Magellan Healthcare, Inc.

Provider Handbook Supplement for the Louisiana Coordinated System of Care

Revised May 2018
# Magellan Healthcare, Inc.
## Provider Handbook Supplement
### for the Louisiana Coordinated System of Care

## SECTION 1: INTRODUCTION
- Welcome
- Contact Information
- About the Louisiana Coordinated System of Care Program

## SECTION 2: MAGELLAN’S PROVIDER NETWORK
- Network Provider Training
- Child and Adolescent Needs and Strengths (CANS)
- Provider Required Training and Audits
- Covered Benefits
- Credentialing/Recredentialing
- Contracting with Magellan
- Behavioral Health Services Provider Manual
- Home and Community Based Setting (HCBS) Rule

## SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN
- Cultural Competency
- Wraparound, Recovery and Resiliency
- Member Access to Care
- Initiating Care
- Concurrent Review
- Advance Directives
- Coordination of Care – Medications and Medication Screening
- Magellan’s Louisiana and Provider Websites

## SECTION 4: THE QUALITY PARTNERSHIP
- A Commitment to Quality
- Provider Input
- Provider Complaint Process
- Member Grievance Process
- Adverse Incident Reporting
- Behavioral Health Record Documentation
- Appeal Determinations
- Site Visits
Member and Provider Satisfaction ................................................................. 41
Fraud, Waste and Abuse .................................................................................. 42
Network Monitoring ....................................................................................... 48

SECTION 5: PROVIDER REIMBURSEMENT .................................................. 50
Submission of Claims for Professional Services ........................................... 50
Claims Disputes ............................................................................................... 52
National Provider Identifier (NPI) Numbers ................................................... 53
SECTION 1: INTRODUCTION

Welcome

Welcome to the Magellan Healthcare, Inc. (Magellan) Provider Handbook Supplement for Louisiana Medicaid Coordinated System of Care (CSoC) program. This handbook supplements the Magellan National Provider Handbook, addressing policies and procedures specific for CSoC. The Handbook Supplement is to be used in conjunction with the national handbook. When information in the CSoC supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in the CSoC supplement prevail.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our Louisiana website at www.MagellanofLouisiana.com and our Magellan provider website at www.MagellanProvider.com. You can look up authorizations and verify the status of a claim online at this provider site, in addition to completing other key provider transactions. We have designed our websites for you to have quick and easy access to information, and answers to questions you may have about Magellan.

You also can reach us at the Magellan Baton Rouge and Shreveport Louisiana Care Management Centers at the following numbers:

♦ Louisiana Member and Provider Services Line: 1-800-424-4489
♦ Email: LACSoCProviderQuestions@MagellanHealth.com

Or you may call our Magellan National Provider Services Line: 1-800-788-4005
CSoC members can contact Magellan at:  Toll-free: 1-800-424-4489   TTY: 1-800-424-4416

For Reporting Fraud & Abuse contact any of the following:
   Magellan’s Corporate Compliance Hotline at 1-800-915-2108 or
   Compliance Unit Email: Compliance@MagellanHealth.com
   Magellan’s Special Investigations Unit Hotline: 1-800-755-0850 or
   Magellan’s Special Investigations Unit Email: SIU@MagellanHealth.com

Or you may report directly to:
Louisiana Department of Health, Fraud Complaint Unit
P.O. Box 91030
Baton Rouge, LA  70821-9030
1-800-488-2917
http://ldh.la.gov/index.cfm/page/219
SECTION 1: INTRODUCTION

About the Louisiana Coordinated System of Care Program

The Coordinated System of Care is designed to provide services and supports to children and youth, who have significant behavioral challenges or co-occurring disorders, and are in or at imminent risk of out-of-home placement. The Coordinated System of Care (CSoC) integrates resources from all of Louisiana’s child-serving agencies, including the Department of Health (LDH), Department of Education (LDOE), Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ).

The family-driven and coordinated approach of CSoC is meant to create and oversee a service delivery system that is better integrated, has enhanced service offerings and achieves improved outcomes by ensuring families who have children with severe behavioral health challenges get the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider, to keep or return children home or to their home communities. Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers and others who support the family.

The goals of the CSoC include:
- Reduce state’s cost of providing services by leveraging Medicaid and other funding sources as well as increase service effectiveness and reduce duplication across agencies,
- Reduce out of home placements in the current number and future admissions of children and youth with significant behavioral health challenges and co-occurring disorders, and
- Improve the overall outcomes of children and their caretakers.

