

**Magellan Behavioral Health\***  
**Provider Handbook Supplement**  
***Harmony Health Plan of Missouri Medicaid***

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# **1. Introduction**

Welcome to the Magellan Behavioral Health (Magellan) Provider Handbook Supplement for Harmony Health Plan of Missouri - MO HealthNet Division (MHD) Medicaid Managed Care program. This handbook supplements the Magellan National Provider Handbook, addressing policies and procedures specific for Harmony Health Plan of Missouri MHD Medicaid Managed Care. The Handbook Supplement for Harmony Health Plan of Missouri is to be used in conjunction with the national handbook. When information in the Harmony Health Plan of Missouri supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in the Harmony Health Plan of Missouri supplement prevail.

Harmony is a managed care plan for the MO HealthNet Division Managed Care Program. In order to meet the behavioral health needs of their MO HealthNet Managed Care members, Harmony has contracted with Magellan to provide a continuum of behavioral health services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.

Members are entitled to the services listed in this section, subject to eligibility requirements, medical necessity and all other limitations set forth in their schedule of benefits. All benefits are subject to the terms of the MO HealthNet Division Managed Care contract between Harmony and the state of Missouri.

For more detail on the program, providers may contact Magellan at 1-888-684-2026.

For information on member enrollment and PCP responsibilities please see the medical plan provider handbook for Harmony Health Plan. These aspects of care are not delegated to Magellan.

## **Covered Services**

- Inpatient hospitalization
- Outpatient services
- Crisis intervention/access services
- Alternative services which are reasonable, cost effective, and related to the member's treatment plan
- Referral for screening to receive case management services
- Emergency Behavioral Health/Substance Abuse services

## **Non Covered Services**

- Services that are not medically necessary
- Services that are experimental/investigational
- Educational services

## 2. Harmony Health Plan/WellCare Member Grievance and Appeal System

Harmony Health Plan (the Plan) maintains distinct grievance and appeals processes for members as well as access to the Medicaid Fair Hearing system. An *appeal* is a request for review of some action taken by or on behalf of the Plan. Member appeals may be submitted by the member or a provider, acting on behalf of the member and with the member's written consent.

A *grievance* is an expression of dissatisfaction about any matter other than an action that can be appealed. A member may file a grievance and a provider, acting on behalf of the member and with the member's written consent, may file the grievance. The Plan ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision making. These decision makers are health care professionals with clinical expertise in treating the member's condition/disease, or have sought advice from providers with expertise in the field of medicine related to the request when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal involving clinical issues.

Members may file oral complaints and/or grievances by calling 1-866-822-1340.

### Submission of Member Appeals

Any party to an action appropriate for appeal (including a reopened and revised determination), including a member, a member's authorized representative or a contracted or non-contracted physician or provider to the Plan, may request that the determination be reconsidered. Providers do not have appeal rights through the member appeals process. The member, a member's representative or a provider acting on the member's behalf may request an expedited, standard pre-service or retrospective appeal determination. The request must come from the physician, not from the physician's office staff. The Plan will not take or threaten to take punitive action against a provider acting on behalf of or in support of a member in requesting an appeal or an expedited appeal. The Plan gives members reasonable assistance in completing forms and other procedural steps for an appeal, including but not limited to providing interpreter services, a toll-free telephone number 1-866-822-1340 (TTY/TDD 1-877-650-0952) and interpreter capability. Members are provided reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. If the request for reconsideration is submitted after 90 calendar days from the notice of action letter, then good cause must be shown in order for the Plan to accept the late request. Examples of good cause include, but are not limited to:

- The member did not personally receive the adverse organization determination notice, or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;

- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The member had incorrect or incomplete information concerning the reconsideration process; or
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

Questions regarding the filing or status of an appeal should be directed to the Customer Service department, which will coordinate with Appeals as appropriate.

A member or a provider on behalf of the member may file an appeal request either verbally or in writing within 90 days of the date of the notice of action. If the Plan does not issue a written notice of action, then the member or provider may file an appeal within one year of the action. If filed verbally through Customer Service, the request must be followed up with a written, signed appeal to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal filing was received. If the member wishes to use a representative, then he/she must complete an Appointment of Representation statement. The member and the person who will be representing the member must sign the statement.

