug 19 ○ □MedPhysical 15 ○ □Child Care 286 ○ □Cocupational Sitess 05 ○ □RX Drug 10 ○ □Martial 83 ○ □EX Drug | 001 O Member signed 002 Member refused to sign 003 Not asked to sign | In the past 4 weeks as a result of EAP counseling: | Clinician Signature Date MM/DD/YY |
| 04 	Polydrug 87 Bereavement 16 Legal 11 Interpersonal Relationships | (reason) | What percentage of improvement did the client experience in activities | [_] |
| 06 _ Eating Disorder 12 _ Family/Children 17 _ Financial 14 _ Family/Friend Emo(Health 269 _ Anxlety 271 _ Other Psychological 18 _ Career Planning 07 _ Other Compulsive Disorder | 004 O Other signed | of daily living? +/% | Telephone Number Extension |
| 05 C Family/Friend AloDrug 245 School Related 280 C Learning/Development Issues | | 9. Alcohol/Other Drug (AOD) Screening complete(? O Yes O No Child under 12? O Yes O No | |
| If required, you will find the har | ď | 10. Risk of Harm . 1. Thread V folence (TOV) level: 0 1 – None 0 1 – None 0 4 – Active thread to violence exists no current danger 0 5 – Client dangerous to selfiothers | |
| copy version in the member's E | AP | (#TOV between 3 – 5, Inten answer a and b, below) a. Dated with Magellon? b. Action plan developed? Yes No NA 2. Duty to avarn issues? Yes No 3. Risk of workplace violence? Yes No | |
| registration packet. | | For help completing this form, see the EASI For | rm Instructions, online at www.MagellanProvider.com. |

©2005-2017 Magellan Health, Inc. rev. 8/17



Getting paid: EAP reimbursement





Access EAP reimbursement resources from the Getting Paid tab at **MagellanProvider.com**.

| My Practice Provider | Network Providing Care | Getting Paid Forms | Education | News & Publications | | | |
|--|---|--|---------------------|---------------------|--|--|--|
| | | Preparing Claims | SEARCH | G | | | |
| | | DSM-5/ICD-10 | o childh | | | | |
| | | HIPAA Coding | | | | | |
| Getting Paid | EAP Reimburseme | Electronic Transactions | | | | | |
| Preparing Claims | | Paper Claim Forms | | | | | |
| DSM-5/ICD-10 | To receive payment for EAP s complete the Employee Assis | | Ask a Specialist | | | | |
| HIPAA Coding | form. | FAQ | | Chat with Us | | | |
| Electronic Transactions | Online EASI Form Use the online application to conveniently and easily submit your EASI | | | | | | |
| Paper Claim Forms | forms. Simply <u>sign in</u> with your secure username and password, and click on Submit an EASI Form on the left-hand menu (under My Claims). EASI Form hard copy for faxing or mailing (PDF) | | | | | | |
| | | | | | | | |
| EAP Reimbursement | | EASI Form Instructions (PDF) | | | | | |
| | |) | | | | | |
| | | | | | | | |
| | EASI Form Instructions (PDF) | <u>Information</u> (PDF) rm within 90 days of the en jistration packet for each sp | | | | | |
| EAP Reimbursement FAQ | EASI Form Instructions (PDF) EAP Reimbursement Contact You must submit the EASI for found in the EAP member reg | Information (PDF) rm within 90 days of the en jistration packet for each sp ecific billing address. | ecific case. Please | refer to the EAP | | | |



Forms: EAP forms





Access EAP forms from the Forms tab at **MagellanProvider.com**.

| n Qut EAQs Abou | LUs Home | V | | Magellan | | | |
|---------------------|--|--|-----------------|---------------------------|--|--|--|
| My Practice | Provider Network Providing Care Getting Paid | Forms | Education | News & Publications | | | |
| | | EAP Forms | | Go | | | |
| | | Admin Forms | | | | | |
| | | Clinical For | ms | | | | |
| Forms | Magellan EAP Forms | Paper Claim Forms | | | | | |
| EAP Forms | | | | R. | | | |
| Admin Forms | Instructions | | | | | | |
| Clinical Forms | | Use these forms when providing Employee Assistance | | | | | |
| Paper Claim For | Program (EAP) services. | | A | K a Specialist | | | |
| | Retain completed clinical forms in the clie | Retain completed clinical forms in the client's chart. | | | | | |
| | Fill out forms completely and/or note why be completed. | a section ca | nnot | | | | |
| | See the <u>EAP provider handbook suppleme</u> services to EAP clients. | ent for policie | s and procedure | es required for rendering | | | |



News & Publications: EAP-Specific Information MagellanProvider.com/EAP





network, you could receive additional EAP and critical incident response

Access the EAP Provider Handbook Supplement and appendices from MagellanProvider.com/EAP

Find answers to your frequently asked questions about being an EAP provider and more resources in <u>our</u> <u>welcome packet</u>.





EAP-Specific Information: EAP Provider Handbook Supplement





Review the EAP Provider Handbook Supplement and appendices.

You must be familiar with and follow the policies and procedures contained within all applicable supplements to Magellan's National Provider Handbook.



Legal statement



The information contained in this presentation is intended for educational purposes only and should not be considered legal advice. Recipients are encouraged to obtain legal guidance from their own legal advisors.

