



**Magellan Healthcare, Inc.\***

## **2017 Handbook for the National Provider Network**

*\*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Behavioral Care of Iowa, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of Nebraska, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Behavioral Health Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively “Magellan”).*

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## SECTION 1: INTRODUCTION

# Welcome

Welcome to the Magellan National Provider Network Handbook. This handbook is your reference guide for navigating Magellan. As a contracted Magellan provider of clinical care, it is your responsibility to be familiar with and follow the policies and procedures outlined in this handbook. Each section of the handbook outlines our philosophy, our policies, your responsibilities to Magellan and our responsibilities to you. The appendices in this handbook contain more extensive information, including:

- Clinical practice guidelines,
- Credentialing criteria, and much more.

This handbook also provides information about the provider self-service features available to you on our website. Please be aware that by accessing the online provider services located at [www.MagellanProvider.com](http://www.MagellanProvider.com), you can accomplish virtually all the business tasks you'll need to complete with Magellan—in one convenient online location.

We hope you find this a helpful tool in working with Magellan to provide quality care to members. We welcome your feedback on how we can make our handbook even better and more helpful to you. Email comments to [Editor@MagellanHealth.com](mailto:Editor@MagellanHealth.com).

## About Magellan

Magellan Health, Inc. is a healthcare management company that focuses on fast-growing, complex and high-cost areas of healthcare, with an emphasis on special population management. Magellan delivers innovative solutions to improve quality outcomes and optimize the cost of care for those we serve. Magellan's customers include health plans, managed care organizations, insurance companies, employers, labor unions, various military and government agencies, third party administrators, consultants and brokers. For more information, visit [MagellanHealth.com](http://MagellanHealth.com).

## Our Products

The Magellan Health affiliate, Magellan Healthcare, offers customers a broad array of mental health and substance abuse clinical management services that combines the best of traditional approaches to healthcare delivery with innovative, emerging solutions. Depending on your credentials, skills and experience, you may receive referrals for the following services:

**Magellan EAP and LifeManagement:** This product focuses on problem resolution by combining traditional Employee Assistance Programs with work-life services such as child and elder care referrals, and adoption and legal assistance.

**Magellan Behavioral Care Management:** Designed to promote our members' behavioral health and wellness while responsibly managing our customers' healthcare dollar, our approach is based on a clinical philosophy of providing timely access to high-quality, clinically appropriate, affordable behavioral healthcare services tailored to members' individual needs.

Key features of our program include:

- Working closely with medical insurers to coordinate and integrate behavioral healthcare with medical care
- Coordinating access to a full continuum of mental health and substance abuse services, with care delivered in the most clinically appropriate, least-restrictive settings.

**Magellan Complex Case Management (CCM):** The primary mission of case management activities is to facilitate positive treatment outcomes through proactively identifying members who would benefit from more intensive services in order to achieve, consolidate and maintain treatment gains. The goals of the CCM program are to optimize the physical, social and mental functioning of our members by increasing community tenure, reducing readmissions, enhancing support systems and improving treatment efficacy through advocacy, communication and resource management.

Magellan values and cultivates a strengths-based, culturally competent and recovery-oriented system of care that allows individuals to achieve their wellness goals. We ground our programs in the principles of recovery, resiliency and cultural competence to further the attainment of a meaningful life in the community for each person we serve.

Our behavioral health products help individuals understand and improve their own health with the right support provided at the right time. As a Magellan Healthcare provider, you play a vital role in improving the health, welfare and productivity of the people we jointly serve.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Network Provider Participation

<b>Our Philosophy</b>	Magellan is dedicated to selecting behavioral healthcare professionals, groups and facilities to provide member care and treatment across a range of services offered by Magellan.
<b>Our Policy</b>	To be an in-network provider of clinical services with Magellan, you must be both credentialed and contracted. Depending on your credentials and our customers' requirements, you may be eligible to provide services for all members, or only for certain customers, products or business segments.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide medically necessary covered services to members whose care is managed by Magellan;</li><li>• Follow the policies and procedures outlined in this handbook, any applicable supplements and your provider participation agreement(s);</li><li>• Provide services in accordance with applicable state and federal laws and licensing and certification bodies;</li><li>• Agree to cooperate and participate with all care management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures;</li><li>• As a first step to being considered for Magellan network participation, go to <a href="http://www.MagellanProvider.com">www.MagellanProvider.com</a> and click on <i>Provider Network/Join the Network</i>. From the bottom of the <i>Join the Network</i> page, select the applicable link: for example, "<i>I am an individual/solo practitioner,</i>" and follow the instructions for Magellan's network inclusion screening process;</li><li>• Follow Magellan's credentialing and recredentialing policies and procedures;</li><li>• Ensure that only group practitioners who are currently credentialed with Magellan render services to Magellan members; and</li><li>• Provide Magellan with a completed Form W-9 for the contracting entity, and updated Forms as warranted, to facilitate timely and accurate claims payment and processing.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none"><li>• Offer assistance with your administrative questions during</li></ul>



normal business hours, Monday through Friday;

- Assist you with understanding and adhering to our policies and procedures, the payer's applicable policies and procedures, and the requirements of our accreditation agencies including, but not limited to the National Committee for Quality Assurance (NCQA) and URAC;
- Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, patient type, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability or any other status protected by applicable law; and
- Develop and implement recruitment activities to solicit providers reflective of the membership we serve, subject to applicable state laws.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Types of Providers

<b>Our Philosophy</b>	Magellan is dedicated to recruiting and retaining individual practitioners and institutional providers with the behavioral healthcare credentials to provide member care and treatment across a range of products and services. Magellan's network of providers includes practitioners in private practice, practitioners in group practices, and provider organizations including facilities and agencies.
<b>Our Policy</b>	<p>Magellan's contracted provider network includes the following categories:</p> <ul style="list-style-type: none"><li>• Individual Practitioner – a clinician who provides behavioral healthcare services and bills under his or her own Taxpayer Identification Number.</li><li>• Group Practice – a practice contracted with Magellan as a group entity and as such bills as a group entity for the services performed by its Magellan-credentialed clinicians.</li><li>• Organization – a facility or agency licensed and/or authorized by the state in which it operates to provide behavioral health services. Examples of organizations include, but are not limited to: general hospitals with psychiatric and/or substance abuse treatment programs, freestanding behavioral health facilities, community mental health centers and agencies. Please refer to the <a href="#">Organizational and Facility Providers Handbook Supplement</a> for additional information about facility/organizational providers including credentialing criteria.</li></ul>
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Ensure your contract with Magellan is appropriate for the provider category within which you fall.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide you with information and guidance to ensure your contractual relationship with Magellan is appropriate to your provider category.</li></ul>

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Credentialing and Recredentialing

**Our Philosophy** Magellan is committed to promoting quality care for its members. In support of this commitment, practitioners must meet and maintain a minimum set of credentials in order to be able to provide services to members.

**Our Policy** To be eligible for referrals, Magellan network practitioners are required to successfully complete the credentialing review process prior to being accepted as a network provider. Magellan credentials practitioners in accordance with established credentialing criteria (See the [Appendix](#) for details) and ensures compliance with applicable regulatory agencies and customer requirements. Magellan network practitioners are required to have their credentials re-reviewed periodically through the recredentialing process. Recredentialing is conducted at least every 36 months unless otherwise required and includes evaluation of practitioner performance in the Magellan network including, but not limited to: clinical care, service and outcomes, member service, and adherence to Magellan policies and procedures.

Magellan's Regional Network and Credentialing Committee (RNCC) utilizes a peer review process to evaluate practitioners' credentials and appropriateness for inclusion in the provider network. Throughout the credentialing process, practitioners have the right to review information submitted to support their credentialing application, correct erroneous information, and upon request, receive the status of their credentialing or recredentialing application.

For more information about facility/organization recredentialing, see the Organizational and Facility Providers Handbook Supplement.

**What You Need to Do** Your responsibility is to submit the necessary documents to facilitate the credentialing review:

- A completed credentialing application
  - Magellan promotes the online universal credentialing process offered by Council for Affordable Quality Healthcare ([CAQH](#)). Be sure to give Magellan access to your credentialing information and review and attest to

its accuracy and completeness. Call the CAQH Help Desk at 1-888-599-1771 or via email at

[providerhelp@proview.caqh.org](mailto:providerhelp@proview.caqh.org) for answers to your questions related to the CAQH application or website.

- Group members may be requested to submit a Group Association Form (GAF), completed and signed by the group administrator;
- Evidence of professional liability insurance coverage, which may include a copy of the current malpractice insurance face sheet; and
- Subject to your professional level and service location, supplemental attestations/documentation may be required to complete the credentialing process.

### What Magellan Will Do

Magellan's responsibility is to:

- Notify you promptly if any required information is missing from your credentialing application;
- Forward your application to the Regional Network and Credentialing Committee (RNCC) for review once the credentialing verification process is complete. The RNCC consists of the medical director, participating network providers, and Magellan clinicians and uses a peer review process to make recommendations on credentialing and recredentialing decisions and ongoing Magellan provider network participation. The RNCC reviews your credentialing information, including, but not limited to:
  - Education, training and experience,
  - Specialty practice areas,
  - Current and prior actions on licensure, certification, facility privileges, participation in Medicare, Medicaid and other federally funded healthcare programs,
  - Malpractice settlements made on behalf of the practitioner, and
  - Member need and access, subject to applicable state laws;
- Respond to requests for credentialing or recredentialing status in a timely manner. Requests for application status can be directed to Magellan's Provider Services Line at 1-800-788-4005;
- Provide practitioners access to information obtained from outside sources during the credentialing process, subject to limitations;  
*Note: Magellan is not required to make certain information available including references, recommendations and peer review protected information.*
- Notify you when the initial credentialing process is complete.

Although Magellan may notify practitioners of successful recredentialing, if no notification is received, successful recredentialing can be assumed.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Updating Practice Information

### Our Philosophy

We are committed to maintaining current, accurate provider practice information in our database so that members have correct information when choosing a provider, and to enable our providers to receive important communications from Magellan in a timely manner.

### Our Policy

Magellan's policy is to maintain accurate databases, updated in a timely manner, with information received from our providers to facilitate efficient and effective provider selection, referral and claims processing, and to provide accurate and timely information in provider-related publications, e.g., provider directories. The most efficient and effective way to communicate administrative information changes and to keep provider information up-to-date is through our online provider portal.

**Providers are required to notify Magellan of changes in administrative practice information using our online Provider Data Change Form (PDCF).** By using the PDCF, providers can update information online in real time, a method more efficient and accurate than other forms of communication. Phone requests and faxes are not accepted. Providers who do not update their data when changes occur, or do not attest to data accuracy as required, may be put "on hold" for new referrals until review and attestation of data accuracy is completed.

*Note: Some changes to provider information may result in the need for a contract amendment such as facility or group name changes, changes of ownership, adding a new service location for a facility or a change to Taxpayer Identification Numbers; these still require notification to your field network coordinator (groups/individuals) or to your area contract manager (facilities). The PDCF application will direct you when these notifications need to occur. Providing or billing for services in any of these situations should NOT commence until you have notified network staff and received confirmation that all required changes have been implemented, which could include the amending of existing agreements or the need for new agreements to be issued.*

**What You Need to Do**

Your responsibility is to:

- Update changes in your administrative practice information listed below using our online Provider Data Change Form by signing in to [www.MagellanProvider.com](http://www.MagellanProvider.com) and selecting *Display/Edit Practice Information*;
- Notify us within 10 business days of any changes in your practice information including, but not limited to changes of:
  - Service, mailing or financial address,
  - Telephone number,
  - Business hours,
  - Email address, and
  - Taxpayer Identification Number;
- Promptly notify us if you are unable to accept referrals for any reason including, but not limited to:
  - Illness or maternity leave,
  - Practice full to new patients,
  - Professional travel, sabbatical, vacation, leave of absence, etc.;
- Promptly notify us of any changes in group practices, including, but not limited to:
  - Practitioners departing from your practice,
  - Practitioners joining your group practice,
  - Changes of service, mailing or financial address,
  - Changes in practice ownership, including a change in Taxpayer Identification Number and/or National Provider Identifier,
  - Telephone number,
  - Business hours, and
  - Email address;
- Promptly notify us of any changes to credentialing information including but not limited to:
  - Licensure or certification, including state licensing board actions on your license,
  - Board certification(s),
  - Hospital privileges,
  - Insurance coverage,
  - New information regarding pending or settled malpractice actions;
- See the Magellan Organizational and Facility Provider Supplement to this Provider Handbook for submitting changes in facility/organizational practices;
- Contact your field network coordinator or area contract manager

if directed to do this by the online application – some changes may require a contract amendment before you can initiate or bill for services;

- Update and maintain your Provider Profile information (enables you to enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.);
- Each time you make any changes noted above using the online PDCF or in response to any request from Magellan, it is important to attest that your data is current and accurate. Even if you have no changes, Magellan requires that you review and attest that your information is correct, including appointment availability, no less than quarterly. Failure to update administrative practice information may impact your network participation status.

**What Magellan  
Will Do**

Magellan’s responsibility for provider data changes is to:

- Maintain our online Provider Data Change Form resulting in real-time information with no additional verification requirements;
- Contact you for clarification, if needed;
- Monitor and follow up on the completion of required quarterly provider data accuracy attestations; and
- Notify you if your change in information impacts your referral and/or network participation status.



## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Contracting with Magellan

### Our Philosophy

Magellan's provider agreements protect members, providers and Magellan by defining:

- The rights and responsibilities of the parties;
- The application of Magellan's policies and procedures to services rendered to members;
- The programs/services available to members;
- The provider network for member use; and
- The reimbursement for covered services.

Depending on a provider's type of practice, Magellan will issue an individual, group or organization agreement.

### Our Policy

- Magellan network providers are required to have an executed Magellan provider agreement in order to bill Magellan for the provision of covered services.

### What You Need to Do

Your responsibility is to:

- Read, understand and sign a Magellan provider agreement;
- Return your signed provider agreement to Magellan for contract execution;
- Comply with the terms of the Magellan provider agreement, including the policies and procedures contained within this handbook and applicable supplements;
- Honor reimbursement provisions for covered services rendered to members;
- Not bill members for covered services other than for co-payments or co-insurance, as outlined in the benefit plan, i.e., no "balance billing;" and
- Adhere to the termination notification period as specified in the provider agreement, if necessary.

### What Magellan Will Do

Magellan's responsibility is to:

- Submit a Magellan provider agreement to providers identified for participation in the Magellan provider network;
- Indicate our customers, products or lines of business covered by the agreement based on the reimbursement schedules provided; and
- Execute the agreement after it has been returned and signed by

the provider and the provider has successfully met contractual requirements. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Sub-Contracting Magellan's Provider Agreements

<b>Our Philosophy</b>	As a matter of value and quality, we promise our customers that only participating providers that meet Magellan's credentialing and contracting standards will deliver services to benefit-eligible members.
<b>Our Policy</b>	Magellan does not allow sub-contracting or sub-delegation of the Individual Provider Agreement or of the Group Provider Agreement. Participating providers are prohibited from allowing interns, non-licensed and/or non-credentialed staff members to treat or be a rendering service provider to any Magellan member.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Understand your obligations and comply with the terms of your Magellan provider agreement;</li><li>• Refrain from allowing interns, non-licensed or non-credentialed staff to deliver services to our members unless otherwise authorized;</li><li>• See the <i>Appendix: Frequently Asked Questions</i> for further information about credentialing and contracting with Magellan.</li></ul>
<b>What Magellan Will Do</b>	Magellan's responsibility is to: <ul style="list-style-type: none"><li>• Communicate our expectations to you that only fully credentialed participating providers may deliver service to our members; and</li><li>• Review treatment records to confirm compliance.</li></ul>

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Business Associate Agreement

<b>Our Philosophy</b>	Magellan network providers are not “business associates” as defined by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the accompanying regulations.
<b>Our Policy</b>	Network providers do not need business associate agreements with us.
<b>What You Need to Do</b>	For Magellan providers rendering behavioral healthcare services to our members, no action is required.
<b>What Magellan Will Do</b>	Magellan will not issue business associate agreements to providers in our network for rendering behavioral healthcare services to our members.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Appealing Decisions That Affect Network Participation Status

### Our Philosophy

Participating providers have a right to appeal Magellan quality review actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network. Customer requirements and applicable federal and state laws may impact the appeals process; therefore, we outline the process for provider appeals in the written notification that details the changes in the conditions of a provider's participation due to issues of quality of care or services.

### Our Policy

*Magellan offers participating providers an opportunity for a formal appeal hearing when Magellan takes action to terminate network participation due to quality concerns.* Providers receive notice in writing of the action. Notification includes: the reason(s) for the action, the right to request an appeal, the process to initiate a request for appeal, summary of the appeal process, and that such request must be made within 33 calendar days from the date of Magellan's written notification. Providers may participate in the appeal hearing either telephonically or in-person and may be represented by an attorney or another person of the provider's choice. Providers are notified in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing. Specifics of the appeal and notification processes are subject to customer, state or federal requirements.

*Professional providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other federal healthcare programs, are offered an internal administrative review only unless otherwise required by customer, state or federal requirements.*

Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than 33 calendar days from the date of Magellan's written notification to request an administrative review if they disagree with the reasons for the termination. The provider is

notified in writing of the outcome within 30 calendar days of the administrative review.

**What You Need to Do**

Your responsibility is to:

- Follow the instructions outlined in the notification letter if you wish to appeal a change in the conditions of your participation based on a quality review determination.

**What Magellan Will Do**

Magellan's responsibility is to:

- Notify you in a timely manner of the determination that the condition of your participation is changed due to issues of quality of care or service;
- Consider any appeals submitted in accordance with the instructions outlined in the notification letter, subject to applicable accreditation and/or federal or state law; and
- Notify you in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing.

## SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

# Contract Termination

**Our Philosophy** Magellan's philosophy is to maintain a diverse, quality network of providers to meet the needs of our customers and members. In addition, we believe that providers should advocate on behalf of members in obtaining care and treatment for behavioral health and substance abuse disorders.

**Our Policy** Network providers will not be terminated from the networks of Magellan and/or its affiliated companies for any of the following reasons:

- Provider advocating on behalf of a member;
- Provider filing a complaint against Magellan;
- Provider appealing a decision of Magellan; or
- Provider requesting a review of or challenging a termination decision of Magellan.

Network providers may be terminated from the networks of Magellan and/or its affiliated companies for the following reasons, including, but not limited to:

- Failure to submit materials for recredentialing within required timeframes;
- Suspension, loss or other state board actions on licensure;
- Provider exclusion from participation in federally or state-funded healthcare programs;
- Quality of care or quality of service concerns as determined by Magellan;
- Failure to meet or maintain Magellan's credentialing criteria;
- Provider-initiated termination; or
- No current business need within the provider's geographic area, subject to applicable state and federal law.

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

- Advocate on behalf of members;
- Maintain your professional licensure in a full, active status;
- Respond in a timely manner to recredentialing requests; and
- Follow contract requirements, policies, and guidelines including appropriate transition of members in care at the time of contract termination.

If you choose to terminate your contract with Magellan, you should:

- Submit your notice of termination in writing, in accordance with the terms of your provider agreement, to:  
Magellan Healthcare  
Attn: Network Operations  
14100 Magellan Plaza  
Maryland Heights, MO 63043  
Fax 1-888-656-0429
- Group provider practices shall immediately notify Magellan, in writing, in the event that a healthcare professional ceases to be affiliated with the provider group for any reason. The group practice must ensure that members under the care of the terminating practitioner are transferred to another group member who is credentialed with Magellan.
- If you are a group member practicing under a group agreement and terminate your affiliation with the group, Magellan expects you to facilitate transition of members in your care to another group member who is credentialed with Magellan.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Respect your right to advocate on behalf of members;
- Not terminate your contract for advocating on behalf of members, filing a complaint, appealing a decision, or requesting a review of or challenging a termination decision of Magellan;
- Notify you when recredentialing materials must be submitted and monitor your compliance;
- Communicate quality concerns and complaints received from members;
- Notify you of the reason for contract termination and your appeal rights, as applicable, if your contract is terminated; and
- Notify members in your care and facilitate care transition plans if your contract is terminated.

*For specific information concerning contract termination obligations of both parties, consult your Magellan agreement.*



## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Care Management Overview

<b>Our Philosophy</b>	Through our care management process, Magellan joins with our members, providers and customers to make sure members receive appropriate services in a timely manner and experience desirable treatment outcomes.
<b>Our Policy</b>	Through various care management models, we actively assist members in optimizing their benefits to meet their behavioral healthcare needs. We do not pay incentives to employees who conduct benefit certification, appeal and dispute processes, or to providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-certification/non-authorization or under-utilization of behavioral healthcare services.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Comply with the member’s insurance benefit certification requirements (synonymous term is authorization) before initiating services. This requirement includes inpatient admission and requests for additional bed days. In most cases this requirement excludes clinically necessary emergency services.</li><li>• Contact Magellan at the number on the member’s benefit card or online at <a href="http://www.MagellanProvider.com">www.MagellanProvider.com</a> to request benefit certification prior to delivery of services.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan’s responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide timely access to appropriate staff;</li><li>• Conduct the benefit certification process with the least amount of intrusion into the care experience;</li><li>• Process referrals and complete the care management process in a timely manner;</li><li>• Process benefit certifications from the initial request to notifying the requesting provider of the benefit certification determination, or appeal or dispute decision, in accordance with the requirements, allowances and limitations of the member’s benefit plan;</li><li>• Base benefit certification determinations, or appeal or dispute decisions, on approved clinical criteria such as Magellan’s Care</li></ul>

Guidelines or other customer-required clinical criteria:

- Require Magellan employees to attend company compliance training regarding Magellan's policy of no incentives for non-certification/non-authorization or under-utilization of care.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Before Services Begin

- Our Philosophy** When members contact Magellan for a referral, our philosophy is to direct them to practitioners who best fit their needs and preferences including provider location, service hours, specialties, spoken language(s), gender and cultural aspects.
- Our Policy** Our policy is to make available for selection and/or refer members to providers who best fit their needs and preferences. We also confirm member eligibility and manage the use of behavioral health insurance benefits.
- What You Need to Do** Your responsibility is to:
- Sign in to [www.MagellanProvider.com](http://www.MagellanProvider.com) or contact Magellan by phone to determine member eligibility for requested services before rendering care to a referred member in a non-emergent situation.
  - Obtain required benefit certification by signing in to our Magellan provider website or contact us by phone when required by the member's benefit plan. View your authorizations (synonymous with certifications), if required by the member's plan, on the Magellan website: Securely sign in to your password-protected account at [www.MagellanProvider.com](http://www.MagellanProvider.com). Under "MyPractice" on the left-hand side, go to *View Authorizations* and follow the steps outlined on the screen.
  - Encourage members to complete the appropriate [Outcomes360<sup>SM</sup>](#) self-assessment tool prior to intake, or during the intake session in your office. (*For further explanation see [Section 4, Outcomes360.](#)*)
  - Contact Magellan as soon as possible following the delivery of emergency services to certify admission to inpatient care or to initiate ambulatory services.
  - When additional time may be needed for members in an inpatient setting or in an intermediate ambulatory service (PHP, IOP), contact Magellan at least one day before the end of the period of time covered by the current benefit certification.
  - Contact Magellan if during the course of treatment you determine that services other than those authorized are required.
  - For members presenting for services other than routine

outpatient, be prepared to provide Magellan with a thorough assessment of the member including but not limited to the following:

- Symptoms,
- Precipitating event(s),
- Potential for risk, such as harm to self or others,
- Level of functioning and degree of impairment (as applicable),
- Clinical history, including medical, behavioral health and alcohol and other drug conditions or treatments,
- Current medications,
- Plan of care, and
- Anticipated discharge and discharge plan (if appropriate).

**What Magellan Will Do**

Magellan's responsibility is to:

- Actively assist with securing appointments 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 our providers through the credentialing process.
- Make benefit certification determinations based upon the information provided by the member and/or the provider during the benefit certification process.
- Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the benefit certification determination information.
- Communicate the benefit certification determination (when necessary) by telephone, online and/or in writing to you as required by regulation and/or contract.

*Note: while most certification/authorization approval notices will only be communicated online, denial notices and other legally mandated correspondence is sent via U.S. Mail and/or fax (where applicable).*

- Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if the benefit certification determination is adverse.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Psychological Testing

<b>Our Philosophy</b>	Magellan’s philosophy is that treatment should be rendered at the most appropriate, least intensive level of care necessary to provide safe and effective treatment that meets the individual member’s biopsychosocial needs. Psychological testing is authorized when it meets Magellan’s Care Guidelines. Psychological testing is not a routine outpatient service and therefore requires a precertification review under most benefit plans.
<b>Our Policy</b>	Our policy is to authorize psychological testing when the clinical interview alone is not sufficient to determine an appropriate diagnosis and treatment plan.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Conduct a complete member assessment;</li><li>• Be familiar with Magellan’s care guidelines for psychological testing;</li><li>• Request prior authorization for psychological testing by completing the Request for Psychological Testing Preauthorization form available in the <a href="#">Clinical Forms</a> area of the Magellan provider website; and</li><li>• Fax or email the completed and signed testing request form to the Magellan care management center with which you customarily work.</li></ul>
<b>What Magellan Will Do</b>	Magellan’s responsibility is to: <ul style="list-style-type: none"><li>• Promptly review your completed request form in accordance with applicable federal and state regulations;</li><li>• Respond in a timely manner to your request;</li><li>• Call you directly if further information is needed; and</li><li>• Offer you the opportunity to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested testing based on clinical criteria.</li></ul>

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Options After an Adverse Benefit Determination

<b>Our Philosophy</b>	We support the most appropriate services to improve healthcare outcomes for individuals and families whose benefits we manage.
<b>Our Policy</b>	Options to request reversal of an adverse benefit certification are given to the member and the requesting provider by telephone and/or in writing. The type of insurance and government regulations will define available options and processes.
<b>What You Need to Do</b>	<p>If you disagree with an adverse benefit determination, you may:</p> <ul style="list-style-type: none"><li>• Initiate a dispute; or</li><li>• Act on behalf of the member and invoke the member’s appeal rights as permitted by state or federal law. The member’s permission may be required (<i>exception – in urgent care cases a health care professional with knowledge of the member’s condition is permitted to act as the member’s authorized representative</i>);</li><li>• For adverse benefit determinations involving a Medicare Advantage enrollee, an additional option of “reopening” will be applied, when meeting the reopening criteria;</li><li>• Clearly identify which reversal option you are requesting: dispute or invoking member rights to appeal; and</li><li>• Be available and have your documentation ready to support the reversal discussion with a peer reviewer.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan’s responsibility is to:</p> <ul style="list-style-type: none"><li>• Offer you the opportunity and contact information to discuss, dispute or appeal the medical necessity decision or adverse benefit determination with a Magellan peer reviewer;</li><li>• Promptly process your request to discuss, dispute or invoke the insured’s right to appeal;</li><li>• Respond in a timely manner verbally, online and/or in writing to your request;</li><li>• Call you directly if additional clinical information is needed; and</li><li>• Notify you of the adverse benefit determination dispute or appeal outcome, including additional options available to you as the requesting and/or treating provider.</li></ul>

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Member Access to Care

**Our Philosophy** Members are to have timely access to appropriate mental health, substance abuse, and/or Employee Assistance Program services from an in-network provider 24 hours a day, seven days a week.