The Plan must make a determination on an appeal within the following time frames:

- Expedited Request: **three business days**
- Standard Request: **30 calendar days**

Members have the right to request continuation of benefits during an appeal or Medicaid Fair Hearing. The member may be liable for the cost of any continued benefits if the Plan's action is upheld. The Plan will continue the member's benefits if the appeal is filed timely, meaning on or before the later of the following:

- Within 10 calendar days of the date on the notice of action (add five calendar days if the notice is sent via U.S. mail);
- The intended effective date of the Plan's proposed action.

The Plan will continue the member's benefits if:

- The appeal terminates, suspends or reduces a previously authorized course of treatment;
- The service is ordered by an authorized provider;
- The authorization period has not expired; and
- The member requests extension of the benefits.

If the Plan continues or reinstates member benefits while the appeal is pending, the member's benefits will be continued until one of following occurs:

- The member withdraws the appeal;

- Ten calendar days pass from the date of the Plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five calendar days if the notice is sent via U.S. mail);
- A State Fair Hearing decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

All appeals must be submitted initially to the Plan and may later be appealed to the Missouri Department of Social Services (DSS) through the Fair Hearing Process. This process shall also be available for dissatisfaction concerning the timeliness of services, timeliness of appeal responses or denials of requests to obtain services outside a rural contracting area.

### **Request for Expedited Determination**

A request for an expedited determination may be made verbally by calling Customer Service or in writing to the Appeals department. The request must state that it is a request for an expedited process and lists reasons why the case should be expedited. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function. A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration. The Plan will make a determination within three business days from receipt of the request. The Plan will make reasonable efforts to notify the member verbally and will also notify the member in writing of the disposition of their request.

### **Denial of Expedited Request**

If the Plan denies the request for the expedited determination, then the Plan will automatically transfer the request to 45 calendar days from the date the Plan received the request for expedited reconsideration to the standard reconsideration process and then make its determination as expeditiously as the member's health condition requires. The plan will make reasonable efforts to give the member prompt verbal notice of the denial, and follow up within two calendar days with a written notice.

### **Request for Standard Determination**

The provider and member must complete an Appointment of Representation statement. The Plan will make a determination and provide notification within 45 calendar days from receipt of the standard request.

### **14-Day Extension**

The Expedited, and Standard Determination periods noted above may be extended by up to 14 calendar days, if the member requests an extension or if the Plan justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, the Plan will provide the member with written notice of the reason for the delay.

## **Affirmation of Denial**

If the Plan upholds its initial action and/or denial, then the member, member's representative or provider will be notified in writing of the decision as well as any additional appeal rights that are available (Medicaid Fair Hearing).

## **Reversal of Denial**

If the Plan overturns its initial action and/or denial, it will notify the member and provider in writing. The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. The Plan also will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

## **Medicaid Fair Hearing**

The member has the right to request a Medicaid Fair Hearing in addition to pursuing the Plan's appeals process. The provider, acting on behalf of the member and with the member's written consent, may also request a Medicaid Fair Hearing. Parties to the Medicaid Fair Hearing include the Plan, as well as the member and his or her representative or the representative of a deceased member's estate. The member, the representative or provider may only request a Medicaid Fair Hearing within 90 calendar days of the date of the notice of action and/or denial. The request must be sent to DSS at the following address:

Division of Medical Services  
Recipient Services Unit  
P.O. Box 3535  
Jefferson City MO 65102

For questions regarding Medicaid Fair Hearings, you may contact the Recipient Services Unit at 1-800-392-2161.

The state must reach its decisions within the specified time frames:

- 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.
- 2) Expedited resolution (if the appeal was heard first through the health plan appeal process) within three working days from the state agency's receipt of a hearing request for a denial of a service that:
  - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal time frames, or

- Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.

3) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the health plan appeal process) within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

The Plan will continue the member's benefits while the Medicaid Fair Hearing is pending if:

1. The Medicaid Fair Hearing is filed timely, meaning on or before the later of the following:
  - Within 10 calendar days of the date on the notice of action (add five calendar days if the notice is sent via U.S. mail); or
  - The intended effective date of the Plan's proposed action.
2. The Medicaid Fair Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
3. The services were ordered by a provider;
4. The authorization period has not expired; and
5. The member requests extension of benefits.

If the Plan continues or reinstates the member's benefits while the Medicaid Fair Hearing is pending, the benefits will be continued until one of following occurs:

1. The member withdraws the request for Medicaid Fair Hearing;
2. Ten days pass from the date of the plan's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five days if the notice is sent via U.S. mail);
3. A Medicaid Fair Hearing decision adverse to the member is made; or
4. The authorization expires or authorized service limits are met.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit, or delay services. The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit or delay services. The Plan will not take punitive action against a provider who requests a Medicaid Fair Hearing on the member's behalf or supports a member's request.