LDH contracts with Magellan Healthcare, a Prepaid Inpatient Health Plan, referred to as the CSoC Contractor. The CSoC Contractor is responsible for coordinating, administering, and managing specialized behavioral health services for Medicaid-eligible children and youth potentially eligible for or enrolled in the Coordinated System of Care (CSoC) waiver, and the services are facilitated by the Wraparound agencies. The four specialized CSoC services are provided by community-based providers, and the CSoC Contractor reviews and authorizes these waiver services.

The four waiver services not available to other Medicaid youth are: Independent Living/Skills Building, Short Term Respite, Youth Support and Training, and Parent Support and Training. Youth eligible for CSoC are between the ages of five and twenty.
The four waiver services can only be delivered by providers who are credentialed, enrolled and paid by Magellan. The providers must meet state requirements including licensing, Home and Community-Based Services (HCBS) provider requirements and provider qualifications as specified in the LDH Service Definitions Manual/Behavioral Health Manual.

Source and supporting documentation used to create this handbook can be found in the federal 1915(c) and (b) (3) Home and Community-Based Services (HCBS) CSoC Waiver and the Department of Health Coordinated System of Care (CSoC) Payment Guidance document.

CSoC is part of a research-based national movement committed to developing plans of care through a team that is guided by the input of youth and their families. The team is called a Child and Family Team (CFT), and the process of developing the plan is called Wraparound. Team members include people who are important to the family; some may be professionals and others may not. Wraparound is an intensive, individualized care planning and management process.

Magellan performs a brief telephonic screen for youth who appear to be experiencing risk. If the results are positive, a certified provider administers a “Child and Adolescent Needs and Strengths (CANS) assessment,” which is then scored by Magellan’s independent assessment team to determine if the youth meets clinical eligibility for CSoC Services. Children and families who qualify for and choose to enroll in CSoC will receive additional services that are not available to everyone through a Wraparound Agency (WAA).

The WAA is responsible for facilitating the wraparound process, convening the child and family teams (CFT), developing along with the CFT members individualized plans of care that cross agencies, and assigning one accountable Wraparound Facilitator. The Wraparound Facilitator coordinates the team process and ensures that resources available in the family’s network of social and community relationships are part of the plan. The WAA offers an intense level of care coordination that supports youth and their families to successfully achieve the goals in their plan.

Refer to the CSoC Standard Operating Procedures (SOP) Manual for a complete description of the Coordinated System of Care. The CSoC SOP includes such topics as participant access and eligibility, referral process, CSoC specialized services, the Wraparound process and many others.
SECTION 2: MAGELLAN’S PROVIDER NETWORK

Network Provider Training

Child and Adolescent Needs and Strengths (CANS) – Online Training and Certification*

The Praed Foundation and Magellan of Louisiana have partnered for online training and certification on the Child and Adolescent Needs and Strengths (CANS) Collaborative website. This online training and certification is specifically on the Louisiana version of the CANS Comprehensive Assessment used in the Coordinated System of Care. Individuals trained live by Louisiana CANS Trainers will use this system for Certification. Providers trained and certified in using the CANS assessment tool can access and use the CANS tools.

*The CANS certification is valid for one year, starting upon certification date, and must be renewed annually. Certified providers for CANS should go to the CANS Training website and recertify before current certification expires.

Provider Required Training and Audits

For required provider training, go to https://www.magellanoflouisiana.com/for-providers/training-events/provider-training-requirements/. Magellan has developed online training courses approved by the state. Providers can access these training courses, sign and submit an attestation form at the end of the training for proof of participation. If providers choose to complete the training requirement via another entity, proof of completion must be kept on file and submitted upon request.

Providers are additionally responsible for completing training requirements as delineated in the Behavioral Health Services Provider Manual for services they render and should maintain proof of completion of these trainings in their personnel records on-site.

Magellan is required to perform provider audits for the Louisiana Coordinated System of Care network. The purpose of this review is to monitor compliance with licensing and training requirements, qualifications and training requirements for unlicensed direct care staff, claims coding and HCBS setting rule.

What You Need to Do

Your responsibility is to:

- Review and become familiar with the required provider trainings, by going to https://www.magellanoflouisiana.com/for-providers/training-events/provider-training-requirements/Complete required trainings and attestation prior to service delivery
- Understand the obligations and comply with the audit request
- Supply the requested documentation at the time of the audit
Covered Benefits

Magellan will manage the provision of clinically necessary services, pursuant to the Behavioral Health Services Provider Manual that is available on the Department of Health website. Providers should furnish clinically necessary services in an amount, duration and scope that are necessary to address the recipient’s behavioral health condition. Magellan will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.
SECTION 2: MAGELLAN’S PROVIDER NETWORK

Credentialing/Recredentialing

Our Philosophy
Any individual or entity that is engaged in the delivery of behavioral health care services is required to meet the credentialing standards of Magellan and all state licensing and regulatory requirements. In establishing and maintaining the provider network, Magellan has established written credentialing and recredentialing criteria for all participating provider types.

