State of Michigan
Provider Orientation
Agenda

• Who is Magellan
• Credentialing and Re-credentialing Requirements
• Magellan Contract
• Member Eligibility & Benefits
• Updating Practice Information
• Member Access to Care
• Outpatient Care Management
• Ambulatory Follow-up
• Clinical Practice Guidelines and Medical Necessity Criteria
• Clinical Appeals
• Commitment to Quality Improvement
• Outcome Assessments/Reporting
• Magellan Paid Claims Requirements
• Electronic Funds Transfer
• Balance Billing Prohibition
• Magellan Provider Website: www.MagellanHealth.com/provider
• Handouts
What Does it Mean to be a Magellan Provider

Being a Magellan provider means you share Magellan’s commitment to providing quality care. This commitment is demonstrated by

- Complying with credentialing requirements in a timely manner
- Obtaining authorization of care as required by the member’s benefit plan
- Rendering care in accordance with Magellan’s clinical practice guidelines when clinically appropriate
- Participating in treatment record reviews when requested
- Informing members of their rights and responsibilities and the importance of collaborating with their primary care providers and others involved in their health care
- Initiating and maintaining ongoing communication with the primary care provider when authorized by the member
- Submitting complete claims in a timely manner
Credentialing/Recredentialing

Our Policy

• Magellan providers are required to successfully complete the credentialing review process prior to being accepted as a network provider and then every three years unless otherwise required by applicable state and federal law, a customer and/or an accrediting entity.

• Only credentialed providers may render services to Magellan members as an in-network provider.

• Clinicians affiliated with a group practice must complete the individual credentialing process in order to render covered services to Magellan members.
Re-Credentialing

Recredentialing Procedures

- Assure that you complete and return your application in a timely manner. Not meeting re-credentialing timeframes is the most common reason for involuntary termination from the network.

- Upon receipt of your completed application, we re-verify your credentials and our Regional Network and Credentialing Committee (RNCC) reviews for continued network participation.

- We review quality indicators – such as complaints, adverse incidents, and treatment records reviews – during the re-credentialing process.
Re-Credentialing

Re-Credentialing Procedures (continued)

• To monitor network quality, Magellan reviews provider credentials every three years as required by contract and/or applicable state law.

• We send a notice to providers only if we cannot access a CAQH application.

• We mail a re-credentialing notification six months prior to the credentialing anniversary, to the mailing address on record for the practitioner. The notification explains the three options available for completing re-credentialing:
  1. Complete the re-credentialing application on the Magellan provider Web site
  2. Request a CAQH ID number to complete an application
  3. Request a paper re-credentialing application.

• Magellan will make three outreach attempts for any missing data i.e. updated malpractice. If provider does not respond, the recredentialing application will be closed and provider will be placed in suspend status with a future term date.
Magellan Contract

➢ Group Contracts

• To be an in-network group provider, the group must be contracted with Magellan and, in order to be referral-eligible, the practitioners within the group must be individually credentialed by Magellan.

• A group member who leaves the group practice and is not also contracted with Magellan under an individual provider participation agreement is no longer considered a Magellan participating provider.
Magellan Contract

Group Contracts (continued)

• When group membership changes (a practitioner joins or leaves your group) you must:
  ▪ Update your group roster via the Magellan provider website
    ○ Note: adding a provider to the group roster does not automatically affiliate them to the group contract or initiate a credentialing application.
  ▪ If the new group member is not already Magellan-credentialed, have him/her begin the credentialing process. This must be completed before they are eligible for referrals.
  ▪ Make sure all necessary documentation is completed to affiliate a practitioner to your practice, e.g., including a Group Association Form and current malpractice information.
Member Eligibility & Benefits

- Benefits are not the same for all members with the same health plan.

- Call the appropriate toll-free number to verify eligibility and benefits before treating a member.

- Verify coverage, co-payments, coinsurance and Serious Mental Illness (SMI) coverage and flexing of inpatient to outpatient days.

- When required, obtain authorization prior to treating member.

- Obtain copy of member’s card at first visit.