### **3. Role of the Provider and Magellan – Member Access to Care**

<b>Our Philosophy</b>	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.
<b>Our Policy</b>	We require in-network providers to be accessible within a time frame that reflects the clinical urgency of the member's situation.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>◆ Provide access to services 24 hours a day, seven days a week.</li><li>◆ Inform members of how to proceed, should they need services after business hours.</li><li>◆ Provide coverage for your practice when you are not available, including, but not limited to an answering service with emergency contact information or instructions.</li><li>◆ Respond to telephone messages in a timely manner.</li><li>◆ Provide immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation.</li><li>◆ 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 prevent acute deterioration of the member's condition.</li><li>◆ Provide services within 48 hours of referral in an urgent clinical situation.</li><li>◆ Provide services within 10 business days of referral for routine clinical situations.</li><li>◆ Provide services within seven days of a member's discharge from an inpatient stay.</li><li>◆ Contact Magellan immediately if member does not show for an appointment following an inpatient discharge so that Magellan can conduct appropriate follow up.</li><li>◆ Not exceed office appointment wait time of one hour.</li><li>◆ Contact Magellan immediately if you are unable to see the member within the timeframes.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"><li>◆ Communicate the clinical urgency of the member's situation when making referrals.</li><li>◆ Assist with follow-up service coordination for members transitioning to another level of care.</li><li>◆ Track and report on follow up and aftercare appointments within seven calendar days after hospital discharge.</li></ul>



### **3. Role of the Provider and Magellan – Initiating Care**

<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>	<p>We assist members in optimizing their benefits by reviewing and authorizing the most appropriate services to meet their behavioral health care needs. Magellan conducts timely pre-authorization reviews in order to evaluate the member's clinical situation and determine the medical necessity of the requested services.</p> <p>We do not pay incentives to employees, peer reviewers (e.g., 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.</p>
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>◆ Understand state and federal Medicaid standards applicable to providers.</li><li>◆ Comply with state and federal Medicaid standards.</li><li>◆ Contact the Magellan Southeast Care Management Center at 1-888-684-2026 prior to the first outpatient appointment, when initiating care, without prior authorization. Members are permitted to contact in-network behavioral health and substance abuse providers without a referral or authorization from his/her primary care provider. Members will be allowed an authorization for four visits annually, defined by his/her benefit year, without prior authorization requirements. You are still encouraged to contact Magellan either online at <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a> or by calling our toll-free number, when a member contacts you directly. Any visits stemming from a member contacting you directly are subject to a medical necessity review and member eligibility requirements. Procedures, such as psychological testing, are subject to prior authorization requirements.</li><li>◆ Complete a health status screen at the initial point of contact and as part of the re-assessment process for members in treatment. Refer members with physical health conditions (as indicated by the screen) to his/her primary care provider for evaluation and treatment of the physical health condition.</li><li>◆ Contact Magellan for pre-certification of services for higher levels of care at 1-888-684-2026.</li><li>◆</li><li>◆ Pre-certify psychological testing by submitting a "Request for Psychological Testing Preauthorization" form. You may obtain this form at <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a>.</li></ul>

- ◆ Provide Magellan with clinical information about the member's presentation as part of the pre-certification process for services beyond traditional outpatient psychotherapy.
- ◆ Not require a primary care physician (PCP) referral from members.
- ◆ Not require pre-certification of members for emergency services, post-stabilization services or urgent care services.
- ◆ Contact Magellan Southeast Care Management Center at 1-888-684-2026 for any questions related to prior authorization and referrals.

**What  
Magellan  
Will Do**

Magellan's responsibility to you is to:

- ◆ Operate a toll-free telephone number to respond to provider questions, comments and inquiries. That number is 1-888-684-2026.
- ◆ Establish a multi-disciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
- ◆ Provide a pre-populated Treatment Request Form to be used to request additional sessions.
- ◆ Make decisions about prior authorizations that are non-urgent within 14 calendar days.
- ◆ Make decisions about expedited services within 24 hours of receipt of complete information.

