Magellan Healthcare, Inc.

Provider Handbook Supplement for US Family Health Plan

Magellan HEALTHCARE℠

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SECTION 1: INTRODUCTION

Welcome

Welcome to the Magellan Healthcare (Magellan) Provider Handbook Supplement for US Family Health Plan This handbook supplements the Magellan National Provider Handbook, addressing policies and procedures specific for US Family Health Plan. The handbook supplement is to be used in conjunction with the national handbook. When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in this supplement prevail.

US Family Health Plan

US Family Health Plan is among the health care choices for eligible beneficiaries under the Department of Defense's TRICARE Prime program. Health care is provided to active duty family members, activated National Guard and Reserve family members, and retirees and their family members, including certain "grandfathered" beneficiaries who are age 65 and older.

Covered Benefits

Magellan will manage the provision of medically necessary services, pursuant to the US Family Health Plan benefit plan in ***New Jersey, Western Connecticut, Southeastern Pennsylvania and parts of New York (including New York City).***

Medically necessary covered services include:

- Outpatient psychotherapy (individual, family, and group)
- Outpatient psychiatric evaluation
- Outpatient hospital services
- Inpatient treatment for mental health and substance abuse
- Office emergency visits
- Partial hospitalization for mental health and substance abuse
- Intensive Outpatient for mental health and substance abuse
- Residential treatment for mental health
- Electroconvulsive therapy (ECT)
- Psychological testing
- Applied Behavior Analysis

For more specific information, please call Magellan at 1-800-971-2273.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Member Access to Care

Our Philosophy

Magellan believes that members are to have timely access to appropriate mental health and substance abuse services from an in-network provider 24 hours a day, seven days a week.

Our Policy

We require in-network providers to be accessible within a timeframe that reflects the clinical urgency of the member's 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 or instructions.
- 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 in an emergent situation that is not life threatening. Non-life threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member's condition.
- Provide services within 24 hours of referral in an urgent clinical situation.
- Provide services within one week of referral for routine clinical situations, and within four weeks of referral for non-routine services
- Provide services within seven days of a member's discharge from an inpatient stay.
- Contact Magellan immediately if a member does not show for an appointment following an inpatient discharge so that Magellan can conduct appropriate follow-up.
- Not exceed office appointment wait time of 30 minutes.
- Update your appointment availability frequently by using the online Provider Data Change tool via the www.MagellanHealth.com/provider website.

What Magellan Will Do

Magellan's responsibility to you is to:

- Communicate the clinical urgency of the member's situation

when making referrals for an urgent or emergent appointment.

- Assist with follow-up service coordination for members transitioning to another level of care.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Initiating Care

Our Philosophy

Magellan joins with our members, providers, and customers to make sure members receive the most appropriate services and experience the most desirable treatment outcomes for their benefit dollar.

Our Policy

We assist members in optimizing their benefits by reviewing and authorizing the most appropriate services to meet their behavioral healthcare needs. Magellan conducts timely preauthorization reviews in order to evaluate the member's clinical situation and determine the medical necessity of the requested services.

What You Need to Do

Your responsibility is to:

- Contact Magellan for precertification of outpatient, partial hospitalization, intensive outpatient services, residential and inpatient services at 1-800-971-2273 or for higher levels of care obtain treatment authorization by accessing the "Request Higher Levels of Care" application at www.MagellanHealth.com/provider.
- Allow members to schedule outpatient appointments without prior authorization for the first eight visits each fiscal year per member.
- Contact the Magellan Care Management Center prior to the first outpatient appointment when initiating care, to check member's benefits and eligibility, obtain co-payment amount, and confirm timely filing deadline. The toll-free number is 1-800-971-2273.
- Contact the Magellan Care Management Center prior to the ninth outpatient appointment to obtain authorization for on-going care.
- Not require a primary care physician (PCP) referral from members.

What Magellan Will Do

Magellan's responsibility to you is to:

- Operate a toll-free telephone number to respond to provider questions, comments, and inquiries. That number is 1-800-971-2273.
- Establish a multidisciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
- Make decisions about expedited services and provide oral notification within 72 hours of receipt of the request, and provide written notification within three calendar days of the oral notification.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Concurrent Review

Our Philosophy

Magellan believes in supporting the most appropriate services to improve health care outcomes for members. We look to our providers to notify us if additional services beyond those initially authorized are needed, including a second opinion for complex cases.