- Routinely verify insurance information with member and re-verify eligibility.
Updating Practice Information

- Keeping your practice date updated is critical to all transactions with Magellan.

Practice data impacts:
- Authorization notifications
- Re-credentialing notifications
- Network/contractual-related communications
- Provider Directories
- Claims payment.

Office managers/group administrators must be cautious when updating practitioner information, particularly when the provider maintains a solo practice and/or works for other group practices.

Update your practice data via our provider website at www.MagellanHealth.com/provider
Updating Practice Information

What You Need to Do – Solo Clinicians

• Notify Magellan within 10 business days of any practice changes including:
  ▪ Service, mailing or financial address
  ▪ Telephone number
  ▪ Email address
  ▪ Business hours
  ▪ Taxpayer Identification Number (TIN)
  ▪ Promptly notify us if you are unable to accept referrals for any reason including
    o Illness
    o Practice not accepting new patients
    o Professional travel, sabbatical, vacation, leave of absence, etc.
Updating Practice Information

What You Need to Do – For Group Practice

- Notify Magellan within 10 business days of any changes in their practice information including:
  - Service, mailing or financial address
  - Telephone number
  - Email address
  - Business hours
  - Taxpayer Identification Number (TIN)
  - Practitioners departing practice
  - Practitioners joining practice
  - Promptly notify us if you are unable to accept referrals for any reason including
    - Illness
    - Practice not accepting new patients
    - Practitioner travel, sabbatical, vacation, leave of absence, etc
What You Need to Do (continued)

- Submit changes to practice information by signing in to [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) and selecting “Display/Edit Practice Information”

- Submit changes for Group Member Adds and Terminations by signing in to [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) and selecting “Display/Edit Practice Information” and then selecting Roster Maintenance option

- Submit fax with notice of termination (and reason) to:
  
  Magellan Health
  Attn: Network Imaging - MO14
  14100 Magellan Plaza
  Maryland Heights, MO 63043
  OR
  Fax: 1-888-656-0429
Updating Practice Information

DOs for Groups and Group Members

- Include all practice locations on the update form, not just those for the group practice. NOTE: The same is true for CAQH applications.
- Verify with practitioners in your group what mailing address he or she wants utilized. Typically solo practitioners wish to maintain their own mailing addresses. This assures that contractual-related notifications reach them at their private practice.
- The group provider, not the office staff, must review and sign the data change form.

DON’Ts for Groups and Group Members

- Identify group financial address on the data change form if the practitioner also has a solo practice. Solo practice financial address should be listed. Claims submitted by a group will get directed to group financial address on record.
Member Access to Care

- 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 the situation.

- You must:
  - 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 a referral in an emergent situation that is not life-threatening.
  - Provide services within 48 hours of a referral in an urgent clinical situation.
  - Provide services within 10 business days of referral for routine clinical services.
Outpatient Care Management

➢ Magellan Healthcare outpatient care management model,
  • Reduces provider administrative tasks
  • Expedites direct access to care
  • Identifies and addresses gaps in behavioral health services and coordination

➢ Our objective is to work with providers to make sure that the members we jointly serve have the best opportunity to return to whole health and productivity.
Key Components of the Outpatient Care Model

The model works through:

- Removal of administrative processes often perceived as access barriers, such as preauthorization and treatment request forms
- Use of proprietary evidence-based, clinically driven claims algorithms to identify only those cases needing care management support or other intervention
- Review of all submitted claims against the clinical algorithms
The Transition to More Targeted Collaboration

- Any resulting care management of psychotherapy is applied to high-risk and outlier cases with a focus on care advocacy, care shaping, successful resolution, and improved quality.

- This includes our gaining a more holistic, comprehensive view of the member and helping them navigate services when necessary.
What Does it Mean for Providers?

- You can initiate routine outpatient services, including counseling and medication management visits, for members without calling Magellan or obtaining preauthorization through our website.

- A decrease in the time you spend on the phone or online with Magellan to obtain authorization for routine outpatient care that meets criteria for continuation.