**Our Policy** Our Access to Care standards enable members to obtain behavioral health services by an in-network provider within a timeframe that reflects the clinical urgency of their situation.

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

- Provide access to services 24 hours a day, seven days a week;
- Inform members of how to proceed, should they need services after business hours;
- Provide coverage for your practice when you are not available, including, but not limited to, an answering service with emergency contact information;
- Respond to telephone messages in a timely manner;
- Provide immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation;
- Provide services within six hours of referral from Magellan in an emergent situation that is not life-threatening;
- Provide services within 48 hours of referral from Magellan in an urgent clinical situation or within 24 hours if required by a specific customer benefit plan;
- Provide services within 10 business days of referral from Magellan for routine clinical situations;
- Provide services within seven days of a member's discharge after an inpatient stay;
- For continuing care, continually assess the urgency of member situations and provide services within the timeframe that meets the clinical urgency; and
- Complete Magellan's appointment availability surveys to assist us in evaluating whether our networks meet access expectations and standards for all required levels of care.

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

- Communicate the clinical urgency of the member's situation when making referrals;
- Assist with follow-up service coordination for members

- transitioning to another level of care from an inpatient stay; and
- Request your participation in appointment availability surveys.



## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Telehealth Services

**Our Philosophy** Members are to have timely access to appropriate mental health, substance abuse and/or Employee Assistance Program services from an in-network provider 24 hours a day, seven days a week. Telehealth may be an acceptable channel to improve access under certain circumstances.

**Our Policy** Magellan defines telehealth as a method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. Telecommunications must be the combination of audio *and* live, interactive video. The Magellan member must have a covered mental health benefit that permits telehealth in order for providers to receive payment for telehealth services.

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

- Complete and return the telehealth services attestation, if you are interested in providing behavioral health services via telehealth;
- Meet the specific requirements outlined in the telehealth services attestation surrounding the provision of telehealth services, including the ability to provide all telehealth sessions through secure and HIPAA-compliant technology; and
- Direct questions to your regional field network representative, or call our national Provider Services Line at 1-800-788-4005.

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

- Answer your questions about the delivery and payment of telehealth services, including proper coding requirements.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Continuity, Coordination and Collaboration

### Our Philosophy

We appreciate the importance of the therapeutic relationship and strongly encourage continuity, collaboration and coordination of care. Whenever a transition of care plan is required, whether the transition is to another outpatient provider or to a less intensive level of care, the transition is designed to allow the member's treatment to continue without disruption whenever possible. We also believe that collaboration and communication among providers participating in a member's healthcare is essential for the delivery of integrated quality care.

### Our Policy

Our commitment to continuity, collaboration and coordination of care is reflected in a number of our policies including, but not limited to:

- Ambulatory follow-up – This policy requires that members being discharged from an inpatient stay have a follow-up appointment scheduled prior to discharge, and that the appointment occurs within seven days of discharge.
- Timely and confidential exchange of information – Through this policy, it is our expectation that, with written authorization from the member, you will communicate key clinical information in a timely manner to all other healthcare providers participating in a member's care, including the member's primary care physician (PCP).
- Timely access and follow-up for medication evaluation and management – Through this policy, our expectation is that members receive timely access and regular follow-up for medication management.

*Note: While Magellan advocates for transition of care plans that offer the minimum amount of disruption possible, the transition process to or from Magellan is determined by our customers' requirements and applicable state and federal laws.*

### What You Need to Do

Your responsibility is to:

- Collaborate with our care management team to develop and implement discharge plans prior to the member being discharged from an inpatient setting;
- Cooperate with follow-up verification activities and provide

written verification of kept appointments via submission of claims or medical records when requested, subject to applicable federal, state and local confidentiality laws;\*

- Work with us to establish discharge plans that include a post-discharge scheduled appointment within seven days of discharge;
- Notify us immediately if a member misses a post-discharge appointment;
- Promptly complete and submit a claim for services rendered confirming that the member kept the aftercare appointment;
- Explain to the member the purpose and importance of communicating clinical information with other relevant healthcare providers;
- Obtain, at the initial treatment session, the names and addresses of all relevant healthcare providers involved in the member's care;
- Obtain written authorization from the member to communicate significant clinical information to other relevant providers;
- Subject to applicable law, include the following in the Authorization to Disclose document signed by the member:
  - A specific description of the information to be disclosed,
  - Name of the individual(s), or entity authorized to make the disclosure,
  - Name of the individual(s), or entity to whom the information may be disclosed,
  - An expiration date for the authorization,
  - A statement of the member's right to revoke the authorization, any exceptions to the right to revoke, and instructions on how the member may revoke the authorization,
  - A disclaimer that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected,
  - A signature and date line for the member,
  - If the authorization is signed by the member's authorized representative, a description of the representative's authority to act for the member;
- Upon obtaining appropriate authorization, communicate in writing to the PCP, at a minimum, at the following points in treatment:
  - Initial evaluation,
  - Significant changes in diagnosis, treatment plan, or

- clinical status,
- After medications are initiated, discontinued or significantly altered, and
- Termination of treatment;
- Collaborate with primary care and applicable medical practitioners to:
  - Support the appropriate use of psychotropic drugs, especially for children and teens on antipsychotics,
  - Promote annual screening or monitoring with blood glucose, HbA1c and LDL-C tests for individuals of all ages on an antipsychotic for the treatment of a serious mental illness such as schizophrenia; and
- Provide suggestions to Magellan’s regional medical or clinical directors on how we can continue to improve the collaboration of care process.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Work with you, the member, and the member’s family to make any necessary transition of care as seamless as possible;
- Facilitate timely communication with the member’s PCP whenever possible including providing you with the name and address of member’s PCP, if the information is available and the member is unable to do so;
- Solicit your input regarding behavioral health pharmacy benefits and formularies;
- Work with the facility provider’s treatment team to arrange for continued care with outpatient providers after discharge;
- Audit medical records to measure compliance with this policy; and
- Actively solicit your input and consider your suggestions for improving the collaboration of care process.

*\* HIPAA Privacy Rule includes these ambulatory follow-up activities within its definition of healthcare operations. The Privacy standards allow providers to disclose members’ Protected Health Information (PHI) to Magellan in support of Magellan’s operations without an authorization from the member.*

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Case Management

**Our Philosophy** Our philosophy is that chronic behavioral conditions with or without comorbid or co-occurring medical conditions often yield better overall health outcomes when traditional treatment is supported by personal health coaching and/or case management. Through Magellan’s telephonic member case management programs, health coaches and care managers provide supplemental education and telephonic coaching services to our members to help them self-manage their condition on a day-to-day basis. Our health coaches and care managers provide outreach services and are available to respond to questions or requests for documented educational information coordinating services across all treating providers.

**Our Policy** Magellan’s policy is to provide educational information, self-help tools and telephonic personal health coaching to members identified and enrolled in our case management programs. These services are provided in support of, and do not replace, the advice and treatment provided by doctors and behavioral healthcare specialists.

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

- Familiarize yourself with the program;
- Contact the Magellan care manager by calling the number for mental health on the member’s benefit card if you have questions about the program or an enrolled member whom you are treating, or to suggest the program for one of your eligible members; and
- Encourage program-eligible members in treatment with you to take advantage of case management services.

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

- Provide notification to you when a member you are treating is enrolled in the program;
- Inform you of how Magellan coordinates interventions with treatment plans for individual members;
- Support you in your interactions with members and decisions regarding care and treatment;
- Provide courteous and respectful service; and
- Monitor clinical outcomes.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Magellan Care Guidelines

### Our Philosophy

Magellan is committed to the philosophy of promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member's biopsychosocial needs. Magellan's Care Guidelines are applied based on the member's individual needs including, but not limited to, clinical features and available behavioral healthcare services.

### Our Policy

Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 20th edition Milliman Care Guidelines for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains for specialty behavioral outpatient services. Magellan also uses ASAM criteria for management of substance use services where required by state or customer contract.

All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services.

Magellan will make the criteria available to providers online at [www.MagellanProvider.com](http://www.MagellanProvider.com) (after secure sign-in) and by hard copy upon request. *(Call the mental health number on the back of the member's benefit card.)*

### What You Need to Do

Your responsibility is to:

- Review and be familiar with Magellan's Care Guidelines;
- If you have questions about which Magellan Care Guideline applies to a specific benefit plan, contact the applicable care management center medical director; and
- Submit suggestions for revisions to the Magellan Care Guidelines using the [comment form](#) located at [www.MagellanProvider.com](http://www.MagellanProvider.com), or by submitting your feedback in writing to the applicable Magellan care management center's medical director.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Make Magellan Care Guidelines available to you free of charge;
- Invite and consider your comments and suggestions for revisions to the Magellan Care Guidelines;
- Conduct a comprehensive annual review of the Magellan Care Guidelines using scientific literature, expert advice from regional Provider Advisory Boards, other committees, and suggestions from the provider and consumer community; and
- Monitor use of the Magellan Care Guidelines to make sure they are applied consistently.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Clinical Practice Guidelines

<b>Our Philosophy</b>	Our philosophy is to promote the delivery of quality behavioral healthcare to our members. In support of this philosophy, we adopt, develop and distribute clinical practice guidelines that serve as an evidence-based framework for practitioners' clinical decision-making in the treatment of our members. A comprehensive literature review gathers up-to-date clinical information, relevant to the needs of our members, from peer-reviewed journals.
<b>Our Policy</b>	Our policy includes offering our network providers relevant clinical practice guidelines to assist in delivering quality care. The clinical practice guidelines that Magellan adopts or develops are consistent with current scientific evidence and best practices.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Review and adhere to Magellan's adopted clinical practice guidelines;</li><li>• If your clinical judgment leads to a decision that varies from recommendations in a guideline, thoroughly document the reasons in the member's clinical record; and</li><li>• Provide your regional medical director, Stakeholder Quality Improvement Group (SQIG) or Provider Advisory Group (PAG) with suggestions for improving our guidelines.</li></ul>
<b>What Magellan Will Do</b>	Magellan's responsibility is to: <ul style="list-style-type: none"><li>• Provide access to Magellan's adopted Clinical Practice Guidelines online at <a href="http://www.MagellanProvider.com">www.MagellanProvider.com</a> or by U.S. mail upon request;</li><li>• Provide you with ordering instructions and/or website addresses for obtaining adopted practice guidelines owned by other organizations, e.g., the American Psychiatric Association;</li><li>• Review each of our practice guidelines for consistency with current published evidence-based medicine and our other policies at least every two years;</li><li>• Monitor your adherence to practice guidelines and provide constructive feedback when appropriate;</li><li>• Encourage you to submit your suggestions for improving our clinical practice guidelines to your regional medical director; and</li><li>• Consider your suggestions for modifications to our guidelines.</li></ul>



## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Clinical Monographs

- Our Philosophy** Magellan’s philosophy is to promote the delivery of quality behavioral healthcare to our members. To accomplish this, our providers and clinician reviewers must be current with various aspects of behavioral health scientific literature.
- Our Policy** Our policy includes the development and distribution of relevant clinical monographs to our clinician reviewers and network providers to assist in arranging for and delivering quality care to our members. The monographs that we develop are consistent with current published evidence-based medicine and clinical best practices.
- What You Need to Do** Your responsibility is to:
- Review and be familiar with our clinical monographs (See the [Appendix](#) of this document); and
  - Notify us with suggestions for improving or updating our clinical monographs.
- What Magellan Will Do** Magellan’s responsibility is to:
- Ensure the availability of our [clinical monographs](#) to you free of charge online at [www.MagellanProvider.com](http://www.MagellanProvider.com), or by U.S. mail upon request; and
  - Request and consider your suggestions for modifications to existing monographs and recommendations for new monographs.

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# New Technologies

**Our Philosophy** We believe it is important to regularly assess innovations in the treatment of behavioral health disorders. These assessments follow industry-standard criteria designed to exclude interventions in the investigational phase, and to make sure that the benefits of well-studied interventions exceed the risk. Just as it is important that we work to enhance each member's care, it is equally important that we do no harm in the process.

**Our Policy** Magellan reviews emerging new technologies for assessing and treating behavioral health disorders. The purpose of these organized reviews is to apply consistent, systematic procedures for identification, clinical assessment, and evaluation of proposed improvements and/or new applications of established technologies.