Our Policy

Concurrent utilization management review is required for all services, including, but not limited to:

- Inpatient and residential services
- Intermediate ambulatory services, such as partial hospital programs (PHP) and intensive outpatient (IOP).
- Office or clinic setting traditional outpatient services.

What You Need to Do

If, after evaluating and treating the member, you determine that additional services are necessary:

- Respond to the Magellan care management team member's request to schedule telephonic clinical review on the last covered day.
- Be prepared to provide the Magellan care manager or physician advisor with an assessment of the member's clinical condition, including any changes since the previous clinical review.
- Request a second opinion if you feel it would be clinically beneficial.
- Contact Magellan at 1-800-971-2273 for precertification of concurrent outpatient services or obtain authorization via secure login at www.MagellanHealth.com/provider.
- Contact Magellan for inpatient services at number listed above.

What Magellan Will Do

Magellan's responsibility to you is to:

- Be available 24 hours a day, seven days a week, 365 days a year to respond to requests for additional information.
- Promptly review your request for outpatient and additional days for inpatient services in accordance with the applicable medical necessity criteria.
- Have a physician advisor available to conduct a clinical review in a timely manner if the care manger is unable to authorize the requested services.
- Respond in a timely manner to your request, verbally and in writing, for additional days.

- Issue a determination and complete oral notification within 72 hours after receipt of the request for authorization of services.
- Operate a toll-free telephone number to respond to provider questions, comments, and inquiries. That number is 1-800-971-2273.
- Establish a multidisciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Advance Directive

Our Philosophy

Magellan believes in a member's right to self-determination in making health care decisions.

Our Policy

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

What You Need to Do

Your responsibility is to:

- Understand state and federal standards regarding psychiatric advance directives.
- Meet state and federal standards regarding psychiatric advance directives.
- Maintain a copy of the psychiatric advance directive in the member's file, if applicable.
- Understand and follow a member's declaration of preferences or instructions regarding behavioral health treatment.
- Use professional judgment to provide care believed to be in the best interest of the member.

What Magellan Will Do

Magellan's responsibility to you is to:

- Meet state and federal advance directive laws.
- Document the execution of a member's psychiatric advance directive.
- Not discriminate against a member based on whether the member has executed an advance directive.
- Provide information to the member's family or surrogate if the member is incapacitated and unable to articulate whether or not an advance directive has been executed.

SECTION 4: THE QUALITY PARTNERSHIP

Complaint and Grievance Process

Our Philosophy

In order to achieve a high level of member satisfaction and care, Magellan believes in providing a mechanism for members, providers, and external agencies to express comments related to care, service, or confidentiality.

Our Policy

Magellan maintains processes for addressing verbal complaints and written complaints/grievances.

What You Need to Do

To comply with this policy, your responsibility is to:

- Submit verbal complaints to Magellan by calling the Magellan Care Management Center at 1-800-971-2273.
- Submit written complaints/grievances to:

Magellan Healthcare
Attn: Complaints Department
14100 Magellan Plaza MO41
Maryland Heights, MO 63043
Or
Fax: 1-888-656-4769

What Magellan Will Do

Magellan's responsibility to you is to:

Verbal Complaints

- Thoroughly investigate each complaint, using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties. Resolve the concern at the time of the initial call or involve a supervisor or the comments coordinator to file a formal complaint and resolve the issue.
- Comments coordinator will resolve the formal complaint and orally notify the complainant of the disposition of the complaint and the opportunity to request a complaint appeal if the complainant is not satisfied with the disposition of the complaint.

Written Complaints/Grievances

- Thoroughly investigate each complaint, using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties.
- Acknowledge receipt of the complaint to the complainant within one business day from the day the complaint is received.