### **3. Role of the Provider and Magellan - Concurrent Review**

<b>Our Philosophy</b>	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.
<b>Our Policy</b>	<p>Concurrent utilization management review is required for all services, including but not limited to:</p> <ul style="list-style-type: none"><li>◆ Inpatient</li><li>◆ Intermediate ambulatory services such as partial hospital programs (PHP) or intensive outpatient (IOP) programs</li><li>◆ Office or clinic setting traditional outpatient services.</li></ul>
<b>What You Need to Do</b>	<p>If, after evaluating and treating the member, you determine that additional services are necessary:</p> <ul style="list-style-type: none"><li>◆ Contact the designated Magellan care management team member at least one day before end of the authorization period by telephone at 1-888-684-2026 for inpatient and intermediate ambulatory services.</li><li>◆ Submit a Treatment Request Form (TRF), including requested clinical information, online at <a href="http://www.Magellanhealth.com/provider">www.Magellanhealth.com/provider</a> for traditional outpatient services before authorization expiration date.</li><li>◆ 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.</li><li>◆ Request a second opinion if you feel it would be clinically beneficial.</li><li>◆ Understand federal and state Medicaid standards applicable to providers.</li><li>◆ Comply with federal and state Medicaid standards.</li><li>◆ Contact Magellan for pre-certification of inpatient services at 1-888-684-2026.</li><li>◆ Contact Magellan prior to the first outpatient appointment, when initiating care, authorize sessions either through the toll-free number on the member card, 1-888-684-2026, or online at <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a>.</li><li>◆ Contact Magellan for authorization of all non-emergent out-of-network services at 1-888-684-2026.</li><li>◆ Submit a Treatment Request Form to request further sessions for outpatient care.</li></ul>

**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).
- ◆ Operate a toll-free telephone number to respond to provider questions, comments and inquiries. That number is 1-888-684-2026.
- ◆ Establish a multi-disciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
- ◆ Review inpatient service requests based on medical necessity criteria and render a decision within 24 hours of initiation of the concurrent review process.
- ◆ Issue written notification to the attending clinician, member and facility for inpatient care.
- ◆ Provide a pre-populated Treatment Request Form (TRF) to be used to request additional outpatient sessions.
- ◆ Review the TRF for completeness.
- ◆ Notify the practitioner within five calendar days if the TRF is incomplete.
- ◆ Notify the practitioner within 14 calendar days if additional clinical information is required.
- ◆ Review complete TRF and issue the authorization or Notice of Proposed Action within 14 calendar days of receipt of the TRF.

### **3. Role of the Provider and Magellan - Advance Directive**

**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.

At the time of enrollment, Harmony Health Plan will provide a member handbook containing information regarding the member's rights under Missouri law. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

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

- ◆ Understand federal and state Medicaid standards regarding psychiatric advance directives.
- ◆ Meet federal and state Medicaid 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 behavioral 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 Missouri 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 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.

### **3. Role of the Provider and Magellan – Medical Record Requirements**

**Our Philosophy** Magellan expects its providers to keep adequate and complete medical records for all members.

**Our Policy** Magellan requires providers to maintain and retain medical records for all members, according to contractual provisions, federal and state laws.

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

- ◆ Maintain records in accordance with the United States Department of Health and Human Services laws, accepted professional standards, accepted medical accounting procedures and sound internal control practices.
- ◆ Maintain records in a secure manner and adopt reasonable measures to prevent unauthorized disclosures.
- ◆ Include documentation of the following information:
  - Identification of the member including name, birth date, address and telephone number;
  - The date(s) the member was seen;
  - The current status of the member, including the reason for the visit;
  - Observation of pertinent physical findings;
  - Assessment and clinical impression of diagnosis;
  - Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, applicable providers shall include in the record the medication and dosage of any medication prescribed, dispensed, or administered; and
  - Any informed consent for office procedures.
- ◆ Retain records for not less than six years from the date of service or as otherwise required by law.

Additionally, for physicians, the following points also apply:

- ◆ Records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee, for a minimum of seven years from the date of when the last professional service was provided.
- ◆ Any correction, addition or change in any record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction,

addition or change shall be included, as well as the reason for the correction, addition or change.

- ◆ A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician.
- ◆ The board shall not initiate disciplinary action pursuant to subsection 2 of section 334.100 R.S.Mo. against a licensee solely based on a violation of section 334.097 R.S.Mo. If the board initiates disciplinary action against the licensee for any reason other than a violation of this section, the board may allege violation of section 334.097 R.S.Mo. as an additional cause for discipline pursuant to subdivision (6) of subsection 2 of section 334.100 R.S.Mo.
- ◆ The board shall not obtain a medical record without written authorization from the member to obtain the medical record or the issuance of a subpoena for the medical record.

**What Magellan  
Will Do**

Magellan's responsibility to you is to:

- ◆ Conduct reviews of clinical records to document and monitor quality of services.
- ◆ Provide notice of reviews and outline information you are to supply to our reviewers.
- ◆ Provide written feedback of review results.