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

- Know Magellan's classification criteria for new technology;
- Know Magellan's criteria for rendering determinations on new technologies as follows:
  - The technology has final approval from government regulatory bodies as appropriate,
  - The scientific evidence is sufficiently definitive to permit conclusions about the effect of the technology on health outcomes,
  - The technology is as safe and effective as existing alternative treatments,
  - The technology improves the net health outcome, i.e., provides evidence that the benefits outweigh the risks,
  - The improvement in health outcome is reliably attainable outside investigative settings;
- Know what new treatments Magellan has determined remain investigational, including but not limited to:
  - Specialized treatment for rapid emotional healing by traumatic incident reduction,
  - Holding therapy (a.k.a. corrective attachment therapy, Z-process) for reactive attachment disorder (RAD),
  - EEG biofeedback (a.k.a. Neurofeedback) for depression and attention deficit hyperactivity disorder (ADHD) in children,

- Alpha wave EEG biofeedback training in the treatment of addictions and ADHD in children,
- Vagus nerve stimulation (VNS) for treatment-resistant depression,
- Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of conditions other than post-traumatic stress disorder (PTSD),
- Hippotherapy in the treatment of autistic disorder,
- PROMETA protocols - treatment of alcohol and methamphetamine withdrawal,
- Quantitative electroencephalographic (QEEG) biomarker technology (referenced EEG [rEEG] and antidepressant treatment response): treatment of refractory depression, eating disorders, ADHD and substance abuse,
- Mandometer<sup>®</sup> treatment of eating disorders,
- Neurotransmitter restoration (NTR) - treatment of drug and alcohol addiction,
- Deep brain stimulation (DBS) in the treatment of treatment-resistant depression and treatment-resistant obsessive-compulsive disorder (OCD),
- Ultra-rapid opiate detoxification under general anesthesia - this technology should not be used due to significant member safety concerns,
- Drug-facilitated interviews with abreaction for the treatment of dissociative disorder and PTSD (except when using a drug-facilitated interview using intravenous amobarbital in urgent diagnosis and treatment of patients presenting with catatonia to prevent morbidity and death in emergencies),
- Social skills training for the treatment of autism,
- Cranial electrotherapy stimulation (CES) for treatment of depression and anxiety,
- Virtual reality exposure therapy (VRET) for the treatment of PTSD (combat war and rape victims) and social phobia (except in the treatment of specific phobia, natural environment and situational types where it is established),
- Immunomodulatory therapy (plasmapheresis and intravenous immunoglobulin) for the treatment of the Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) formerly known as (PANDAS),
- Accelerated Resolution Therapy<sup>®</sup> (ART) for the treatment

- of post-traumatic stress disorder (PTSD), phobias, obsessive-compulsive disorder (OCD), anxiety and depression,
  - Ketamine for the treatment of treatment-resistant depression,
  - Increased Caloric Inpatient Refeeding Protocols for the treatment of Anorexia Nervosa,
  - Interactive Metronome Therapy for the treatment of ADHD,
  - Use of Single Photon Emission Computed Tomography (SPECT) in psychiatric treatment,
  - Transcranial Ultrasound Stimulation (TUS)/Transcranial Doppler Sonography (TCD)/Ultrasonic Neuromodulation [UNMOD) for mood modulation,
  - Relationship Development Intervention (RDI) for the treatment of autistic disorder,
  - Genetic testing for psychiatric disorders, except for GeneSight™ testing which is considered evidence-informed; and
  - Use of marijuana and marijuana containing products for the treatment of psychiatric disorders.
- Know what treatments Magellan considers to be obsolete/outmoded/abandoned:
    - Rapid Opiate Detoxification under General Anesthesia; and
    - Sexual Orientation Change Efforts (SOCE) for eliminating or suppressing homosexuality;
  - Understand that Magellan does not recommend or endorse the use of investigational treatments; and
  - Understand that most health plans contain exclusions of coverage for investigational treatments.

**What Magellan Will Do**

Magellan's responsibility is to:

- Consider requests to conduct technology assessments on innovative behavioral health treatments;
- Continue to remain current on innovations in the treatment of behavioral health disorders; and
- Conduct technology assessments when indicated.

*\* Magellan does reimburse for eye movement desensitization and reprocessing in the treatment of PTSD.*

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

# Provider Website

**Our Philosophy** Magellan is committed to reducing administrative burdens on our providers by offering web-based tools for retrieving and exchanging information.

**Our Policy** Magellan’s provider website at [www.MagellanProvider.com](http://www.MagellanProvider.com) is our primary portal for provider communication, information and business transactions. This website is continually updated to provide easy access to information and greater convenience and speed in exchanging information with Magellan. We encourage you to use this website often as a self-service tool for supporting your behavioral health practice.

**What You Need to Do** To realize the benefits of the [www.MagellanProvider.com](http://www.MagellanProvider.com) website, you should:

- Have access to a computer, internet service provider and current web browser software;
- Sign in to Magellan’s website to access secure applications (e.g., eligibility, authorizations and claims) by using your username and password;
- Forgot your website sign-in? Click the *Forgot Password?* Or *Forgot Username?* links in the Sign-In box if you need to obtain your sign-in information;
- Visit [www.MagellanProvider.com](http://www.MagellanProvider.com) frequently to take advantage of new capabilities and access resources; and
- Provide us with feedback on any difficulties you may experience in using our online resources or on ideas you have for enhancements.

*\*For group practices, the first individual to sign in will be designated “Group Administrator.” The group administrator is responsible for providing access to Magellan online applications to appropriate group practitioners.*

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

- Maintain operation of online services 24 hours a day, seven days a week;
- Inform users of service problems if they occur;
- Use your feedback to continually improve our website

capabilities;

- Contingent upon Magellan customer approval and availability of information, provide online access to the following applications:
  - Member eligibility inquiry,
  - Request for initial and subsequent outpatient authorization (when required by the member's benefit plan),
  - Request for initial authorization of inpatient, partial hospitalization and residential services,
  - Authorization inquiry and report download,
  - View authorization approval letters,
  - Claims submission (for professional services only for which Magellan is the designated claims payer),
  - Claims inquiry and online explanation of payments (EOPs),
  - Request to join the Magellan network,
  - Check credentialing and contract status (individual and group practitioners), and complete recredentialing online,
  - Display/edit practice data (enables you to monitor and ensure the accuracy of your practice information, including staff rosters),
  - Provider Profile (enables you to enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.),
  - Electronic funds transfer (EFT) signup,
  - Outcomes360 assessment tools for member outcomes reporting with provider support materials,
  - Cultural competency tools,
  - Online demos to help providers navigate website applications,
  - Comprehensive library of clinical practice information, and
  - Other tools and information beneficial to providers serving Magellan members.

## SECTION 4: THE QUALITY PARTNERSHIP

# A Commitment to Quality

**Our Philosophy** Magellan is committed to Continuous Quality Improvement (CQI) and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.

**Our Policy** In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide safe, effective, patient-centered, timely, efficient and equitable care in a culturally sensitive manner.

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

- Follow the policies and procedures outlined in the “What You Need to Do” sections in this handbook;
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under *Audit Tools* in the [Appendix](#) of this handbook;
- Provide treatment records as requested for quality of care issues, and adhere to clinical practice guidelines and HEDIS®-related measures;
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities;
- Use evidence-based practices;
- Adhere to principles of member safety;
- Attend or log on to provider training and orientation sessions;
- Participate in the completion of a remediation plan if quality of care concerns arise;
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together;
- Incorporate the use of secure technology into your practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, and online access to personal health record information;
- Assist with transition of care if a member’s benefits have been

exhausted, you leave the network, or you receive a referral of a member whose provider has left the network;

- Assist in the investigation of member complaints and adverse incidents;
- Attend meetings of our quality committees and provider advisory groups, if requested;
- Review member-specific clinical reports, when available;
- Complete and return provider satisfaction surveys;
- Be knowledgeable in quality improvement methods and tools including NCQA's HEDIS® measures;
- Contact your Magellan care management center's QI director for information about Quality Improvement Program results.

### **What Magellan Will Do**

Magellan's responsibility is to:

- Consider your feedback on clinical practice guidelines, Magellan's Care Guidelines, prevention/screening programs, member safety policies, and new technology assessments;
- Consider your feedback in our quality committees and provider advisory groups;
- Develop methods to compare treatments, outcomes and costs across the provider network in an effort to diminish the need for case-by-case review of care;
- Provide information about individual provider performance including member experience/satisfaction, member ratings, care manager experience, clinical outcomes and other metrics to providers, members and customers;
- Provide outcome assessment tools and reports for use with members;
- Provide member-specific clinical reports, when available;
- Monitor provider satisfaction with our policies and procedures as they affect you and your practice;
- Pay claims within applicable timeframes;
- Provide detailed information about how we will assess your practice during site visits and treatment record reviews;
- Join with you to develop a clear remediation plan to improve quality of care when necessary;
- Provide timely information and decisions on credentialing and recredentialing processes; and
- Resolve complaints and appeals within applicable timeframes.



## SECTION 4: THE QUALITY PARTNERSHIP

# Cultural Competency

**Our Philosophy** Magellan is committed to embracing the rich diversity of the people we serve. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who are visually and hearing impaired. All people entering the behavioral healthcare system must receive equitable and effective treatment in a respectful manner, recognizing individual spoken language(s), gender and the role culture plays in a person's health and well-being.

**Our Policy** Magellan staff is trained in cultural diversity and sensitivity, in order to refer members to providers appropriate to their needs and preferences. Magellan also provides cultural competency training, technical assistance and [online resources](#) to help providers enhance their provision of high-quality, culturally appropriate services. Magellan continually assesses network composition by actively recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population.

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

- Provide Magellan with information on languages you speak;
- Provide Magellan with information about any practice specialty you hold on your credentialing application.

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

- Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions and those with disabilities;
- Provide access to language assistance, including Braille for the visually impaired, and bilingual staff and interpreter services to those with limited English proficiency, during all hours of operation at no cost to the consumer;
- Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area;
- Provide access to TDD / TTY services for the hearing impaired;
- Monitor gaps in services and other culture-specific provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness.

## SECTION 4: THE QUALITY PARTNERSHIP

# Member Safety

<b>Our Philosophy</b>	Magellan believes in the delivery of high-quality, safe behavioral healthcare services. We reinforce this commitment by embedding objective and systematic monitoring mechanisms into our policies and procedures.
<b>Our Policy</b>	Magellan monitors the safety of members receiving treatment from our providers. Monitoring includes, but is not limited to, member feedback, performance indicator reviews, site visits, treatment record reviews and surveys.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Have a written member safety plan;</li><li>• Enhance and monitor the safety of members as related to their treatment while in your care;</li><li>• Be familiar with Magellan clinical guidelines related to member safety and use them in treatment decisions and management;</li><li>• Be familiar with activities encouraged by Magellan as stated in the Patient Safety Activity Survey to promote safe and effective coordination and transition of care;</li><li>• Communicate to Magellan your plan and outcomes related to member safety when requested; and</li><li>• Complete the annual Member Patient Safety Activity Survey.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide information about the data being requested and the rationale, methods and standards employed in the review process;</li><li>• Work closely with you to improve performance on indicators that are below standard;</li><li>• Evaluate member drug profiles of high-volume prescribing providers related to benefits coverage, clinical appropriateness and member medication use safety; and</li><li>• Communicate the results of member safety monitoring to our providers, customers and members.</li></ul>

## SECTION 4: THE QUALITY PARTNERSHIP

# Accreditation

**Our Philosophy** Excellence in clinical care and service can be affirmed through recognition by national accrediting bodies, such as the National Committee for Quality Assurance (NCQA), URAC and The Joint Commission (TJC).

**Our Policy** Our policies, procedures and quality initiatives are guided by national accreditation standards, including, but not limited to:

- Provider accessibility standards;
- Site visits and treatment record reviews;
- Credentialing and recredentialing requirements;
- Clinical practice guidelines;
- Collaboration and coordination of care;
- Care management and case management review processes;
- Prevention/Screening programs;
- Member experience (satisfaction) surveys;
- Member safety policies and initiatives;
- Complaint, appeal and grievance policies and procedures;
- Confidentiality policies and procedures;
- Medical integration and coordination policies and procedures;
- Provider quality remediation and review;
- Member communication, including distribution of the Member's Rights and Responsibilities statement;
- Provider participation on our quality improvement committees;
- Quality improvement and care management program descriptions;
- Member requests to change providers and transition of care tracking;
- Claim and encounter verification elements for annual HEDIS® reporting.

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

- Follow the policies and procedures outlined in this handbook; and
- Collaborate/cooperate with quality improvement activities and initiatives.

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

- Advise you of our policies and procedures.

## SECTION 4: THE QUALITY PARTNERSHIP

# HEDIS® and Performance Measurement

### Our Philosophy

We support and promote the use of evidence-based performance measures that help drive the adoption of recommended care and improvements in population health. “HEDIS,” which stands for Healthcare Effectiveness Data and Information Set, is owned by the National Committee for Quality Assurance (NCQA [www.ncqa.org](http://www.ncqa.org)). HEDIS comprises the most widely used measure set driving healthcare quality rating systems, as well as individual measures which are increasingly used by employers, health plans and government agencies to drive pay for performance quality programs. The number of HEDIS measures related to the management of behavioral health disorders treatment has increased since the inception of HEDIS more than 20 years ago.