- Investigate the complaint, consulting with subject matter experts if necessary.
- Respond to the complainant in writing within 30 business days of receipt of the complaint, or per guidelines as established by client contract or State regulations.
- Written response advises the complainant of the opportunity to request a complaint appeal if the complainant is dissatisfied with the disposition of the complaint/grievance.

SECTION 4: THE QUALITY PARTNERSHIP

Appeals and Retro Determination

Our Philosophy

Magellan supports the right of members and their providers acting on the member's behalf to appeal adverse organization determinations.

Our Policy

Our customer organizations and applicable federal and State laws impact the clinical appeals process. Therefore, the procedure for appealing a clinical determination is outlined fully in the adverse determination notification letter.

What You Need to Do

To comply with this policy, your responsibility is to:

- Refer to the adverse determination (non-authorization) notification letter for the specific procedures for appealing a clinical determination; however:
  - Expedited pre-admission appeals must be requested within three calendar days of the day of determination.
  - Standard level 1 pre-admission appeals must be requested within ninety calendar days of the date of the notice of an adverse organization determination or the EOB.
  - Standard level 2 pre-admission appeals must be requested within ninety calendar days of the date of notice of the level 1 determination.
  - Expedited appeals must be requested by noon the next business day for concurrent reviews or within three calendar days for pre-admission.
  - The provider or facility may only appeal on behalf of the member if they have obtained the member's written consent unless it is an administrative appeal of an initial determination when the service is not covered under Medicare.
  - Oral requests for standard appeals must be followed by a written and signed request.
- Submit appeal requests to:

Magellan Healthcare
PO Box 2128
Maryland Heights, MO 63043
or
Fax: 1-888-656-3820

What Magellan Will Do

Magellan's responsibility to you is to:

- Notify you orally of the initial non-authorization determination and the appeal process for your State and/or the member's benefit plan, to be followed by a written adverse determination within three calendar days.
- Accept information from the member and their representative (generally including the facility and provider) supporting the request for appeal, allowing the examination of the member's case file (including medical records and other documents considered during the appeal) before and during the appeal process.
- Not take any punitive action against any provider that requests or supports an appeal.

SECTION 5: PROVIDER REIMBURSEMENT

Provider Reimbursement

Our Philosophy

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

Our Policy

Magellan reimburses behavioral health and substance abuse treatment providers in accordance with reimbursement schedules for professional services. The reimbursement schedules contain current procedural terminology (CPT) codes for traditional outpatient providers and a combination of CPT and Healthcare Common Procedure Coding System (HCPCS) codes. The reimbursement schedule(s) is attached to your Magellan provider agreement.

What You Need to Do

Your responsibility is to:

- Contact the Magellan Care Management Center prior to the first outpatient appointment when initiating care, to check member's benefits and eligibility, obtain co-payment amount, and confirm timely filing deadline. The toll-free number is 1-800-971-2273.
- Collect applicable co-payments from members.
- Contact the Magellan Care Management Center at the number above to preauthorize care for outpatient and inpatient services.
- Sign up for online claims submission and electronic funds transfer (EFT) through www.MagellanHealth.com/provider.
- Submit a clean claim form for the services that you have provided using Magellan's EDI options through www.MagellanHealth.com/provider, or through an accepted clearinghouse, or via paper claim.
- The postal address for claims is:

  Magellan Healthcare
  P.O. Box 1099
  Maryland Heights, MO 63043

- Submit your claim for reimbursement within 60 calendar days of date of service or discharge.
- Bill using your contracted taxpayer identification number.
- Hold the member harmless and not bill the member for any amount, including the difference between Magellan's reimbursement amount and your standard rate. This practice is called balance billing and is prohibited.

- Contact the Magellan Care Management Center if you are not certain which services require pre-authorization, what your reimbursement rate is, or for any questions that you have concerning the member in care.

What Magellan Will Do

Magellan's responsibility to you is to:

- Pay your claims promptly—90 percent within 30 calendar days from the date the clean claim is received.
- Provide a toll-free number for you to call for provider assistance.
- Respond to your claims questions and help resolve issues.
- Review our reimbursement schedules periodically.
- Include all applicable reimbursement schedules as exhibits to your contract.
- Communicate changes to reimbursement rates in writing prior to their effective date.