Provider Orientation

FOR PROVIDERS TREATING MEMBERS WITH AUTISM SPECTRUM DISORDERS

NOVEMBER 2019
Agenda

Welcome to the Magellan network

- Assessment and treatment planning
- Credentialing, recredentialing and contracting
- Claim submission options
- Magellan provider website
- Wrapping up
Welcome to the Magellan network!

You play an important role in serving Magellan members.

The need for board certified behavior analysts (BCBAs) continues to rise, due to increased awareness of autism spectrum disorders and the number of children being diagnosed (the CDC estimates that **one in 59 children** are affected).

- Most states have passed or proposed legislation requiring health insurers to provide coverage for autism treatment.
- Fewer states have adopted more comprehensive legislation requiring coverage of specialized services including applied behavior analysis (ABA) and other rehabilitative behavioral services for the treatment of autism.
- Magellan’s health plan and employer customers are looking to Magellan to provide full-service support for this disorder.

More resources in this area and earlier detection can help ensure that children get the help they deserve.

On behalf of the young members you serve, along with their families and communities, thank you!
Member eligibility and benefits

- **Benefits are not the same for all Magellan members**
- **Call the appropriate toll-free number** to verify eligibility and benefits before treating a member
- **Verify coverage** and member co-payments, coinsurance and/or deductible
- **Obtain authorization** by completing assessment and treatment planning
- **Routinely verify insurance** information with the member and re-verify eligibility
- **Obtain a copy** of the member’s card at first visit
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Expectations for ABA and other qualified ASD providers: assessment and treatment planning

1. Either a Magellan dedicated autism care manager will refer the member to you, or a customer service agent will share a list of in-network providers with the member, parent or guardian, who may then contact you.

2. You fax your request for pre-authorized functional behavioral assessment units, using the ABA Request for Initial Authorization form, with the diagnostic report to Magellan.

3. Once you receive authorization from Magellan, you conduct the initial assessment and develop the treatment plan.

4. You request and obtain pre-authorization for additional services by completing the ABA Treatment Plan / Concurrent Review Template.

5. Follow Magellan medical necessity criteria and clinical practice guidelines.
Requesting authorization

Purpose: To authorize care based on a thorough assessment of the member’s unique needs, with services delivered at the least intensive, appropriate level of care.

1. **Request**
   - Requesting pre-authorization is the responsibility of the provider / program / facility.

2. **Frequency**
   - Frequency of authorization reviews may depend on federal and state requirements, clinical rationale of services being requested, and the member’s clinical need for ABA services.

3. **Assessment**
   - Typically, for newly diagnosed cases in need of an initial evaluation, Magellan will authorize an initial assessment for 8-12 hours to complete a functional behavior assessment.
Find the forms to submit the initial assessment and treatment plan / concurrent review for authorization on www.MagellanProvider.com/Autism (requires sign in).

Complete the ABA Request for Initial Authorization for the initial assessment and plan development; services are authorized in 15-minute increments.

Complete the ABA Treatment Plan/Concurrent Review Template for concurrent services, which are also authorized in 15-minute increments. Alternately, you may use your own template, but make sure to include Magellan’s required components.
Authorization determinations

Magellan will:

- **Make an authorization decision** based upon review of the clinical information submitted and any conversations with you.

- **Advise you** of the ABA or other behavioral rehabilitative service type and units authorized, number of sessions or days authorized, and a start and end date for authorized services.

- **Communicate authorization** decisions by telephone.

- **Offer the opportunity to discuss** the determination with a physician advisor if we are unable to authorize the requested service(s) for clinical reasons.
The autism treatment plan includes the following domains of focus:

- Speech/Language/Communication, Sociability, Sensory/Cognitive Awareness and Health/Physical Behavior
- Specific interventions and measurable goals developed from concerns identified during assessment and evaluation, and family priorities.

Magellan surveys families of individuals with ASD about their satisfaction regarding the services provided.
Required components of the treatment plan

The Behavior Plan section of the report should include:

• At least two behaviors targeted for reduction (e.g., aggression, stereotype, SIB, elopement, property destruction, PICA, etc.).