Our Policy
Magellan’s credentialing policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Magellan utilizes accepted industry standards in the credentialing and recredentialing processes for professionals.

What You Need to Do
Magellan network providers are required to participate in Magellan’s credentialing and recredentialing processes, and must meet Magellan’s credentialing criteria (Refer to the Magellan National Provider Handbook Appendix).

What Magellan Will Do
Magellan’s responsibility to you is to:
- Notify you promptly if any required information is missing from your credentialing application;
- Process all applications to meet established standards for timeliness;
- Notify you when the credentialing process is complete; and
- Recredential providers every three years.
SECTION 2: MAGELLAN’S PROVIDER 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 issues an individual, group or organization agreement.

Our Policy

To be eligible for referrals of and reimbursement for covered services rendered to Louisiana Coordinated System of Care members, each provider, whether an organization, individual practitioner or group practice, must sign a Magellan Provider Participation Agreement agreeing to comply with Magellan’s policies, procedures, and guidelines. In the event that you apply for network inclusion and are declined, Magellan will provide written notice of the reason for the decision.

Magellan does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

What You Need to Do

Your responsibility is to:

- Sign a Magellan provider agreement;
- Understand the obligations and comply with the terms of the Magellan provider agreement;
- Be familiar with and follow the policies and procedures contained within this handbook supplement and the Magellan National Provider Handbook; and
- Complete required trainings prior to service delivery.

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 the clients and services covered by the agreement based on the reimbursement schedule(s) provided; and
- Execute the agreement after it has been returned and signed by the provider and the provider has successfully completed the credentialing process. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.
SECTION 2: MAGELLAN’S PROVIDER NETWORK

Behavioral Health Services Provider Manual

The Behavioral Health Services Provider Manual provides detailed information related to, but not limited to, licensure and specific provider requirements, staffing qualifications, training requirements, service components and eligibility criteria. The CSoC Service Authorization Criteria provides the admission and continued stay criteria for all levels of care within the program.

The information in this section is subject to change at any time; please check frequently using the website link noted below.

- Behavioral Health Services Provider Manual
- Louisiana Coordinated System of Care Medical Necessity Criteria
SECTION 2: THE ROLE OF THE PROVIDER AND MAGELLAN

Home and Community Based Setting (HCBS) Rule

Our Philosophy

Magellan is committed to ensuring compliance with Centers for Medicare & Medicaid Services (CMS) regulations defining the settings in which it is permissible for states to pay for CSoC Waiver Services. The purpose of these regulations is to ensure that individuals receive CSoC Waiver Services in settings that are integrated in and support full access to the greater community. The regulations also aim to ensure that individuals have free choice of where they live and who provides services to them, as well as ensuring that individual rights are not restricted. The rule sets expectations for settings in which CSoC Waiver Services can be provided. This rule requires that the settings:

- Be selected by the individual from options that include non-disability specific settings. Individuals must also have choice regarding the services they receive and by whom the services are provided.
- Ensures the individual right of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes independence and autonomy in making life choices without regimenting such things as daily activities, physical environment, and with whom they interact.

In addition, the rule also specifies certain settings in which CSoC Waiver Services cannot be provided. This includes settings that have always been statutorily excluded such as hospitals, nursing facilities, intermediate care facilities for the developmentally disabled (ICF/DD), and institutions for mental disease (IMD).

Our Policy

Magellan staff is trained in these requirements and works collaboratively with LDH to ensure compliance with these regulations.

What You Need to Do

If you are a CSoC Waiver Service provider, your responsibility is to:

- Ensure that your provider site meets the HCBS Rule requirements:
  - Provider service setting should be located among other residential buildings, private businesses, retail
businesses, restaurants, doctor’s office, etc. that facilitates participant integration within the greater community.

- The provider service setting should not be located in a building that also provides inpatient institutional treatment (such as a nursing facility, institute for mental disease, ICF/DD, or hospital).
- The provider service setting should not be located in a building on the grounds of or immediately adjacent to a public institution.
- The provider service setting should be physically accessible.
- Participant information should be kept private.
- Provider should have policy requirements that assure staff do not talk to other staff about an individual in the presence of other persons or in the presence of the individual as if s/he were not present.