Measures that are dependent on accurate claims submission from behavioral health providers to determine eligibility and/or compliance include:

- *Follow-Up After Hospitalization for Mental Illness,*
- *Follow-Up After Emergency Department Visit for Mental Illness,*
- *Follow-Up Care for Children Prescribed ADHD Medication,*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence,*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia,*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia, and*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.*

Additional measures triggered by at least one medication fill, requiring patient adherence for a defined period of time to the medication, and/or recommended monitoring/testing include:

- *Antidepressant Medication Management,*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics, and*

- *Adherence to Antipsychotic Medications for Individuals with Schizophrenia.*

A third group of measures impacted by behavioral health providers and not listed above include:

- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents,*
- *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults, and*
- *Depression Remission or Response for Adolescents and Adults.*

Many HEDIS measures require collaboration with the primary care provider (*See Section 3 of this handbook – [Continuity, Coordination and Collaboration.](#)*)

## Our Policy

Provider participation in HEDIS related data collection for identified members is mandatory. **Magellan’s network providers are contractually required to submit claims in a timely manner and, if requested, provide a copy of the behavioral health service from the treatment record** if a claim has not been submitted. We must have this documentation so that we may fulfill our state and federal regulatory and accreditation obligations and obtain the most accurate data reporting possible.

HIPAA permits our providers to disclose protected health information (PHI) to Magellan. A signed consent from the member is not required under the HIPAA privacy rule for you to release the requested information to Magellan. We are a managed care organization contracted with health plans, the Department of Human Services, which administers the Medicaid program and Federally-Facilitated Exchanges, and the Centers for Medicare & Medicaid Services (CMS, [www.cms.gov](http://www.cms.gov)) which administers the federal Medicare program. The member’s enrollment into any of these programs facilitates Magellan’s access to his or her medical records.

*Note: See section on [Confidentiality](#) for additional information on this topic.*

## What You Need to Do

Your responsibility is to:

- Submit your claims in a timely manner for all services provided (within 30 days of the encounter);

- Assure that you and your office staff respond to our requests for medical record documentation in a timely manner;
- Notify our staff immediately if the patient listed on a request for medical records is not a part of your practice;
- Allow a record review for a member who is no longer with Magellan or for a member who is deceased, as medical record reviews may require data collection for services obtained over multiple years; and
- Provide medical records for a member who was seen by a physician who has retired, died or moved, as data collection can go back as far as 10 years.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Provide education and information as needed regarding HEDIS and other performance measures for which we request your cooperation and assistance;
- Collect and submit required HEDIS and other performance measurement reports according to population, product line and service areas to health plans that report to NCQA and/or state and/or federal entities to meet contract requirements;
- Communicate with you by phone, fax, in writing or through secure electronic communications to request medical record documentation to verify service delivery in the absence of claims data or where medical record information is required; and
- Either schedule an on-site review at your location or ask that you transmit the verification information to Magellan staff. The method chosen will typically depend upon the volume of records being requested from your office.

## THE QUALITY PARTNERSHIP

# Prevention/Screening Programs

### Our Philosophy

Reducing the occurrence and severity of substance use and mental disorders, detecting them early in their course, and providing appropriate, high-quality treatment are the goals of our prevention/screening programs. In support of this philosophy, we have developed and implemented a number of prevention/screening programs that are designed to sustain, quickly restore, or enhance that well-being. These programs include, but are not limited to:

- Screening for Co-existing Substance Abuse and Mental Health Disorders;
- Screening Members with Significant Medical Issues for Depression;
- Postpartum Depression Prevention;
- Perinatal Depression Prevention;
- Offspring Depression of Depressed Parents Prevention;
- Cardiac and other Comorbid Medical Conditions Depression Prevention;
- Follow-up after Hospitalization Early Re-hospitalization Prevention; and
- Substance Use Relapse Prevention.

### Our Policy

We develop prevention/screening programs that improve physical and mental well-being, encourage members to seek help early, and overcome stigma. Programs are developed with the input of healthcare experts, are research-based and are designed to meet or exceed accreditation preventive health standards. Our care management centers select which programs to implement based on the unique needs of the members in their area.

### What You Need to Do

Your responsibility is to:

- Become familiar with the Magellan prevention/screening programs in your region. See this handbook [Appendix](#) for descriptions.
- Contact the applicable Magellan care management center medical director to get further information, and to provide input into the development and revision of prevention/screening programs and interventions;
- Consider participating in the prevention/screening programs (e.g., serving as a consultant, distributing prevention/screening

materials in your office, administering screening tools as part of routine care); and

- Practice prevention/screening-minded treatment, e.g., consider the prevention/screening needs in the member's entire family, not just the member presenting for treatment.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Inform you about the prevention/screening programs we offer;
- Advise on how you can participate in our prevention/screening programs;
- Continue to develop and improve our prevention/screening programs;
- Inform you about the effectiveness of our prevention/screening programs; and
- Seek and consider your input on our prevention/screening programs.



## SECTION 4: THE QUALITY PARTNERSHIP

# Outcomes360

### Our Philosophy

Measuring clinical outcomes is an important component of delivering high-quality care and is useful in engaging members in treatment planning. Research shows that real-time feedback to members in counseling improves outcomes. Magellan's outcomes program, known as [Outcomes360<sup>SM</sup>](#), uses a suite of patient-reported outcome (PRO) tools, available in English and Spanish, to measure treatment progress and program outcomes. Outcomes tools are matched to population and program needs. The [Child and Adolescent Needs and Strengths](#) (CANS MH) is also available on the [www.MagellanProvider.com](http://www.MagellanProvider.com) website under *MyPractice/My Outcomes* (after secure sign-in) for CANS certified staff. See the [Outcomes Library](#) of our provider website under Education for information on the required training and certification test to use the CANS tool.

### Our Policy

Our policy is to use evidence-based measurement instruments and partner with leading quality measurement companies to develop and use clinical assessment tools to monitor and improve the safety and effectiveness of care and services provided to our members.

### What You Need to Do

Your responsibility is to:

- Encourage members to complete clinical assessments at the time of intake and periodically during the course of treatment, as well as involve them in discussions about findings, as applicable;
- Access member-specific outcomes reports as applicable on the [MagellanProvider.com](http://www.MagellanProvider.com) website under *MyPractice/My Outcomes* (after secure sign-in);
- Review additional training materials for providers and handouts for members available online in our Outcomes360 library, at [www.MagellanProvider.com](http://www.MagellanProvider.com) under the *Education* tab;
- Use standardized assessment tools in treatment planning, assessment of progress and discharge planning;
- Participate in quality studies, outcomes research and other initiatives, as requested.

### What Magellan Will Do

Through Outcomes360, Magellan's responsibility is to:

- Provide scientifically sound outcome measurement tools;
- Provide training and technical support for [Outcomes360](#);
- Conduct quality improvement studies that measure how well

program interventions improve outcomes;

- Collaborate with recognized universities and other institutions on research and outcome studies; and
- Inform you of the purpose of quality studies and outcomes research that may affect you.

## SECTION 4: THE QUALITY PARTNERSHIP

# Outcomes and Reimbursement

### Our Philosophy

Magellan believes that provider reimbursement, in addition to market and geographical considerations, should reflect clinical performance and outcomes. The latest clinical research demonstrates that clinicians who use outcomes information in their practice, e.g., Feedback Informed Treatment, provide more efficient and effective treatment for individuals in their care. We strongly encourage you to incorporate member satisfaction and outcome information into your ongoing practice.

### Our Policy

Magellan develops provider reimbursement practices that support the use of evidence-based measurements and produce positive clinical outcomes achieved in the most efficient and effective manner. In an effort to promote transparent and collaborative care, we include outcomes, efficiency and effectiveness data in the information we may share publicly about our panel of clinicians through ratings in our Provider Search. This information may impact the reimbursement rates and/or quality-related incentives providers receive.

### What You Need to Do

Your responsibility is to:

- Encourage your members in care to complete clinical assessment tools during intake and periodically during the course of treatment, as well as involve them in discussions about findings, as applicable. *Refer to the previous section – [Outcomes360](#) – for further details.* We include this aspect of your practice patterns in the information we share about your efficiency and effectiveness as a clinician on our panel, and your use of outcomes tools in your clinical practice may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentive payments we may offer;
- Update and maintain your provider profile information by signing in to [www.MagellanProvider.com](http://www.MagellanProvider.com) and selecting *Display/Edit Practice Information/Provider Profile*. This enables you to enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.;
- Review your online dashboard and performance scorecard to understand your practice patterns with Magellan members, and

take action to improve measures based on the information presented; and

- Participate in quality studies, outcomes research and other initiatives, as requested. Your participation may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentive payments we may offer.

*Note: Find information on clinical outcome tools in the [Outcomes Library](#) at [www.MagellanProvider.com](http://www.MagellanProvider.com) under Education.*

**What Magellan Will Do**

Magellan's responsibility is to:

- Provide scientifically sound outcome measurement tools;
- Offer online tools so you can update your practice information and provider profile which is seen by others who access our online Provider Search;
- Make your performance data available to you using online dashboards and performance scorecards; and
- Develop reimbursement methods that reflect your use of evidence-based practice and achievement of efficient and effective outcomes.

## THE QUALITY PARTNERSHIP

# Provider Input

**Our Philosophy** Magellan believes that provider input concerning our programs and services is a vital component of our quality program.

**Our Policy** We obtain provider input on our programs and services through provider satisfaction surveys, regional Provider Advisory Groups, our provider website, and through special requests for feedback, such as for our clinical practice guidelines, Magellan Care Guidelines and prevention/screening program development.

Magellan welcomes compliments about our staff members or a positive experience you have had with us. We also welcome suggestions and offer providers the opportunity to file a formal administrative complaint. A formal administrative complaint is defined as: an issue you need to have addressed in order to provide efficient and effective care and services to your clients and our members. Examples of a formal administrative complaint may include dissatisfaction with an administrative process, an interaction with a Magellan staff member, the timeliness of a response to an inquiry regarding credentialing and/or contracting status or process, the timeliness of a response to a general inquiry, or dissatisfaction with website applications. A formal administrative complaint is not a disagreement or dissatisfaction with a particular claim or authorization decision.

**What You Need to Do**

Your responsibility is to:

- Provide feedback on our clinical practice guidelines, Magellan Care Guidelines, prevention/screening programs, new technology assessments and other guidelines and policies, if requested;
- Return completed provider satisfaction surveys, if requested;
- Attend our Provider Advisory Group or other committee meetings, if requested;
- Provide feedback on special projects, including research studies, as requested; and
- Provide suggestions, compliments or file a formal administrative complaint by contacting Magellan using any of the following methods:
  - Online through the secure comment function on the Magellan provider website at

[www.MagellanProvider.com](http://www.MagellanProvider.com):

- Sign in,
- Under *My Messages* on your home page, click on the *Suggestions/Compliments/Complaints* link,
- Pick the subcategory “*Who can I contact regarding complaints,*”
- Click *continue*,
- Complete the fields and enter your message,
- Click send;
- Call 1-800-327-8780 and let the network representative who answers the call know that you would like to file an administrative complaint;
- Call our national Provider Services Line at 1-800-788-4005 and let them know that you would like to file an administrative complaint and they will direct you to the correct person to handle your complaint;
- Call or email the local or regional network staff you are already familiar with; or
- Write a letter to:
  - Magellan Healthcare
  - Attn: Provider Administrative Complaints
  - P.O. Box 1619
  - Alpharetta, GA 30009

**What Magellan Will Do**

Magellan’s responsibility is to:

- Advise you of the forums available for your feedback;
- Actively request your input in the development and/or update of our policies and procedures;
- Consider your input while developing or reviewing new and established policies, procedures, programs, and services; and
- Document all formal administrative complaints in the Magellan complaint system and notify you of timely of action taken for a satisfactory resolution.

## SECTION 4: THE QUALITY PARTNERSHIP

# Member Rights and Responsibilities

**Our Philosophy** Magellan protects the rights and responsibilities of all members. We are committed to having everyone involved in the delivery of care respect the dignity, worth and privacy of each member.

**Our Policy** We have established member rights and responsibilities that promote effective behavioral healthcare delivery and member satisfaction, and that reflect the dignity, worth, and privacy needs of each member.

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

- Review Magellan’s Members’ Rights and Responsibilities Statement with members in your care at their first appointment (Copies available in the [Appendix](#) of this handbook);
- Sign and have the member sign the statement and retain a copy in the member’s record;
- Give members the opportunity to discuss their rights and responsibilities with you;
- Review with the members in your care information such as:
  - Procedures to follow if a clinical emergency occurs,
  - Fees and payments,
  - Confidentiality scope and limits,
  - Member complaint/grievance process, and
  - Treatment options and medication;
- Obtain members’ consent to share information with primary care physicians and other treating providers.

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

- Make available the Magellan Members’ Rights and Responsibilities Statement for distribution (See this handbook [Appendix](#));
- Provide instructions on how and when to share the statement with members (See “What You Need to Do” above); and
- Make available the Members’ Rights and Responsibilities statement in languages and formats that members can understand.

## SECTION 4: THE QUALITY PARTNERSHIP

# Confidentiality

**Our Philosophy** Confidentiality is a key tenet of our operations and processes. To that end, we have developed policies and procedures that serve to protect the privacy of confidential health information that is used or disclosed by Magellan.