• Detailed definition, topography, and proposed function of each behavior.

• Interventions.

• Baseline data.

• Mastery criteria.

• Current frequency/graph of progress.

• Replacement behavior/skill acquisition goals.

• Caregiver training goals with progress information.

• The following as relevant to treatment: background, current services, as well as treatment hour recommendation and duration.

All treatment plans must adhere to BACB guidelines.
Sample authorization for ABA services*

- Initial FBA and plan development uses CPT® 97151 (15-minute increments).
- Continued services/direct intervention uses 97153 (15-minute increments).
- Direct by a QHP uses 97155; caregiver training uses 97156; social skills group uses 97154.

Examples:

- 16 units of 97155 means the authorization includes four hours for supervision.
- 240 units of 97153 means the authorization includes 60 hours for direct intervention.

* Coding and unit durations may vary by region.

<table>
<thead>
<tr>
<th>Number of Hours</th>
<th>Treatment/ Billing Code – Description</th>
<th>Provider Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 to 12 hours or equivalent units</td>
<td>97151 - Initial assessment and plan development</td>
<td>Performed by BCBA/credentialed licensed provider</td>
</tr>
<tr>
<td>1</td>
<td>97156 Caregiver training</td>
<td>Provided by behavior analyst or bachelors/ non-certified support staff-level provider</td>
</tr>
<tr>
<td>1.5</td>
<td>97155 – Supervision</td>
<td>ABA services rendered conjointly, in-person, by a behavior analyst or non-certified support staff during directly supervised ABA service provision</td>
</tr>
<tr>
<td>22.5</td>
<td>97153 – Direct intervention</td>
<td>Provided by certified technician</td>
</tr>
</tbody>
</table>
Magellan medical necessity criteria for outpatient ABA:*  

- Established DSM-5 diagnosis of ASD.
- A severe challenging behavior that presents a health or safety risk or significantly interferes with home or community activities.
- Less intensive behavior treatment or other therapy has been considered or has been insufficient.
- Patient is medically stable and does not require 24-hour medical/nursing monitoring.
- Treatment plan should be established upon individualized goals, with measurable objectives.

- Treatment plan should include parent/caregiver training and support.
- Magellan’s medical necessity criteria are based on scientific evidence.
- Magellan clinical leaders review the criteria annually, taking into consideration:
  - Current scientific evidence.
  - Provider feedback.

* Covered services may differ by region and/or health plan.
Magellan clinical policy resources—practice guidelines

**AAP Guidelines**

The primary goals of treatment are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress.


Magellan *clinical practice guidelines*:

- Magellan has adopted American Academy of Pediatrics (AAP) guidelines.
- AAP guidelines call for more research on ABA’s effect on health outcomes, treatment efficacy.

# National ABA codes*

<table>
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<th>Category I</th>
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<th>Notes</th>
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<tr>
<td>Functional Behavior Assessment (FBA)</td>
<td>97151</td>
<td>15 minutes</td>
<td>BCBA only (HO).</td>
</tr>
<tr>
<td>FBA</td>
<td>97152</td>
<td>N/A</td>
<td>This is not a covered code.</td>
</tr>
<tr>
<td>Direct</td>
<td>97153</td>
<td>15 minutes</td>
<td>Only available for technicians (HN).</td>
</tr>
<tr>
<td>Social Skills</td>
<td>97154</td>
<td>15 minutes</td>
<td>Two or more clients; technician only (HN).</td>
</tr>
<tr>
<td>Direct by Qualified Health Professional (QHP)/Supervision</td>
<td>97155</td>
<td>15 minutes</td>
<td>We do accept overlap with technician; all services are direct (HO, HN).</td>
</tr>
<tr>
<td>Parent Training – 1:1</td>
<td>97156</td>
<td>15 minutes</td>
<td>Parent training with or without member present (HO, HN).</td>
</tr>
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<td>Parent Training - Group</td>
<td>97157</td>
<td>15 minutes</td>
<td>Group parent training with or without member present (HO, HN).</td>
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<tr>
<td>Social Skills</td>
<td>97158</td>
<td>15 minutes</td>
<td>Two or more clients; QHP only (HO, HN).</td>
</tr>
<tr>
<td>Reassessment</td>
<td>90889</td>
<td>15 minutes</td>
<td>Reassessment/report writing hours; indirect. Not available in all markets (HO). Up to three hours per six months.</td>
</tr>
<tr>
<td>Functional Assessment (FA) of Severe Behaviors</td>
<td>0362T</td>
<td>15 minutes</td>
<td>Severe behaviors, authorized as medically necessary. Not available in all markets (HO).</td>
</tr>
<tr>
<td>Direct for Severe Behaviors</td>
<td>0373T</td>
<td>15 minutes</td>
<td>Two or more technicians; QHP has to be onsite. Not available in all markets (HN).</td>
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*For states other than California, Pennsylvania and Texas*
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## Pennsylvania ABA codes