- Notify Magellan immediately if your site does not meet these requirements or if you have questions regarding compliance.
- Not to deliver services to members in restrictive settings. The only exception for service delivery applies to WAA facilitation, which can be delivered for up to a 90-day period for the purposes of discharge and transition planning.

**What Magellan Will Do**

Magellan’s responsibility to is to:

- Evaluate your provider site to ensure compliance at the time of initial credentialing and recredentialing.
- Monitor your provider site annually to ensure compliance.
- Work with you on a corrective action plan if you are not compliant.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Cultural Competency

Our Philosophy

Magellan is committed to the provision of services that is responsive to the unique cultural, ethnic, or linguistic characteristics of the population we serve. We believe that all people entering the behavioral health care system must receive equitable and effective treatment in a respectful manner, recognizing individual spoken language(s), gender and cultural aspects.

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 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 any practice specialty information you hold on your credentialing application.
- Provide oral and American sign interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to members. Members must be provided with information instructing them how to access these services.
- In general, any document that requires the signature of the behavioral health recipient, and that contains vital information regarding treatment, medications, or service plans must be translated into their preferred/primary language if requested by the behavioral health recipient or his/her guardian.

What Magellan Will Do

Magellan’s responsibility to you is to:

- Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities.
- Provide language assistance, including bilingual staff and interpreter services, to those with limited English proficiency during all hours of operation at no cost to the recipient.
- Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area.
- Monitor gaps in services and other culture-specific provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor effectiveness.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Wraparound, Recovery and Resiliency

Our Philosophy

Recovery has as many definitions as there are people who experience it. Magellan defines recovery this way: that all people living with behavioral health conditions have the capacity to learn, grow, and change and can achieve a life filled with meaning and purpose. We define resiliency as all people having qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope.

Our Policy

Magellan staff is trained in Wraparound, recovery and resiliency values and practices in order to refer members to providers able to offer services and supports that promote individual recovery, and help build resiliency. Magellan assesses network practices, programs, and training needs on an ongoing basis to ensure a culture of recovery and resiliency is accessible for members.

What You Need to Do

Your responsibility is to:

- Understand and apply core elements of recovery and resiliency to service delivery.
- Understand and integrate best and promising practices related to recovery and resiliency programs and initiatives.
- Provide regular training on aspects of recovery and resiliency.
- Ensure service plans are person-centered and strength-based.
- Understand and integrate different cultural aspects of recovery and resiliency when delivering services.
- Coordinate care with the Wraparound Agency and actively participate in the child and family team process.

What Magellan Will Do

Magellan’s responsibility to you is to:

- Provide ongoing education to deliver services that maximize opportunities for individual recovery and development of personal resiliency to members.
- Provide tools and technical assistance to improve recovery and resiliency programs and practices.
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 use 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:

- Assure that members know how to access care 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 access to an appointment within one hour of referral in an emergent situation. An emergency occurs when the member’s clinical situation could result in serious jeopardy to their health and wellbeing.
- Provide access to an appointment within 48 hours of referral in an urgent clinical situation. An urgent clinical situation occurs when the member’s clinical situation will likely get worse if not seen in a timely fashion.
- Provide access to an appointment within 14 days of referral for routine clinical situations.
- Provide access to an appointment within seven days of a member’s discharge from an inpatient and residential stay.
- Contact Magellan immediately if you are unable to see the member within these timeframes.
- Provide outreach to members who do not follow up with recommended services.
- If you need to schedule non-emergency transportation, please call the member’s Healthy Louisiana Plan as follows:
  - Aetna Better Health....................... 1-877-917-4150
  - Healthy Blue............................. 1-844-521-6941
  - AmeriHealth Caritas....................... 1-888-913-0364
What Magellan Will Do

Magellan’s responsibility to you is to:

- Communicate the clinical urgency of the member’s situation when making referrals.
- Assist with follow-up service coordination for members transitioning from inpatient to an outpatient level of care.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Initiating Care

Our Philosophy
Magellan wants members to receive the most appropriate services and experience the most desirable treatment outcomes.

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

We do not pay incentives to employees, peer reviewers (e.g., physician advisors), or providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-authorization or under-utilization of behavioral health care services.