**Our Policy** Magellan protects access to protected health information (PHI) in the following ways:

- Utilizing strict guidelines for how member information may be used and disclosed;
- Requiring all employees to be familiar with the process for responding to any unauthorized uses or disclosures of confidential member information;
- Requiring Magellan staff, employees and visitors to sign statements concerning confidentiality of information, release of information, and communication requirements;
- Making sure that the Authorization to Use or Disclose Protected Health Information form we use complies with applicable state and federal laws and our customer-specific requirements;
- Monitoring provider adherence to privacy policies and procedures through site visits, quality reviews, and routine contact;
- Monitoring member feedback through the complaint process, member satisfaction survey results, and internal quality audits;
- Complying with applicable state and federal laws and accrediting organization standards;
- Establishing proper mechanisms for timely and appropriate responses to member rights issues, including but not limited to member requests for confidential communications, access to protected health information, amendments to protected health information, and accounting of disclosures;
- Implementing technical barriers to systems by requiring authorization and passwords to access systems containing confidential information; and
- Requiring the minimum necessary information for routine uses and disclosures of health information.

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

- Comply with applicable state and federal laws and regulations



that address member privacy and confidentiality of PHI;

- Utilize HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws;\*
- Use only secure email (secure messaging) when requesting member PHI;
- Establish office procedures regarding communication with members (e.g., telephone and cellphone use, and written, fax and internet communication);
- Establish a process that allows members access to their records in a confidential manner;
- Distribute the Magellan Member's Rights and Responsibilities Statement to members; and
- Participate in and comply with Magellan's quality review, site visit process and contract obligations.

**What Magellan Will Do**

Magellan's responsibility is to:

- Collaborate with you to protect member privacy and confidentiality;
- Request the minimum necessary PHI to perform needed healthcare operations and payment activities; and
- Only respond to electronic (internet) requests for PHI through secure email channels.

*\* When the HIPAA Privacy Rule is applicable, it allows Magellan and our providers to use and disclose PHI for treatment, payment and healthcare operations activities.*

## SECTION 4: THE QUALITY PARTNERSHIP

# Site Visits

**Our Philosophy** Magellan conducts site visits with providers to assess the quality of care and services provided, evaluate adherence to policies and procedures, and to support various quality improvement activities.

**Our Policy** Magellan conducts site visits at individual and group practices, and at facilities and organizations, to directly assess the physical appearance of the facility/office, adequacy of waiting and treatment room space, physical accessibility, appointment accessibility, staffing, and treatment record-keeping practices. Magellan provider network staff conducts administrative aspects of site reviews, while Magellan licensed clinicians and Quality Improvement (QI) staff review specific clinical documents, as needed. Provider site visits may be conducted as a part of credentialing for participation in Magellan's network and on other occasions as determined by quality or clinical reviews.

Site visits may include, but not be limited to, a review of the following:

- Routine appointment availability, and procedures for access;
- Availability of care in emergencies and after-hours situations;
- Procedures to maintain confidentiality of member information;
- Procedures for disclosure of member information;
- Physical site environment, including appearance, accessibility, etc.;
- Staff orientation, training and supervision (as appropriate);
- Treatment record-keeping practices;
- Documentation in member records;
- Documentation of contact with PCP (when authorized by the member);
- Credentials verifications of licensed clinical staff; verification and other human resources procedures for direct care staff; and
- Quality improvement and safety management programs.

**What You Need to Do**

Your responsibility is to:

- Comply with requests for site visits;
- Provide information in a timely manner, including files as requested by the site visit reviewer;
- Be available to answer questions from the reviewer; and

- Participate in developing and implementing a corrective action plan if required.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Advise you in writing if a site visit is required;
- Advise you of what you need to do to prepare for the site visit;
- Notify you of the results of the site visit in a timely manner; and
- Work with you to develop a corrective action plan, if required.

## SECTION 4: THE QUALITY PARTNERSHIP

# Treatment Record Reviews

<b>Our Philosophy</b>	In support of our commitment to quality care, we request that our providers maintain organized, well-documented member treatment records that reflect continuity of care for members. We expect that all aspects of treatment will be documented in a timely manner, including face-to-face encounters, telephone contacts, clinical findings and interventions.
<b>Our Policy</b>	<p>Magellan reviews provider treatment records of Magellan members to:</p> <ul style="list-style-type: none"><li>• Monitor documentation and record-keeping practices against Magellan’s and other required standards;</li><li>• Measure network provider adherence to Magellan-approved clinical practice guidelines;</li><li>• Review potential quality of care concerns;</li><li>• Investigate member complaints about the clinical or administrative practices of a Magellan provider; and</li><li>• Evaluate appropriate documentation of services for which claims were submitted.</li></ul>
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Follow the detailed instructions provided if you are selected for a review;</li><li>• Make the records requested available for our review;*</li><li>• Cooperate with Magellan in developing and carrying out a quality improvement corrective action plan should opportunities for improvement in documentation be identified; and</li><li>• With the increasing use of electronic health records, we expect you to develop administrative policies to ensure that you and your staff use this technology appropriately to enhance efficiency in your clinical documentation, while mitigating inappropriate use of other features, such as copy-paste, that may increase the risk of fraud, waste and abuse.</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan’s responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide detailed information prior to the review concerning the rationale, methods and standards used in the review process;</li><li>• Request the minimum necessary protected health information to perform treatment record reviews;</li></ul>

- Inform you of the results of the treatment record review;
- Request an action plan to correct deficiencies, if required;
- Suggest steps to be taken to improve quality of treatment record documentation;
- Work with you to review a corrective action plan; and
- Perform a follow-up review of treatment records to assure corrective action has been effective in improving your record documentation, if required.

*\* When the HIPAA Privacy Rule is applicable, it allows Magellan and our providers to use and disclose PHI for treatment, payment and healthcare operations activities.*

## SECTION 4: THE QUALITY PARTNERSHIP

# Member Experience of Care and Services Surveys

<b>Our Philosophy</b>	Member satisfaction, and thus obtaining member input, is an essential component of our quality program. Members' ratings of their experience of care and services comprise one of our core performance measures.
<b>Our Policy</b>	At least once a year, we survey a representative sample of members who have received services to determine their level of satisfaction with Magellan, and with key aspects of the care and/or services received from providers in our network.
<b>What You Need to Do</b>	<p>Your responsibility is to:</p> <ul style="list-style-type: none"><li>• Provide timely, safe, high-quality care and service to those members you treat;</li><li>• Implement actions identified from satisfaction survey results when informed by Magellan;</li><li>• Involve members in their treatment plan;</li><li>• Encourage members to provide feedback on the care and services received; and</li><li>• Update your practice and provider profile information, which members see in online provider searches, and monitor your reviews from members (from your <i>Display/Edit Practice Information</i> page on <a href="http://www.MagellanProvider.com">www.MagellanProvider.com</a>, click the <i>Member Ratings</i> tab.)</li></ul>
<b>What Magellan Will Do</b>	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none"><li>• Inform you of aggregate survey findings and respond to any questions you may have regarding the surveys;</li><li>• Share aggregate results of our member satisfaction surveys with our providers, customers, accreditation entities and members;</li><li>• Use member survey findings to identify opportunities for improvement and to develop and implement actions for improving our policies, procedures, and services; and</li><li>• Make website-based tools available to you so that you can update your practice information, update your provider profile and view your ratings from our members you have served, when available.</li></ul>

## SECTION 4: THE QUALITY PARTNERSHIP

# Provider Satisfaction Surveys

**Our Philosophy** Successful collaboration and provider satisfaction are among our core performance measures. Obtaining our network providers' input is vital to our ability to collaborate and is an essential component of our quality program.

**Our Policy** Annually, we survey participating providers in our provider network who have rendered services to members during the survey period to determine their level of satisfaction with Magellan and with key aspects of the service they received from us while assisting our members.

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

- Complete the survey and return it using any one of the electronic means made available, (e.g., via email, Magellan's website, text or facsimile); and
- Contact Magellan with any comments, suggestions or questions.

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

- Monitor provider satisfaction with Magellan and Magellan's policies and procedures;
- Share aggregate results of our provider satisfaction surveys with our providers, customers, accreditation entities and members; and
- Use provider survey findings to identify opportunities for improvement and to develop and implement actions for improving our policies, procedures and services.

## SECTION 4: THE QUALITY PARTNERSHIP

# Adverse Outcome Reporting

**Our Philosophy** In our quest for our members to receive quality behavioral healthcare services, we routinely review quality of care concerns and adverse outcome occurrences to identify opportunities for improvement.

**Our Policy** We initiate a quality of care review for known incidents in which an individual, who is a Magellan member at the time of the incident and who has been in treatment within six months of the incident, completes a suicide or homicide and/or engages in another type of serious incident that results in serious harm to the member or others.

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

- As soon as possible, contact the Magellan care management center that initiated the referral to report any of the following incidents involving a Magellan-referred member currently in treatment, or a member who was discharged from treatment within 180 days prior to the occurrence of:
  - Death,
  - Suicide or serious suicide attempt,
  - An incident of violence initiated by the member,
  - Other incident resulting in serious harm to the member or others, that includes but is not limited to serious complications from a psychotropic medication regimen that required medical intervention.

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

- Serve as a resource to manage the clinical situation presented by the adverse incident or potential adverse incident;
- Investigate all adverse incidents in a timely manner; and
- Document and review available data surrounding the event to identify potential areas for quality improvement that might prevent similar events in the future.



## SECTION 4: THE QUALITY PARTNERSHIP

# Inquiry and Review Process

**Our Philosophy** Magellan is committed to developing and maintaining a high-quality provider network.

**Our Policy** Magellan maintains a process for inquiry, review and action when concerns regarding provider performance are identified.

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

- Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Magellan provider network.

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

- Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised;
- Advise you if an on-site review, treatment record review and/or other type of review is required;
- Review all inquiries for adequate resolution of any performance concerns;
- Advise you when a corrective action plan and follow-up are required;
- Advise you of a change in the conditions of your network participation, if determined to be required;
- Advise you, in writing, if any action is taken as a result of the inquiry and review process; and
- Advise you of your right to appeal if the decision is to terminate your participation in the provider network due to quality of care or service issues. The procedure for appeals is included in written notification of such a determination and includes your submission of any appeal request and any additional information not previously presented, in writing, within 33 calendar days of the mailing of the determination notice. Appeals are heard by the members of the National Network and Credentialing Committee (NNCC) Appeals Subcommittee. Written notification of the subcommittee's determination of the appeal includes the specific reasons for the decision.

## SECTION 4: THE QUALITY PARTNERSHIP

# Fraud, Waste, Abuse and Overpayment

### Our Philosophy

Magellan takes provider fraud, waste and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. Magellan has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.

Magellan promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their patients.

### Our Policy

Magellan has implemented a comprehensive compliance program to ensure ongoing compliance with all contractual and regulatory requirements. Magellan's Compliance Program describes our comprehensive plan for the prevention, detection and reporting of fraud, waste, abuse and overpayment across various categories of healthcare related activities and operations. The elements of the Compliance Program include: [I] Written Policies and Procedures; [II] Designation of a Compliance Officer and a Compliance Committee; [III] Conducting Effective Training and Education; [IV] Developing Effective Lines of Communication; [V] Auditing and Monitoring; [VI] Enforcement Through Publicized Disciplinary Guidelines and Policies Dealing With Ineligible Persons; [VII] Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and [VIII] Whistleblower Protection and Non-Retaliation policy.

Magellan does not tolerate fraud, waste or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. Magellan's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste, abuse and overpayment in government programs and private insurance.

- Our policies in this area reflect that both Magellan and providers

are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., [Medicare](#) and [Medicaid](#), included in the [Appendix](#)), federally funded contracts and private insurance. Magellan complies with all applicable laws, including the Federal False Claims Act, state false claims laws (See [State-Specific Information](#) on our website), applicable [whistleblower protection](#) laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded healthcare programs, e.g., Medicare Advantage, State Children’s Health Insurance Program (SCHIP) and Medicaid, and other payers. Visit our website to review these policies. See the [CMS Fraud-Prevention/Medicaid Program Integrity Educational Resource](#) for additional information.

## What You Need to Do

Your responsibility is to:

- Comply with all federal and state laws and Magellan requirements regarding fraud, waste, abuse and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse.
- Ensure that you provide and bill only for services to members that are medically necessary and consistent with all applicable requirements, regulations, policies and procedures.
- Ensure that all claims submissions are accurate;
- Notify Magellan immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;
- Notify Magellan immediately when you receive information about changes in a Magellan member's circumstances that may affect the member's eligibility including all of the following:
  - (i) Changes in the member's residence,
  - (ii) The death of a member.

- *Understand Fraud, Waste, Abuse and Overpayment:*  
*Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. Fraud includes any act that constitutes fraud under applicable federal or state law.

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

*Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.

*Overpayment* means any funds that a person receives or retains under Medicare, Medicaid, SCHIP and other government funded healthcare programs to which the person, after applicable reconciliation, is not entitled under such healthcare program. Overpayment includes any amount that is not authorized to be paid by the healthcare program whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse or mistake.