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<tr>
<td>Functional Behavior Assessment (FBA)/Reassessment</td>
<td>97151</td>
<td>15 minutes</td>
<td>BCBA only (HO). Code is also used for BHRS for CBC account only.</td>
</tr>
<tr>
<td>FBA/Reassessment</td>
<td>97152</td>
<td>NA</td>
<td>This is not a covered code.</td>
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<tr>
<td>Functional Behavior Assessment (FBA)/Reassessment</td>
<td>97151</td>
<td>15 minutes</td>
<td>BCBA only (HO). Up to eight hours on reassessment can be requested. (Note: Eight hours of 97151 or six hours of 97151, plus two hours of 97152 can be requested.)</td>
</tr>
<tr>
<td>FBA/Reassessment</td>
<td>97152</td>
<td>15 minutes</td>
<td>Up to two hours of 97152 for every six months of authorization can be requested.</td>
</tr>
<tr>
<td>Direct</td>
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- Wrapping up
Credentialing / recredentialing

OUR POLICY

Master’s/doctoral level practitioners are required to successfully complete the credentialing review process prior to being accepted as a network provider and every three years unless otherwise required by applicable state and federal law, a customer and/or an accrediting entity.

Only credentialed providers may bill for ABA services as in-network providers.

Bachelor’s level behavior analysts and support staff/technicians are not required to complete credentialing with Magellan if they are under the supervision of the licensed, credentialed practitioner.

Review behavior analyst credentialing criteria at MagellanProvider.com/Autism
Recredentialing procedures

Ensure you keep your CAQH application current and respond to any requests from our credentialing department; not meeting recredentialing 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 recredentialing process.
1. To monitor network quality, Magellan reviews provider credentials every three years as required by contract and/or applicable state law.

2. Approximately six months prior to the recredentialing due date, Magellan will attempt to access your CAQH application. If we cannot, we will send a notification to mailing address on record. To avoid delays to the recredentialing process, please do the following:

   • Log on to CAQH at [http://proview.caqh.org](http://proview.caqh.org) and complete your application, sending all required documents to CAQH. Ensure that you have re-attested to your information and have authorized Magellan to access your application.
   • If you do not have access to the CAQH universal application, you may request a paper recredentialing application.

3. Magellan will make three outreach attempts to acquire any missing data e.g., updated malpractice information. If the provider does not respond, the recredentialing application is closed and the provider is placed in suspended status and will be terminated as of the recredentialing due date. Final notification is issued to the mailing address on file for the practitioner.
To be an in-network provider, you must be contracted with Magellan under an individual provider participation agreement as well as being credentialed by Magellan before you can be considered eligible for referrals.

If you were a practitioner who left a group to practice solo, and you are not also contracted with Magellan under an individual provider participation agreement, you are no longer considered a Magellan participating provider.
GROUP CONTRACTS

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

2. A practitioner 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.

3. Magellan expects all practitioners in a participating group to be credentialed and participating in the Magellan network; members accessing a participating practice must be assured access to participating practitioners.
GROUP CONTRACTS (continued)

4. When group membership changes (e.g., 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 the provider is eligible to receive referrals

- **Make sure all necessary documentation is completed** in order to affiliate a practitioner to your practice, including current malpractice information.
ORGANIZATIONAL CONTRACTS

1. To be an in-network organizational provider, the agency/organization must be contracted with Magellan AND must be organizationally credentialed.