What You Need to Do
Your responsibility is to:
- Understand federal Medicaid standards applicable to providers.
- Comply with federal Medicaid standards.
- Be familiar with the applicable Louisiana Medical Necessity Criteria and the ASAM-PPC-2R for Addiction Services.
- For inpatient psychiatric treatment and crisis services, call Magellan at 1-800-424-4489. For other levels of care, authorizations are requested by the Wraparound Agency on your behalf through the youth’s Plan of Care.
- Be aware that members may receive up to five diagnostic assessments, 24 outpatient psychotherapy (individual, family, and/or group) sessions (contingent on eligibility), and 12 medication management sessions per year without needing prior authorization.
- Not require a primary care physician (PCP) referral from members.
- Not require pre-certification of members for emergency services.

What Magellan Will Do
Magellan’s responsibility to you is to:
• Operate a toll-free telephone line to respond to provider questions, comments and inquiries. That number is 1-800-424-4489.
• Establish a multi-disciplinary Utilization Management Committee to oversee all utilization functions and activities.
• Make decisions about prior authorizations within contractual guidelines and timeframes.
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 generally required for services including, but not limited to:

- Inpatient Hospitalization
- Crisis Intervention

What You Need to Do
If, after evaluating and treating the member, you determine that additional services are necessary:

- Follow the concurrent review procedures for the services that you are providing to the member.
- 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.
- Understand federal and state Medicaid standards applicable to providers.
- Comply with federal and state Medicaid standards.

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

- Be available 24 hours a day, seven days a week, and 365 days a year to respond to requests for authorization of care.
- Promptly review your request for additional days or visits in accordance with the applicable medical necessity criteria.
- Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.
- Respond in a timely manner to your request, verbally and in writing, for additional days or visits.
- Issue an adverse determination within two business days after receipt of the request for authorization of services; within one business day for concurrent hospitalization decisions; and within one hour for post-stabilization or life-threatening conditions (for emergency behavioral health conditions, no prior authorization is required).
• Operate a toll-free telephone line to respond to provider questions, comments and inquiries. That number is 1-800-424-4489.
• Establish a multi-disciplinary Utilization Management Committee to oversee all utilization functions and activities.
• Review inpatient service requests based on medical necessity criteria and render a timely decision.
• Issue online notification to the attending clinician and facility for inpatient care.
• Review the Plan of Care for authorization requests within the requirements of Louisiana Medicaid and Wraparound philosophy.
• Notify the practitioner if the request is incomplete.
• Review the complete treatment request and issue the authorization or Notice of Action within 14 calendar days.
### SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

## Advance Directives

### 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 right to make decisions in advance about health care treatment, including their right to refuse, withhold or withdraw from medical and/or mental health treatment, through advance directives. Magellan supports the state and federal regulations, which provide for adherence to a member’s advance directive for mental health treatment.

### What You Need to Do
Your responsibility is to:
- Understand and meet federal and state Medicaid standards regarding advance directives for mental health treatment.
- Meet state of Louisiana and federal advance directive for mental health treatment laws.
- Maintain a copy of the advance directive for mental health treatment in the member’s file, if applicable.
- Comply with a member’s advance directive for mental health treatment or the decisions of the member’s representative, to the fullest extent possible, consistent with the appropriate standard of care, reasonable medical practice, the availability of treatments requested, and applicable law.
- Ensure consistency with the continuity of the appropriate standard of care if a decision is made to withdraw from providing treatment because you are unable or unwilling at any time to carry out preferences or instructions contained in an advance directive for mental health treatment or the decisions of the member’s representative, by ensuring that another provider agrees to treat the member prior to the effectiveness of withdrawing from treatment.

### What Magellan Will Do
Magellan’s responsibility to you is to:
- Meet state of Louisiana and federal advance directive for mental health treatment laws.
- Document the execution of a member’s advance directive for mental health treatment.
- Not discriminate against a member based on whether the member has executed an advance directive for mental health treatment.
• 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 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Coordination of Care – Medications and Medication Screening

<table>
<thead>
<tr>
<th>Our Philosophy</th>
<th>Magellan believes it to be imperative to provide coordination of physical and behavioral health care, including medications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Policy</td>
<td>Providers are required to coordinate and communicate with primary care physicians when clients have co-occurring physical and behavioral health conditions and/or are taking medications for which there may be drug interactions.</td>
</tr>
<tr>
<td>What You Need to Do</td>
<td>Providers must document in the treatment record the coordination of care with any other physician providing services to the client when the member has provided written consent to do so. If that consent is not granted, the refusal should be noted in the member’s record. Providers must attempt to obtain the member’s consent once the provider is aware that the member has a co-occurring physical and behavioral health condition and/or is taking medications. If the member refuses, the provider must document this refusal in the member’s record.</td>
</tr>
<tr>
<td>What Magellan Will Do</td>
<td>Coordination is monitored through the care management process and through on-site and off-site retrospective reviews of treatment records.</td>
</tr>
</tbody>
</table>
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Magellan’s Louisiana and Provider Websites