*Some examples of fraud, waste, abuse and overpayment include:*

- Billing for services or procedures that have not been performed or have been performed by others;
- Submitting false or misleading information about services performed;
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement);
- Not complying with regulatory documentation requirements;
- Lack of documentation to support services performed;
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion);

- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute, the Stark Law, Exclusion Authorities Law or Civil Monetary Penalties Law constitutes a false or fraudulent claim under the False Claims Act;
- Routinely waiving patient deductibles or co-payments;
- Providing or ordering medically unnecessary services and tests based on financial gain;
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient);
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient);
- Providing services over the telephone or internet and billing face-to-face codes;
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session);
- Treating all patients weekly regardless of medical necessity;
- Routinely maxing out members' benefits or authorizations regardless of whether or not the services are medically necessary;
- Inserting a diagnosis code not obtained from a physician or other authorized individual;
- Improper use of electronic health records (refer to CMS Toolkit on Electronic Health Records at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/electronic-health-records.html> for additional information);
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals);
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs;
- Lying about credentials, such as degree and licensure

- information; and
- Use of unlicensed or non-credentialed staff.
- *Report Suspected Fraud, Waste, Abuse and Overpayments*  
Magellan expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayments. Magellan will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from Magellan, you are contractually obligated to report the overpayment and to return the overpayment to Magellan within sixty (60) calendar days after the date on which the overpayment was identified. You must also notify Magellan in writing of the reason for and claims associated with the overpayment.

Reports may be made to Magellan via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit email: [Compliance@MagellanHealth.com](mailto:Compliance@MagellanHealth.com)
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit email: [SIU@MagellanHealth.com](mailto:SIU@MagellanHealth.com)

*Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.*

- *Self-Disclosure Reporting*  
With regard to Medicare, Medicaid, SCHIP and other federally funded healthcare programs, providers can disclose self-discovered evidence of potential fraud, waste, abuse and overpayments to federal and state regulatory agencies with oversight of the applicable healthcare program. Providers can also self-disclose information to Magellan. According to the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) website, “Providers who wish to voluntarily disclose self-discovered evidence of potential fraud to OIG may do so under the Provider Self-Disclosure Protocol (SDP). Self-

disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.” Additional information regarding the HHS-OIG Provider SDP is available at <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>.

States also have state-specific Self-Disclosure Protocols. Additional information regarding state-specific procedures for Provider Self-Disclosures is typically available by visiting the state’s Office of Inspector General website or the website of other applicable state regulatory agencies with oversight of the state’s Self-Disclosure Protocol.

With regard to non-government funded healthcare programs, providers can disclose self-discovered evidence of potential fraud, waste, abuse and overpayments to Magellan and other applicable state regulatory agencies including but not limited to the state’s Insurance Agency.

- *Remember!*  
Magellan will not retaliate against you or any of our employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits Magellan from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. Magellan also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.
- *Cooperate with Magellan’s Audits and Investigations*  
Magellan’s expectation is that you will fully cooperate and participate with its fraud, waste, abuse and overpayment audits and investigations. This includes, but is not limited to, permitting Magellan access to member treatment records and allowing Magellan to conduct on-site audits or reviews.
- *What is the difference between an audit and investigation?*  
An *audit* is an objective and systematic assessment of how well a provider/program is performing as well as meeting expectations and applicable regulations. This is a routine process and can

happen at any time. An *investigation* is usually undertaken in response to reports of misconduct. It is a process of detailed examination to achieve certain objectives.

- *What to Expect During a Fraud, Waste, Abuse or Overpayment Audit or Investigation*

Magellan's Special Investigation Unit (SIU) investigates all reports of fraud, waste, abuse and overpayment. Allegations can come from a number of different internal and external sources. SIU takes every allegation of fraud, waste, abuse and overpayment seriously and is required to investigate every allegation. The investigative process varies depending on the allegation.

SIU may choose to conduct a *desk* or *on-site* audit during the course of an audit or investigation.

During a *desk audit*, you will receive a request for member treatment records and other relevant documentation via certified mail, fax and/or email. You are expected to provide a timely response for information requests. Details on how to transmit the documentation will be provided to you in the initial record request letter. If you use electronic health records, SIU will ask you to complete the "Electronic Health Records Questionnaire."

An *on-site audit* can be *announced* or *unannounced* and can occur at any of your contracted service locations. Prior to an announced on-site audit, you will receive notice of audit via fax, e-mail or mail. The notice will provide details and instructions about the audit. You will not receive advance notice of an unannounced audit. SIU staff will provide you with proper identification as well as a written audit notice providing further details and instructions.

During on-site audits, you will be expected to provide treatment records, personnel files, scheduling documentation, and policies and procedures to SIU staff for review. If any of the information is maintained electronically, you will be expected to provide SIU staff with electronic access.

SIU may also take the following steps during the course of an



audit or investigation:

- Review your submitted claims for red flags;
- Interview you and/or staff;
- Review supporting documentation and conduct relevant background checks; and
- Interview members without provider interference.

At the conclusion of an audit or investigation, SIU will report results to the provider in the form of a findings letter. SIU may also be required to report the findings to a customer oversight agency, place a provider on a pre-payment review and/or a corrective action plan where permitted. Any overpayment identified will be referred to Magellan's Cost Containment department for recovery by refund check or future claims retractions in compliance with contractual and regulatory requirements.

- *Conduct routine self-audits*

Providers are encouraged to conduct routine self-audits to measure and ensure internal compliance. During the course of an investigation, a provider may also be asked to complete a self-audit. For more information on self-auditing, please refer to the CMS "Program Integrity: Self-Audit Toolkit" at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html>.

## What Magellan Will Do

Magellan's responsibility is to implement and regularly conduct fraud, waste, abuse and overpayment prevention activities that include:

- Extensively monitor and audit provider utilization and claims to detect fraud, waste, abuse and overpayment;
- Actively investigate and pursue fraud, waste, abuse, overpayment and other alleged illegal, unethical or unprofessional conduct;
- Report suspected fraud, waste, abuse, overpayment and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations;
- Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases;
- Conduct routine data mining activities to identify suspicious patterns in claims data;
- Verify eligibility for members and providers;

- Utilize internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs;
- Train all Magellan employees annually on Magellan's Corporate Code of Conduct and Compliance Program including, but not limited to fraud, waste, abuse and overpayment prevention, detection and reporting; and
- Make the Magellan Provider Handbook available to our providers.

## SECTION 4: THE QUALITY PARTNERSHIP

# Provider Exclusion from Federally or State-Funded Programs

### Our Philosophy

Magellan promotes provider compliance with all federal and state laws on provider exclusion.

The U.S. Department of Health and Human Services (HHS) through the Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federally funded healthcare programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online. According to the HHS-OIG, the “basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.” “The effect of an OIG exclusion is that no Federal healthcare program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person. The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one healthcare profession to another while excluded. This payment prohibition applies to all methods of Federal healthcare program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system or other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded. Excluded persons are prohibited from furnishing administrative and management services that are payable by the Federal healthcare programs. This prohibition applies even if the administrative and management services are not separately billable.” Additional information is available by reviewing the *U.S. Health and Human Services Office of Inspector Special Advisory Bulletin: “Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs - Issued May 8, 2013* (<http://oig.hhs.gov/exclusions/files/sab-05092013.pdf>).

In addition, the U.S. General Services Administration’s (GSA) web-based System for Award Management (SAM) Exclusion Database is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts, and certain types of federal

financial and non-financial assistance and benefits. The SAM Exclusion Database replaced the U.S. General Services Administration's (GSA) web-based Excluded Parties List System (EPLS), which is no longer in use.

States also can exclude individuals and entities from participating in state-funded contracts and programs.

### **Our Policy**

Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan's policy is to ensure that excluded individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan's federally and state-funded healthcare contracts, including but not limited to contracts issued under Medicaid (Title XIX), Medicare (Title XVIII), Social Services Block Grants (Title XX programs), or the State Children's Health Insurance Program (Title XXI). This policy is applicable to all Magellan lines of business.

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

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

- Screen all employees, agents and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the HHS-OIG LEIE website at <http://www.oig.hhs.gov/>, the U.S. General Services Administration's (GSA) web-based System Award Management (SAM) Exclusion Database website at <https://www.sam.gov/portal/public/SAM/>, and other applicable state exclusion/termination/suspension/sanction lists to capture sanctions, terminations, suspensions, exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency any exclusion, termination, debarment, ineligibility or suspension information discovered.

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

- Check each month to ensure that you, your employees, agents, directors, subcontractors, officers, partners, managing employees, affiliates<sup>1</sup> or persons with an ownership or control interest in you, the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you, the provider entity, of 5 percent or greater are not terminated, debarred, suspended or otherwise excluded under the HHS-OIG LEIE at <http://www.oig.hhs.gov/>, the SAM Exclusion Database at <https://www.sam.gov> or any applicable state exclusion/termination/suspension/sanctions list; and
- Immediately notify Magellan in writing of the sanction, termination, debarment, suspension or exclusion of you, your employees, managing employees, agents, subcontractors, directors, officers, affiliates, partners or persons with an ownership or control interest in you, the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you, the provider entity, of 5 percent or greater.
- Disclosure Requirements – Medicaid providers are required to disclose information regarding:
  1. The identity of all persons with an ownership or control interest in the provider/disclosing entity; the identity of all persons with an ownership or control interest in any subcontractor in which the disclosing entity/provider has a direct or indirect ownership interest of 5 percent or more; information about the type of relationships among the persons with ownership interest; and information about the provider’s agents and managing employees in compliance with 42 CFR 455.104;
  2. Certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105; and
  3. Including you, the provider, the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person’s involvement in any program under the Medicaid, Medicare, or Title XX program

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<sup>1</sup> Affiliate, as defined in the Federal Acquisition Regulation at

(Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.

**What Magellan Will Do**

Magellan's responsibility is to conduct fraud, waste and abuse prevention activities that include:

- Checking the SAM Exclusion Database, HHS-OIG LEIE, and applicable state exclusion lists during credentialing/recredentialing, prior to the employment of any prospective Magellan employee and prior to contracting with any vendor/subcontractor, and monthly thereafter;
- Ensuring that excluded/terminated/debarred/ suspended/ineligible individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan's product offerings. This policy is applicable to all Magellan lines of business; and
- Cooperating with law enforcement authorities in the prosecution of healthcare and insurance fraud cases, and reporting fraud-related data to federal and state agencies in compliance with applicable federal and state regulations and contractual obligations.

## SECTION 4: THE QUALITY PARTNERSHIP

# HIPAA Transaction Standards

<b>Our Philosophy</b>	To address the Health Insurance Portability and Accountability Act (HIPAA) and its regulations regarding standard interface between healthcare organizations and providers, we send and receive HIPAA Standard Transactions. HIPAA Standard Transactions define the required formats for encounter data, referrals, authorizations, enrollment and claims data between members, providers, healthcare organizations and others that require this information.
<b>Our Policy</b>	To receive and send standard electronic transactions, as defined by HIPAA legislation, Magellan has contracted with national clearinghouses*. For many of these transactions, Magellan also offers HIPAA-compliant website-based applications, including but not limited to professional claims submission.
<b>What You Need to Do</b>	Your responsibility is to: <ul style="list-style-type: none"><li>• Comply with HIPAA Standard Transactions requirements for all covered transactions submitted to Magellan;</li><li>• Apply for and use National Provider Identifier (NPI) on all electronic transactions submitted to Magellan; and</li><li>• Use current standard procedure, diagnostic and revenue codes on all claims transactions submitted to Magellan.</li></ul>
<b>What Magellan Will Do</b>	Magellan's responsibility is to: <ul style="list-style-type: none"><li>• Be able to receive and send the following HIPAA Standard Transactions:<ul style="list-style-type: none"><li>835 – Outbound – Electronic Remittance Advice</li><li>837P – Inbound – Professional Claim</li><li>837I – Inbound – Institutional Claim</li><li>820 – Premium Payment</li><li>276-277 – Claim Status/Response</li><li>270-271 – Eligibility Inquiry/Response</li><li>834 – Enrollment;</li></ul></li><li>• Utilize clearinghouse services or offer online services to provide the administrative functions required to establish HIPAA-compliant electronic communications; and</li><li>• Inform you about how to contact us to initiate electronic communications.</li></ul> <p><i>*Refer to the <a href="#">Clearinghouse Contact Information</a> on the Magellan provider website for current Magellan clearinghouses.</i></p>

## SECTION 4: THE QUALITY PARTNERSHIP

# HIPAA Standard Code Sets

<b>Our Philosophy</b>	The coding standards established by the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set regulations eliminate local and proprietary codes and establish industry standards for identifying procedures, diagnosis and medical supplies.
<b>Our Policy</b>	<p>The HIPAA legislation specifically identifies the following procedure and diagnostic code sets as standards:</p> <ul style="list-style-type: none"><li>• ICD-10-CM*</li><li>• CPT®-4 and modifiers</li><li>• HCPCS Level II and modifiers</li><li>• Revenue codes</li><li>• Place of Service codes</li><li>• Type of Bill codes.</li></ul> <p>Magellan requires the use of these standard code sets (and successor code sets when published upon their effective dates) on both paper and electronic claim transactions.</p> <p>* Visit <a href="http://www.MagellanProvider.com">www.MagellanProvider.com</a> for <a href="#">information on ICD-10-CM</a> (found under the Getting Paid top-menu item).</p>
<b>What You Need to Do</b>	<p>As a Magellan provider, your responsibility is to:</p> <ul style="list-style-type: none"><li>• Make sure all electronic information submitted to Magellan utilizes current standard codes in accordance with HIPAA requirements;</li><li>• Apply for and utilize a National Provider Identifier (NPI) on all claims submitted to Magellan;</li><li>• Obtain a current copy of <a href="#">Magellan's Universal Services List</a> (USL) for standard codes for most facility and program services;</li><li>• Research, be knowledgeable and comply with HIPAA requirements;</li><li>• Make sure all paper claims submitted to Magellan utilize current standard codes; and</li><li>• Use successor code sets on their effective dates.</li></ul>
<b>What Magellan Will Do</b>	<p>To comply with HIPAA, Magellan will:</p> <ul style="list-style-type: none"><li>• Recognize standard procedure and diagnostic codes and will communicate those standards to providers;</li><li>• Be compliant with HIPAA's standard coding requirements;</li></ul>



- Accept only compliant codes in covered electronic transactions;
- Accept only covered electronic transactions that include an NPI;
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions;
- Advise you on how to contact us to initiate electronic communications;
- Provide notice on remittance vouchers for services submitted with invalid codes; and
- Maintain helpful information about HIPAA code sets on [www.MagellanProvider.com](http://www.MagellanProvider.com).