- Reduction of your administrative burden, providing more time for you to spend with your patients and your practice.
Services Still Requiring Preauthorization

- High-risk cases and higher levels of care such as inpatient, residential, and partial hospitalization services.
- Specialty care such as intensive outpatient treatment, psychological testing, outpatient ECT, transcranial magnetic stimulation (rTMS), hypnotherapy, applied behavior analysis, and biofeedback.*

*When covered by applicable plan
Follow-Up After Hospitalization

- Follow-up specialists from Magellan assist members and facilities in finding and keeping a post-discharge appointment within seven days of discharge.

- Their effort facilitates better coordination of care between members and providers after an inpatient stay.

- While a member is in an inpatient facility, Magellan care managers and follow-up specialists partner with the facility’s treatment team to make arrangements within seven days for continued care with outpatient care providers.

- Follow Up Specialists later contact the provider to confirm the member attended their scheduled appointment within seven days of discharge.
How Can an Outpatient Provider Office Help?

- Recognize that members who attend an appointment within seven days of discharge are significantly less likely to readmit.

- Make the return-to-outpatient appointment convenient.

- Encourage members to attend their after-care appointments.

- Return calls to Magellan’s After Care Follow-up Specialists (AFU) confirming patient attendance.

- Submit claims in a timely manner.

- Remember that all providers are considered Magellan “business partners;” therefore it is HIPAA compliant to give information about whether a member attended their seven-day ambulatory follow up outpatient appointment.
Clinical Practice Guidelines
and Medical Necessity Criteria

- Magellan’s medical necessity criteria and clinical practice guidelines are available on our provider website at www.MagellanHealth.com/provider.

- We review and update the medical necessity criteria annually.

- We review and update each clinical practice guideline on a two-year cycle.
Clinical Appeals

- Client requirements and applicable federal and state laws govern the clinical appeals process.

- The procedure for appealing a clinical determination is outlined in the non-authorization letter.
Commitment to Quality Improvement

In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards and apply them in clinical work with members.

Key quality measures include:

- Clinical record documentation
- Coordination of care
- Member rights and responsibilities
- Notification of adverse incidents
- Monitoring of Atypical Antipsychotic Medication

We obtain provider feedback through various channels including provider satisfaction surveys, our National Provider Service Line and Magellan provider website.
Outcome Assessments/Reporting

➢ Outcomes360℠
  - Magellan’s secure web-based outcomes measurement system – known as Outcomes 360 – features tools that enable members and/or their caregivers to assess and track progress towards their mental and physical health.
  - Magellan worked closely with Quality Metric, Incorporated, the industry leader in health status measurement, to design these brief outcomes measurement tools.

➢ Consumer Health Inventory (CHI)
  - The CHI is a self-report measure that screens for depression, anxiety, and alcohol and substance use. The CHI also assesses functional health status, strengths, symptoms, substance use and recovery progress.
  - It is completed by individuals age 14 and older.
  - Members can complete the assessment at the beginning of treatment, and then at 30-, 60- and 180-day intervals.

➢ Accessing the CHI
  - To administer the CHI, go to www.MagellanHealth.com/provider and sign in using your secure username and password and click on Manage Outcomes.
  - Three options are available on the website for a member to complete the assessment
    1. Providers can supply Magellan with the member’s email in the appropriate field and a link to the assessment will be sent to them
    2. Complete an online assessment
    3. Providers can access a printable version that may be submitted via fax in.

➢ Reporting
  - Both member and provider reports are generated to use in treatment planning and monitoring of progress over time
  - Providers can access the report under the Manage Outcomes link on www.MagellanHealth.com/provider
  - Members are emailed a copy of the results

➢ For more information, go to www.MagellanHealth.com/provider and click on the topic “Education” and then “Outcomes Library.”
Consumer Health Inventory (CHI)

The CHI is a self-report measure that screens for depression, anxiety, and alcohol and substance use, and assesses functional health status, strengths, symptoms, substance use and recovery progress. It is completed by individuals age 14 and older. Building on the core SF-12 with QualityMetric, Magellan brought its behavioral health management expertise into the development of the CHI.