Our Philosophy

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

Our Policy

The Magellan website specific to the Louisiana Coordinated System of Care (CSoC) program is: www.MagellanofLouisiana.com. Here, providers can find resources they need to provide care through the CSoC program. This Internet location contains information providers need to stay current with Magellan in Louisiana, including the latest updates, clinical practice guidelines and training links, as well as state and region-specific information. Providers and members also can search for a provider by ZIP Code, or search by level of care. Magellan’s Louisiana website also enables the provider to link to our central provider website to complete transactions such as checking member eligibility and submitting claims.

Through MagellanofLouisiana.com, providers can also access all of the powerful tools and information they need by linking to MagellanProvider.com. The following are some of the resources and features available on www.MagellanProvider.com:

- Magellan’s National Provider Handbook
- Provider Focus Newsletter
- View Authorizations
- Check Claims Status
- Claims Courier (Magellan’s web-based claims submission tool)
What You Need to Do

The following are helpful hints for using the Magellan provider website. The www.MagellanProvider.com website is optimized for use with Microsoft Internet Explorer 6.0 versions and above. Other versions and different browsers can still access our website, but the viewing experience and functionality may be reduced. If using Internet Explorer 8.0, users may need to adjust their Compatibility View Settings (Tool Menu) to add both www.MagellanHealth.com and www.MagellanProvider.com.

The Administrator is the user who is responsible for managing website access for an Entity. This person creates logins for staff who need to access MagellanProvider.com for an individual practice, group, or facility. At a group or a facility, this may be an office manager, IT manager, etc. For an individual practice, the practitioner is automatically the Administrator. There is only one Administrator per Entity. Each user needs to have a unique login and password. The website Administrator for each provider can add new users and also grant them specific permission levels. Based on their job functions, all users may not require access to the same functions.

Logins become “deactivated” after six or more months of non-use. A user also may forget their login or password, or they may lock themselves out after three or more unsuccessful login attempts. Users can regain access to the website by following the link “Forgot Password” underneath the Provider Sign-in on the MagellanProvider.com home page. If a user runs into trouble resetting their password or gaining access to the website, they should contact their Administrator.

When signing up to use the website, users will select a “challenge” question. It is recommended that the answer be a simple, one-word response.

Note that any field with an asterisk (*) is a required field.

When searching for a member in Eligibility, users must fill in the three fields with the asterisk (Last Name, First Name and State). The next two fields are optional (Date of Birth and Member Number) and can be utilized with common names and searches that return many members with the same name. Be sure to spell the member’s name exactly as it appears on the member’s health plan ID card.
What Magellan Will Do

Magellan’s responsibility to you is to:

- Maintain operation of online services on a 24 hours a day, seven days a week basis;
- Inform users of service problems if they occur; and
- Use your feedback to continually improve our website capabilities.
SECTION 4: THE QUALITY PARTNERSHIP

A Commitment to Quality

Our Philosophy
Magellan supports the delivery of quality care with the primary goal of improving the health status of members and, where the member’s condition is not amenable to improvement, maintaining the member’s current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes identifying members at risk of developing conditions, implementing appropriate interventions, and designating adequate resources to support the intervention(s).

Our Policy
In support of our Quality Improvement Program, our providers are required to be familiar with Medicaid and Magellan guidelines and standards and apply them in clinical work with members.

What You Need to Do
To comply with this policy, your responsibility is to:

- Understand federal and state Medicaid standards applicable to providers.
- Comply with federal and state Medicaid standards.
- Provide input and feedback to Magellan to actively improve the quality of care provided to members.
- Participate in quality improvement activities if requested by Magellan.

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

- Actively request input and feedback regarding member care.
- Work with members, providers, community resources and agencies to improve the quality of care provided to members.
- Operate a toll-free telephone line, 1-800-424-4489, to respond to provider questions, comments and inquiries.
- Establish a multi-disciplinary Quality Oversight Committee to oversee all quality functions and activities.
- Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.
- Provide designated staff with expertise in quality assessment, utilization management and continuous quality improvement.
SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

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

Our Policy
Magellan obtains provider input through provider participation in various workgroups and committees of the Care Management Center. We offer providers opportunities to give feedback through participation in our quality programs, or via requests for feedback in provider publications.