## SECTION 5: PROVIDER REIMBURSEMENT

# Claims Filing Procedures

### Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to avoid administrative denials that delay payment and require resubmission of claims.

### Our Policy

Magellan reimburses mental health and substance abuse treatment providers using fee schedules for professional services. Magellan's professional reimbursement schedules include the most frequently utilized HIPAA-compliant procedure codes for professional services. Most Magellan provider contracts require claims to be submitted within 60 days of the provision of covered services. Magellan will deny claims not received within applicable state mandated or contractually required timely filing limits. A claim must contain no defect or impropriety, including a lack of any required substantiating documentation, HIPAA-compliant coding or other particular circumstance requiring special treatment that prevents timely payments from being made. If the claim does not contain all required information, it may be denied.

*Note: If applicable state law defines "clean claim," Magellan applies the state-mandated definition.*

Magellan does not pay for sessions that a member fails to attend, and the provider may not bill Magellan or covered payers for such sessions or services. A member who misses a scheduled appointment may be billed directly, but only if the provider has notified the member in writing of the missed appointment policy and the member has acknowledged that policy in writing. Members may not be billed in excess of the applicable network fee schedule for such services.

In addition, CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally

to all patients (Medicare and non-Medicare), then the Medicare policy/guideline does not preclude the physician or supplier from charging the Medicare patient directly.

### What You Need to Do

Your responsibility is to:

- Contact Magellan prior to rendering care, if the member's benefit plan requires authorization for the service.
- Complete all required fields on the CMS-1500 or UB-04 form accurately.
- Collect applicable co-payments or co-insurance from members.
- Submit a clean claim for services rendered, including your usual charge amount. Do not automatically bill your contracted rate as the charge amount. Follow the detailed claim form completion standards in the *Appendix* of this handbook.
- Submit claims for services delivered in conjunction with the terms of your agreement with Magellan.
- Use only standard codes sets as established by the Centers for Medicare & Medicaid Services (CMS) or the state of your licensure for the specific claim form (UB-04 or CMS-1500) you are using. (You can find additional information under the previous section, *HIPAA Standard Code Sets*.)
- Submit claims within 60 days of the provision of covered services.
- Contact Magellan for direction if authorized services need to be used after the authorization has expired.
- Not bill the patient for any difference between your Magellan contracted reimbursement rate and your standard rate. This practice is called "balance billing" and is not permitted by Magellan.
- Refer to the "Dos" and "Don'ts" of claims filing in the *Appendix* of this handbook.
- Refer to the provider website for information on member plan and claim information:
  1. Go to [www.MagellanProvider.com](http://www.MagellanProvider.com).
  2. Securely sign in with your username and password. (Click *Forgot Password?* or *Forgot Username?* if you need to obtain your website sign-in.)
  3. Click *Lookup Contact Info* from the left-hand menu.
  4. Enter the appropriate plan name to access information on plan, claims and appeals information. Here you will find the claims P.O. Box number for the member's plan. The claims P.O. Box number is required for electronic claims as well as

paper claims.

- Contact the Customer Service number indicated on the member's ID card for assistance.
- You may bill a member directly who misses a scheduled appointment, but only if you have provided written advice notifying the member of your missed appointment policy and the member has acknowledged that policy in writing. Members may not be billed in excess of the applicable network fee schedule for such services.

**What Magellan Will Do**

Magellan's responsibility is to:

- Provide verbal notice, send an authorization letter and/or provide electronic authorization when we authorize services.
- Process your claim promptly upon receipt, and complete all transactions within regulatory and contractual standards.
- Apply National Correct Coding Initiative (NCCI) claim edits to claim submissions. The NCCI claim edits module is a group of system edits defined by CMS to assure correct coding.
- Inform you of any reasons for administrative denials and action steps required to resolve the administrative denial.
- Send you or make available online an Explanation of Payment (EOP) or other notification for each claim submitted including procedures for filing an appeal.
- Provide appropriate notice regarding corrective action or information required if a claim is denied, and reconsider the claim upon receipt of requested information.
- Adjudicate claims based on information available. If the information requested is not received within 45 days, the claim may be denied for insufficient information, subject to applicable state and federal law.
- Regularly update the Universal Services List and HIPAA-compliant billing codes on the Magellan provider website.
- Review our reimbursement schedules periodically in consideration of industry standard reimbursement rates and revise them when indicated.
- Include all applicable reimbursement schedules as exhibits to your contract.
- Comply with applicable state and federal regulatory requirements regarding claims payment.
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

## PROVIDER REIMBURSEMENT

# Electronic Claims Submission

- Our Philosophy** We offer a variety of methods through which providers can submit claims electronically to support our providers' submission preferences. This enhances our ability to pay providers in a timely and accurate manner.
- Our Policy** Magellan is committed to meeting the Centers for Medicare & Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA) compliance standards. We have several contracted clearinghouses through which both facility-based claims and professional claims can be submitted. In addition, Magellan offers a claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. Both of these options are available on Magellan's website and are offered at no cost to our providers.
- What You Need to Do** Your responsibility is to:
- If you are able to transmit data in a HIPAA-compliant 837 format, submit claims directly to Magellan through a direct-submit upload process. To establish this process, you will need to go to our [EDI Testing Center](#), create a unique username/password, download the Abbreviated Companion Guide, and upload a test file to run through HIPAA validation. You must repeat this test successfully twice. Once HIPAA validation has been successfully completed using this automated tool, Magellan will contact you to initiate the process to production status so you can submit actual claim files. If you have any questions or need assistance, feel free to contact us at [EDISupport@MagellanHealth.com](mailto:EDISupport@MagellanHealth.com) or our EDI hotline at 1-314-387-5890.
  - Utilize the Claims Courier application on Magellan's website. You can gain access to Claims Courier by signing onto the site with your username and password, and following the instructions for *Submit a Claim Online*. This tool has functionality that allows providers to electronically submit claims completed on a CMS-1500. The application allows providers to efficiently submit a new claim, view the status of a claim, use previously submitted claims to create a new claim, edit a claim submitted earlier the same day, and resubmit a

claim for correction of place of service, units and/or charge amount. Consider using the services of one of our contracted clearinghouses\* if you submit a high volume of claims, or for claims submitted on a UB-04.

**What Magellan  
Will Do**

Magellan's responsibility is to:

- Continue to maintain online claims applications and relationships with clearinghouses to assure flexibility in the claims submission process.
- Provide electronic funds transfer (EFT) and electronic remittance advice (835) for electronic claims.

*\* Refer to the [Clearinghouse Contact Information](#) on the Magellan provider website for current Magellan clearinghouses.*

## PROVIDER REIMBURSEMENT

# Electronic Funds Transfer

**Our Philosophy** Electronic funds transfer (EFT) is the industry standard and a secure method that allows payments to providers in a timely manner. EFT significantly reduces administrative burdens and ultimately benefits your practice.

**Our Policy** Magellan is committed to meeting the Centers for Medicare & Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA) compliance standards and Affordable Care Act (ACA) mandates. **Magellan requires network providers to sign up for EFT via the Magellan provider website and receive all payments electronically.**

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

- Register for EFT by completing and submitting the EFT website application. Sign in securely to [www.MagellanProvider.com](http://www.MagellanProvider.com) and click *Display/Edit Practice Information* to access the application.
- Notify us when you change your bank account by submitting a request to end the EFT for the original bank, and then creating an EFT request with your new bank account information. You can add a new EFT request from our secure EFT website application on the Magellan provider website (click *Display/Edit Practice Information*).
- Obtain EOB information through the *Check Claims Status* application on your *MyPractice* page, after secure sign-in on the Magellan provider website.

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

- Conduct a secured transmission test with your bank to make sure payments are transferred properly.
- Perform at least two \$0 transaction tests between Magellan and your bank using current claims.
- Provide EOB information through the *Check Claims Status* application on your *MyPractice* page on the Magellan provider website.
- Provide support to providers – you may sign in to the Magellan provider website and use *My Messages* on the *MyPractice* page, or call our Provider Services Line at 1-800-788-4005.

## MEDICARE BENEFICIARIES

# Medicare

### Our Philosophy

As a contracted supplier of behavioral healthcare management services to Medicare Advantage plans, Magellan oversees benefits for Medicare enrollees. As a Medicare Advantage plan contractor, Magellan, along with our contracted provider network, is subject to the standards and procedures established by the Centers for Medicare & Medicaid Services (CMS).

### Our Policy

Our Medicare network includes behavioral health providers permitted by CMS to provide services to Medicare enrollees. We actively evaluate the cultural diversity of our networks in an effort to include clinicians who are able to meet the cultural needs of our members. In addition, our provider agreements are consistent with CMS requirements.

### What You Need to Do

Magellan encourages providers in our Medicare provider network to actively pursue information on their role in treating Medicare enrollees. CMS and Medicare information can be accessed directly at [www.cms.gov](http://www.cms.gov).

As a provider in our Medicare network and in order to receive referrals of Medicare enrollees, you agree to:

- Be currently credentialed with Magellan;
- Hold an executed provider agreement with Magellan that includes a Medicare addendum;
- Be enrolled in Medicare and have a current National Provider Identifier (NPI) (Any physician or other eligible professional who prescribes Part D drugs must enroll in the Medicare program in order to prescribe drugs to their patients with Part D prescription drug benefit plans);
- Be free of any Medicare/Medicaid sanctions from the Office of the Inspector General (OIG);
- Have not opted out of Medicare;
- For hospitals, be accredited by The Joint Commission or certified by Medicare;
- Accept referrals of Medicare enrollees for covered services within the scope of your practice;
- Deliver services in accordance with the terms of your provider agreement, the Medicare addendum, and the policies and



procedures outlined in this handbook and applicable supplements;

- Comply with any CMS, Magellan or Medicare Advantage health plan training requirements including, but not limited to, annual completion of Medicare Fraud, Waste and Abuse training (unless exempt based on enrollment in Original Medicare), Medicare General Compliance Training and review of Magellan’s Code of Conduct;
- Ensure that new providers complete Medicare Fraud, Waste and Abuse training (unless exempt based on enrollment in Original Medicare), complete Medicare General Compliance Training and review Magellan’s Code of Conduct within ninety (90) days of hire;
- Inform Magellan prior to engaging with an offshore subcontractor who will receive, process, transfer, handle, store or access protected health information (PHI);
- Maintain records for a period of ten (10) years;
- Render all services in your office or facilities or in mutually agreeable locations;
- Deliver services in a culturally competent manner;
- Render services that are consistent with professionally recognized standards of healthcare;
- Protect the confidentiality of enrollee information;
- Involve enrollees in treatment decisions;
- Be aware of and comply with laws applicable to individuals or entities receiving federal funds;
- Render services in a timely manner, consistent with Magellan’s access standards;
- In emergent cases (life threatening or non-life threatening) call Magellan upon stabilization of the enrollee. Preauthorization of emergency care is not required. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and is time-limited in intensity and duration;
- Render Urgently Needed Services (UNS) as needed. Preauthorization is not required. UNS are covered services provided when an enrollee is temporarily absent from a service area and when such services are medically necessary and immediately required:
  - As a result of an unforeseen illness, injury, or condition; and
  - When it is not reasonable, given the circumstances, to obtain services through Magellan;

- Be aware of, and document in the enrollee’s record, whether or not a psychiatric advance directive exists;
- Make sure services rendered are consistent with Magellan’s policies, quality improvement programs, clinical/care management guidelines and Magellan’s Care Guidelines;
- Participate in and cooperate with quality review and improvement activities related to services provided to enrollees;
- Adhere to Medicare appeals procedures (including expedited appeals);
- Inform enrollees or the enrollee representatives of their right to appeal any treatment determination even if the determination occurs “pre-service” – before any service is delivered. You may be asked to provide information that is relevant to the reconsideration;
- Comply with CMS reporting requirements in a timely and accurate manner and certify to the truth and completeness of encounter data submitted to Magellan;
- Maintain appropriate clinical records in accordance with Health and Human Services (HHS) and all other applicable federal, state, and local laws and regulations; and
- Adopt reasonable measures to prevent the unauthorized disclosure of Medicare records. Medical records must be maintained in a secure manner.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Pay clean claims promptly in accordance with CMS standards for quality and service; and
- Pay claims in accordance with the reimbursement schedule outlined in your provider agreement.

*Note: Magellan’s care management centers serve Medicare enrollees across the country. For questions about a specific plan or case, call the care management center that referred the enrollee to you. For information about Medicare and related laws and regulations, providers are encouraged to obtain information directly from CMS.*