Both member and provider reports are generated immediately to print and use in treatment planning and monitoring of progress over time. Provider reports also are available to view anytime on this website or on the My Practice page after secure sign-in, by clicking Manage Outcomes under My Outcomes.

A new, shortened version of the CHI has replaced the previous version of the tool, effective July 1, 2015. Read more in Provider Focus.

The Tool

- CHI Sample Assessment Tool (PDF) - new
- CHI Sample Assessment Tool - Spanish (PDF) - new

For Provider Use of the Tool

- CHI Provider Overview (PDF)
- Guide to Launching the CHI (PDF) - new
- How to Access Member Reports (PDF) - new
- How to Access Provider Aggregate Reports (PDF) - new
- Provider Technical Requirements
- Print Fax Tips (PDF) - new
- CHI Provider Guide (PDF) - new

For Use with Members

- Outcomes360 Member Information Sheet (PDF)
- CHI Member Information Flyer (PDF)
- CHI Provider Office Poster (PDF)
- Consumer Use of Outcomes (PDF)
Magellan Paid Claims Requirements

- Timely filing of claims is 60 days from the date of service.

- Exceptions to timely filing requirements:
  - Member-submitted claims
  - COB claims where Magellan is the secondary payer
  - Medicare claims
  - Plans written outside of Michigan follow timely filing requirements for that state

- Accepted methods for submission of claims:
  - Electronic Data Interface (EDI) via direct submit
  - Electronic Data Interface (EDI) via a clearinghouse
  - “Claims Courier”—Magellan’s Web-based claims submission tool
  - CMS-1500 or UB-04
Electronic Funds Transfer (EFT)

- EFT is mandatory for all Magellan paid claims
- What are the benefits of EFT?
  - Claims payments get to your bank account more quickly than the standard process of mailing and cashing or depositing a check
  - No risk of lost or misplaced checks
  - More time to devote to your practice
- Sign up is quick and easy on the provider website
  - Sign into www.MagellanHealth.com/provider
  - Select “Display/Edit Practice Information”
  - Select Electronic Funds Transfer
Balancing Billing Prohibition

- Members cannot be billed for the difference between your usual and customary charge and your contracted rate. This practice is called “balance billing” and is prohibited under the terms of your Magellan Provider Participation Agreement.

- In addition, members cannot be billed, nor can deposits be collected from members for any amounts other than a member co-payment, coinsurance or deductible.

- Members may only be billed for missed appointments if you have a clear policy of your billing practice for missed appointments and the policy is signed by the member.

- If a member does not keep a scheduled appointment, you are not permitted to bill Magellan for the missed appointment.
www.MagellanHealth.com/provider

Welcome Providers

This website offers user-friendly tools and essential information to support you in providing quality care to Magellan members.

Access Services
- Check Member Eligibility
- Submit a Claim
- Check Claims Status
- Request/View Authorizations
- Electronic Funds Transfer
- My Notifications
- Display/Edit Practice Info
- Manage Outcomes
- Free CE Courses

Get Information
- Provider Handbook and Supplements
- State- and Plan-Specific Information
- EAP Information
- Provider Focus (newsletter)
- Clinical Practice Guidelines
- Medical Necessity Criteria
- Online Demos

Sign In
Username:
Password:
Remember Me
Sign In
New User

Provider Focus
Not a Magellan provider? Join the network!
www.MagellanHealth.com/provider

Features:

- User guides/demos
- National provider handbook and supplements
- Provider Focus newsletter
- Eligibility and benefits information
- Authorization inquiry
- Display/edit practice information
- Update Provider Profile
- Display/Edit Rosters (for group and facility providers)
- View Outcomes Reports
 Claims inquiry
 Claims Courier
 Electronic claim submission information
 EDI Testing Center
 Companion guides for various transaction types
 HIPAA billing code set guides
 EAP information and forms
 EAP online billing
 Re-credentialing form for solo practitioners
 Clinical guidelines
 Medical necessity criteria
 Outcomes 360 Library
 CEUs and CMEs
Confidentiality Statement for Providers

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Thanks