What You Need to Do
To comply with this policy your responsibility is to:

- Provide input and feedback to Magellan to actively improve the quality of care provided to members.
- Participate in quality improvement and utilization oversight activities if requested by Magellan.

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

- Actively request input and feedback regarding member care.
- Operate a toll-free telephone line to respond to provider questions, comments and inquiries. That number is 1-800-424-4489.
- Establish a multi-disciplinary Quality Oversight Committee to oversee all quality functions and activities.
- Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.
- Provide designated staff with expertise in quality assessment, utilization management and continuous quality improvement.
- Develop and evaluate reports, indicate recommendations to be implemented, and facilitate feedback to providers and members.
- Conduct provider satisfaction surveys annually.
## SECTION 4: THE QUALITY PARTNERSHIP

### Provider Complaint Process

**Our Philosophy**
In order to achieve a high level of member satisfaction and care, Magellan believes in providing a mechanism for providers and external agencies to express complaints related to care, service, confidentiality, policy, procedure, payment or any other communication or action by Magellan.

**Our Policy**
Magellan maintains processes for addressing verbal and written complaints.

**What You Need to Do**
To comply with this policy, your responsibility is to:

- Submit verbal complaints by calling the toll-free provider line at 1-800-424-4489.
- Submit written complaints to Magellan Healthcare, Inc., P.O. Box 83680, Baton Rouge, LA 70884-3680, Attn: Appeals Department.

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

- **Verbal Complaints**
  
  - Thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties. Resolve concern at the time of the initial call, or involve a supervisor or designee to resolve the issue.
  
  - Resolve the complaint and verbally notify the complainant of the disposition of the complaint and the opportunity to appeal if an adverse decision is involved.
  
  - Make every effort to ensure that executives with the authority to require corrective action are involved in the provider complaint process.
  
  - Provide assistance in filing. Contact us by calling toll-free provider line at 1-800-424-4489.
  
  - If complaint cannot be resolved at the time of the call, we will respond to the complainant in writing within 30 calendar days of receipt of the complaint.

- **Written Complaints**
  
  - Thoroughly investigate each provider complaint using
applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties.

- Investigate the complaint, consulting with subject matter experts if necessary.
- Provide assistance in filing. Contact us by calling toll-free provider line at 1-800-424-4489.
- Acknowledge complainant within 3 business days of receipt of the complaint.
- Respond to the complainant in writing within 30 calendar days of receipt of the complaint.
- Make every effort to ensure that executives with the authority to require corrective action are involved in the provider complaint process.
- Make every effort to ensure that all appeals will be completed by individuals who have not been previously involved in the decision and who have the appropriate clinical expertise (for complaints involving clinical issues).
- Make every effort to ensure that no punitive action will be taken against any provider that makes a complaint

Please see Section 5 regarding provider complaints involving claims payment.
SECTION 4: THE QUALITY PARTNERSHIP

Member Grievance Process

Our Philosophy

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

Our Policy

Magellan maintains processes for addressing verbal and written grievances.

What You Need to Do

To comply with this policy your responsibility is to:

- Assist members in submitting verbal grievances by calling the toll-free member line at 1-800-424-4489.
- Assist members in submitting written grievances to Magellan Healthcare, Inc.
  P.O. Box 83680
  Baton Rouge, LA 70884-3680
  Attn: Appeals Department.

What Magellan Will Do

Magellan’s responsibility to you is to:

- Acknowledge the grievance in writing within three (3) business days from date of receipt.
- Provide assistance in filing. Contact us by calling toll-free member line at 1-800-424-4489.
- Provide the member the right to request continuation of services while utilizing the grievance system.
- Thoroughly investigate each member grievance using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties. Resolve concern at the time of the initial call, or involve a supervisor or designee to resolve the issue.
- Resolve the grievance and provide written notification of the resolution to the grievant within thirty (30) calendar days.
- Make every effort to ensure that no punitive action will be taken against any member that makes a grievance.
SECTION 4: THE QUALITY PARTNERSHIP

Adverse Incident Reporting

Our Philosophy
Magellan is committed to accomplishing early identification of potential or existing risk in order to eliminate or mitigate risks to members and Magellan.

Our Policy
Magellan requires providers to notify Magellan in writing within 24 hours of the knowledge of the occurrence of a reportable incident, including restraints and seclusions.

What You Need to Do
To comply with this policy your responsibility is to:

- Complete Adverse Incident training to understand definitions of reportable incidents.
- Notify Magellan within 24 hours of the occurrence of a reportable incident involving a Louisiana CSOC member, whether it occurs at the provider’s location or at another location.
- Providers can use the Magellan Adverse Incident Reporting Form located on our website or a form of your choice as long as all required fields are included.