2. Agencies must either be accredited by JCAHO, CARF, or COA and/or hold acceptable program/agency licensure to meet organizational credentialing standards.

3. Typically, individual provider credentialing within the agency is not required; however, only those practitioners that meet Magellan’s individual credentialing standards may treat members.

4. Organizations must provide roster information for all ABA or other rehabilitative behavioral service providers at the time of contracting and update Magellan when staffing changes.
Helpful hints for credentialing and contracting (for practitioners)

If possible, use CAQH (Universal Provider DataSource®).

• Make sure you indicate the one TIN with which you will bill on your Form W-9 — either your Social Security Number (SSN) OR Employer Identification Number (EIN) — NOT BOTH.

• Please note and explain in the comments section of the application any periods of unemployment of more than six months.

• Keep copies of your completed contract and application.
A commitment to quality:
• Magellan maintains a Continuous Quality Improvement (CQI) program.
• Magellan’s providers are an integral component of the quality program.

Magellan obtains meaningful input from providers through:
• Regional Network and Credentialing Committees
• Annual provider satisfaction surveys
• Provider Advisory Groups

We provide information to providers through:
• Provider Focus newsletter
• Provider forums and webinars
• Magellan provider website
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

We obtain provider feedback through various channels including provider satisfaction surveys, our national Provider Services Line and the Magellan provider website.
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Magellan-paid claims requirements

Timely filing of claims:
- Commercial: 60 days par
  *Calculated from date of service
- Medicare: 60 days par
  *Calculated from date of service

Exceptions to timely filing requirements:
- Coordination of benefits claims* where Magellan is the secondary payer
- Other exceptions by health plan (requires website sign in)

*Same limits as listed to the left, except calculated from date of primary carrier explanation of benefits

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

- Submit claims with CPT® or HCPCS procedures on a 837P or CMS-1500.
- Also submit with the appropriate billing modifier in conjunction with the CPT code.
- Include all HIPAA-compliant diagnosis codes (ICD-10 required).

Hints for claim completion:

- Give complete information on the member (name, address, DOB).
- Give complete provider information.
  - TIN (Tax ID Number)
  - Rendering provider name and degree
  - Billing “pay to” provider name and address
  - National Provider Identifier (NPI) for both the rendering and billing provider
- Attach primary carrier’s explanation of benefits when billing as the secondary insurer.
Magellan claim tips (continued)

☑️ Top reasons for claim rejection/denials:

- Missing or invalid CPT/HCPCS code
- Missing or invalid diagnosis code
- Missing or inaccurate place of service code
- Missing name and/or degree level of provider (when required)
- Missing or invalid NPI

☑️ For more claims tips, visit the Getting Paid tab at www.MagellanProvider.com.
Checking claims status

2. Select **Check Claims Status** from menu.
3. Search for claim by member or subscriber name, date of service, etc.
   - Can view claim details such as check number, date and payment method.
   - If claim is denied, reason code and description provided.
   - Contact instructions available if provider has questions.
   - Can view EOB online.
It is mandatory that providers sign up for EFT for 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

Explanation of Benefits (EOB) are available on www.MagellanProvider.com
1. Sign into the secure network
2. Click on Check Claims Status from the left-hand menu
3. Click on the EOB Search on the top tab
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A secure location for your transactions — sign in and get started!