## **4. Quality Partnership - Commitment to Quality**

<b>Our Philosophy</b>	Magellan supports the delivery of quality care, with the primary goal of improving the health status of members and, where the member's condition is not amenable to improvement, maintaining the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes identifying members at risk of developing conditions, implementing appropriate interventions, and designating adequate resources to support the intervention(s).
<b>Our Policy</b>	In support of our Quality Improvement Program, our providers are required to be familiar with Medicaid and Magellan guidelines and standards and apply them in clinical work with members.
<b>What You Need to Do</b>	<p>To comply with this policy your responsibility is to:</p> <ul style="list-style-type: none"><li>◆ Understand federal and state Medicaid standards applicable to providers.</li><li>◆ Comply with federal and state Medicaid standards.</li><li>◆ Provide input and feedback to Magellan to actively improve the quality of care provided to members.</li><li>◆ Participate in quality improvement activities if requested by Magellan.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"><li>◆ Actively request input and feedback regarding member care.</li><li>◆ Work with members, providers, community resources and agencies to improve the quality of care provided to members.</li><li>◆ Operate a toll-free telephone number to respond to provider questions, comments and inquiries.</li><li>◆ Establish a multi-disciplinary Quality Oversight Committee to oversee all quality functions and activities.</li><li>◆ Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.</li><li>◆ Provide designated staff with expertise in Quality Assessment, Utilization Management and continuous Quality Improvement.</li></ul>



## **4. Quality Partnership - Provider Input**

<b>Our Philosophy</b>	Magellan believes that provider input concerning our programs and services is a vital component of our quality programs.
<b>Our Policy</b>	Magellan obtains provider input through provider participation in various workgroups and committees of the Southeast Care Management Center. We offer providers opportunities to give feedback through participation in our quality programs, or via requests for feedback in provider publications.
<b>What You Need to Do</b>	<p>To comply with this policy your responsibility is to:</p> <ul style="list-style-type: none"><li>◆ Understand federal and state Medicaid standards applicable to providers.</li><li>◆ Comply with federal and state Medicaid standards.</li><li>◆ Provide input and feedback to Magellan to actively improve the quality of care provided to members.</li><li>◆ Participate in quality improvement and utilization oversight activities if requested by Magellan.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none"><li>◆ Actively request input and feedback regarding member care.</li><li>◆ Operate a toll-free telephone number to respond to provider questions, comments and inquiries.</li><li>◆ Establish a multi-disciplinary Quality Oversight Committee to oversee all quality functions and activities.</li><li>◆ Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.</li><li>◆ Provide designated staff with expertise in quality assessment, utilization management and continuous quality improvement.</li><li>◆ Develop and evaluate reports, indicate recommendations to be implemented, and facilitate feedback to providers and members.</li><li>◆ Participate in annual quality improvement projects that focus on clinical and non-clinical areas and provide annual reports on results using a valid process for evaluation of the impact and assessment of the quality improvement activities.</li></ul>

## **4. Quality Partnership – Provider Complaint and Appeal Process**

### **Our Philosophy**

In order to achieve a high level of member satisfaction and care, Magellan believes in providing a mechanism for providers to submit a complaint or a provider appeal. A complaint is a written or verbal expression which indicates dissatisfaction or dispute with Magellan policy, procedure, claims or any aspect of Magellan functions. A provider appeal allows the right to appeal actions of Magellan to a provider who has a claim for reimbursement or request for authorization of service delivery denied or not acted on with reasonable promptness; or is aggrieved by any rule, policy, procedure or decision by Magellan.

### **Our Policy**

Magellan maintains processes for addressing verbal and written complaints and provider appeals, from providers.

Our customer organizations and applicable federal and state laws impact the clinical appeals process. Therefore, the procedure for appealing a clinical determination is outlined fully in the adverse determination notification letter. However, Magellan is not delegated to handle member appeals, including appeals filed by participating or non-participating providers on behalf of members, so those must be sent directly to WellCare to be processed. WellCare also deems all pre-service and concurrent provider appeals to be appeals on behalf of the member, so those also must be sent directly to WellCare to be processed. Magellan is only delegated to handle post-service (retrospective) provider appeals where the provider appeal is NOT on behalf of the member

### **What You Need to Do**

To comply with this policy your responsibility is to:

- ◆ Submit oral complaints, within one year of the date that you became aware of the issue, by calling the Southeast Care Management Center at 1-888-684-2026 or the number provided in the non-authorization determination letter, or submit written complaints within the same timeframe to:  
Magellan Health Services  
Attn: Complaint Dept  
P.O. Box 1619  
Alpharetta, GA 30009
- ◆ The Southeast Care Management Center is open from 7:00 a.m. to 7:00 p.m., Eastern time, but providers also may submit complaints and appeals to the Magellan After-Hours Solutions Department, which is open 24 hours a day / 7 days a week / 365 days a year.

- ◆ Providers may file an appeal of the complaint resolution within 60 days of the receipt of the resolution.
- ◆ Submit oral or written provider appeals within 60 days of receipt of a non-certification determination decision (or receipt of a complaint determination) by calling the number or using the address in the non-certification determination letter or the complaint determination letter. Providers may submit a second level appeal of the first level provider appeal determination within 60 days of receipt of the first level provider appeal determination.

### **What Magellan Will Do**

Magellan's responsibility to you is to:

- ◆ Thoroughly investigate each provider complaint and appeal using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties. Resolve concern at the time of the initial call or involve a supervisor or designee to resolve issue.
- ◆ The Magellan Provider Relations team is available to meet personally with you if necessary.
- ◆ Provide an opportunity for you to present your case in person.
- ◆ Resolve expedited complaints within 48 hours of receipt of the complaint. Non-expedited complaints are investigated and responded to within 10 calendar days of receipt of the complaint. Appeals of the complaint decision can also be expedited or non-expedited. An Appeal of the complaint resolution is completed and a written decision is issued within 60 calendar days of receipt of the complaint appeal.
- ◆ Level 1 provider appeals are completed and a written decision is issued within 60 calendar days. Level 2 provider appeals are completed and a written decision is issued within 60 calendar days of the date it was received.
- ◆ Ensure that executives with the authority to require corrective action are involved in the provider complaint process.
- ◆ Investigate the grievance or complaint, consulting with subject matter experts if necessary.

## **5. Provider Reimbursement – Professional Services**

<b>Our Philosophy</b>	Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements.
<b>Our Policy</b>	Magellan reimburses behavioral health and substance abuse treatment providers in accordance with reimbursement schedules for professional services. The reimbursement schedule(s) is attached to your Magellan provider agreement.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>◆ Contact the Southeast Care Management Center at 1-888-684-2026 prior to initiating care to check eligibility and authorize sessions. All non-emergent services must be pre-authorized. As explained in <i>Section 3. Role of the Provider and Magellan – Initiating Care</i> of this supplement, members are allowed four visits annually defined by his/her calendar year, without prior authorization requirements, but you are still encouraged to contact Magellan when a member contacts you directly. You also may obtain pre-authorization and check member eligibility online at <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a>.</li><li>◆ Collect applicable co-payments from members.</li><li>◆ Contact the Southeast Care Management Center at 1-888-684-2026 to verify eligibility, obtain co-payment amount and pre-certify care for all higher levels of care.</li><li>◆ Sign up for online claims submission and electronic funds transfer (EFT) through <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a>.</li><li>◆ Submit a clean claim form for the services that you have provided through <a href="http://www.MagellanHealth.com/provider">www.MagellanHealth.com/provider</a>, through an accepted clearinghouse, or via paper claim.</li><li>◆ The postal address for MO HealthNet Managed Care claims is: Magellan Health Services P.O. Box 1396 Maryland Heights, MO 63043</li><li>◆ Submit your claim for reimbursement no later than 90 days from the date the covered services are rendered.</li><li>◆ Bill using your contracted Taxpayer Identification Number.</li><li>◆ Hold the member harmless and not bill the member for any amount, including the difference between Magellan's reimbursement amount and your standard rate. This practice is called balance billing and is prohibited.</li><li>◆ Contact the Southeast Care Management Center at 1-888-684-2026 if you are not certain which services require pre-authorization, what your reimbursement rate is, or for any questions that you have concerning the member in care.</li></ul>

**What Magellan  
Will Do**

Magellan's responsibility to you is to:

- ◆ Process your claims promptly - 45 calendar days from the date the clean claim is received.
- ◆ Provide a toll-free number for you to call for provider assistance (1-888-684-2026).
- ◆ Respond to your claims questions and help resolve issues.
- ◆ Review our reimbursement schedules periodically in consideration of Medicaid changes.
- ◆ Include all applicable reimbursement schedules as exhibits to your contract.
- ◆ Communicate changes to reimbursement rates in writing prior to their effective date.