You should receive a username and temporary password during the contracting process.
Secure Magellan website features (requires sign in)

- Check member eligibility (for most customer plans).
- Access autism-related forms for initial authorization and continued treatment.
- View and print EOBs.
- Submit a claim for professional services (CMS-1500) and check on claim payment status.
- Register for electronic funds transfer.
- Access MyMessages for secure communication with Magellan staff.
Magellan website features (before sign in)

- Award-winning *Provider Focus* newsletter
- Electronic claims submission information
- HIPAA billing code set guides
- Medical necessity criteria information
- Clinical practice guidelines
- Most clinical and administrative forms
- Cultural competency resources
- Demos of all our online tools/applications (go to *Education/Online Training*)

- Plus, search for *autism* resources in our member-friendly library through Healthwise at [https://www.healthwise.net/magellanhealth](https://www.healthwise.net/magellanhealth)
Updating practice information

Updating your practice data is critical to all transactions with Magellan. You must validate your practice data quarterly, at a minimum.

Practice data impacts:
- Authorization notifications.
- Recredentialing 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.
Updating practice information

What you need to do

- Magellan’s mandatory online Provider Data Change Form (PDCF) allows you to update your information in real time.
  2. Sign in to the secure network.
  3. Click Display/Edit Practice Information from the left-hand menu.

- Training is available online under the Education heading on the provider website.

- Magellan network staff members also are available to assist with provider training.
Updating practice information

Use the **mandatory** Provider Data Change Form to report changes in your practice information.
Updating practice information (continued)

What you need to do – solo clinicians

Notify Magellan promptly of any changes in your individual practice information including:

- General information
- Contact information
- Access / availability
  Promptly notify us if you are unable to accept referrals for any reason including:
  - Illness
  - Practice not accepting new patients
  - Professional travel, sabbatical, vacation, leave of absence, etc.
- Specialties
- Service, mailing or financial address
Updating practice information (continued)

What you need to do – group practices and organizations/facilities

Notify Magellan promptly of any changes in your practice information including:

- General information
- Contact information
- Access / availability
  Promptly notify us if you are unable to accept referrals for any reason including:
  - Illness
  - Practice not accepting new patients
  - Professional travel, sabbatical, vacation, leave of absence, etc.
- Specialties
- Service, mailing or financial address
- Practitioners departing the group practice
- New practitioners joining the group practice
Creating your provider profile

This feature on our provider website allows providers to enhance the information that members see in our online Provider Search tools. You can:

• Upload a photo
• Include a personal statement
• Share awards and distinctions
• Share top attributes

Making more in-depth information about network providers available to members helps support consumer choice and ultimately contributes to the best care and positive clinical outcomes for members.

Practitioners who are part of a group also have the ability to sign in to the provider website and update their profile.

To access the provider profile:

1. Sign in to the website with your secure username and password at www.MagellanProvider.com
2. From the left-hand My Practice menu, select Display/Edit Practice Information
3. Click the Provider Profile tab
Manage Your Profile

Enhance your profile - visible to Magellan members via our Provider Search tool - and attract new member referrals! You can upload a photo, enhance your biographical information, and share your professional attributes.

Note: To make revisions to your other practice information, please select the Provider Data Change Form tab above.

To begin, please select the TIN/MIS for this profile:

Please select...
Agenda

- Welcome to the Magellan network
- Assessment and treatment planning
- Credentialing, recredentialing and contracting
- Claim submission options
- Magellan provider website
- Wrapping up
In providing *first-class provider service*, Magellan focuses on:

- Prompt, accurate claims payment.
- Ease of credentialing and recredentialing.
- Healthy referral volume.
- Easily accessible provider resources (clinical, training, consultation, etc.).
- Secure transactions on our provider website to ensure privacy.
- Personalized service when you need assistance.
Thank You!

Questions?

For clinical questions, including those about authorization, assessment and treatment planning, contact care management at the program specific phone number (see back of the member’s identification card, as this will vary).

For questions about the Magellan website functions, contracting/credentialing and claims:

- Email ProviderServices@MagellanHealth.com.
- Call the Magellan Provider Services Line at 1-800-788-4005.
The information contained in this presentation is intended for educational purposes only. It is not intended to define a standard of care or exclusive course of treatment, nor be a substitute for treatment. It should not be considered legal advice. Recipients are encouraged to obtain legal guidance from their own legal advisors.