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

- Review incidents to ensure immediate member safety issues are resolved.
- Initiate investigations of adverse incidents and require corrective actions as needed.
- Track and trend incidents to identify and address systematic member safety issues.
SECTION 4: THE QUALITY PARTNERSHIP

Behavioral Health Record Documentation

Our Philosophy

Magellan is committed to ensuring behavioral health record documentation meets federal and state regulations as well as Magellan standards.

Our Policy

Magellan conducts routine treatment record reviews to monitor network provider behavioral health record documentation against Magellan standards and to measure network provider performance against important clinical process elements of Magellan approved clinical practice guidelines. Magellan may also conduct treatment record reviews under special circumstances to investigate or follow up on quality of care concerns, adverse incidents, or grievances about the clinical or administrative practices of a provider.

What You Need to Do

To comply with this policy your responsibility is to:

• Ensure the members behavioral health record is:
  o Accurate and legible;
  o Safeguarded against loss, destruction, or unauthorized use and is maintained in an organized fashion for all members evaluated or treated, and is accessible for review and audit; and
  o Readily available for review and provides clinical data required for Quality and UM review.

• The behavioral health record includes, minimally, the following:
  o Member identifying information including name, identification number, date of birth, gender, and legal guardianship (if applicable);
  o Primary language spoken by the member and any translation needs of the member;
  o Services provided through the provider, date of service, service site, and name of service provider;
  o Behavioral health history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by a provider;
  o Treatment Plan and Plan of Care, if required;
  o Documentation of freedom of choice (e.g., Freedom of Choice form), particularly with regard to choice between institutional and waiver services (Wraparound Agencies only);
  o The brief and comprehensive CANS and IBHA as applicable;
  o Referrals including follow-up and outcome of referrals;
o Documentation of emergency and/or after-hours encounters and follow-up;
o Signed and dated consent forms (as applicable);
o Documentation of advance directives, as appropriate;
o Documentation of each visit must include:
  - Date and begin and end times of service;
  - Chief complaint or purpose of the visit;
  - Diagnoses or medical impression;
  - Objective findings;
  - Patient assessment findings;
  - Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG);
  - Medications prescribed;
  - Health education provided;
  - Name and credentials of the provider rendering services and the signature or initials of the provider; and
  - Initials of providers must be identified with correlating signatures.

• Provider’s treatment record documentation must match all submitted claims and align with service billed on the claim (e.g., diagnosis, DOB, procedure code).

• Provide one (1) free copy of any part of member’s record upon member’s request.

• All documentation and/or records shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

**What Magellan Will Do**

Magellan’s responsibility to you is to:

• Conduct Treatment Record Reviews, reviews of member medical and treatment records, to ensure that providers render high quality healthcare that is documented according to established standards.

• Provide verbal and written feedback of results and collaborate with providers to improve any identified deficiencies.
SECTION 4: THE QUALITY PARTNERSHIP

Appeal Determinations

Our Philosophy
Magellan supports the right of members, and their providers acting on the member's behalf, to appeal adverse clinical 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 Notice of Action (non-authorization) letter.

What You Need to Do
To comply with this policy your responsibility is to:

- Refer to the Notice of Action (non-authorization) letter for the specific procedures for appealing a clinical determination; however:
  - Appeals must be requested within 60 calendar days of the date on the Notice of Action letter.
  - The provider or facility may only appeal on behalf of the member if they have obtained the member's written consent, which must be submitted with the appeal request. Also, written consent must be obtained after an adverse decision has been issued in a case.
  - Oral requests for standard appeals must be followed by a written and signed request within fifteen (15) days of the oral request, unless expedited.

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

- Allow you, the member, or the member’s authorized representative to file an appeal after receiving the Notice of Action. The appeal must be filed within 60 calendar days of the date of the Notice of Action.
- Allow you to expedite the appeal when you or the member indicate that the time it would take to complete a standard appeal would seriously jeopardize the member’s life, health, or ability to attain, maintain or regain maximum function. Expedited appeals will be completed and verbal and written notification sent within 72 hours of the request.
- Send a written reminder that an oral appeal request must be followed by written confirmation that includes the consent from the member or authorized representative.
- Process the appeal as a standard appeal, if an expedited appeal is not requested or is not warranted based on the facts. A Notice
Resolution of a standard appeal will be mailed within 30 calendar days of the initial request for appeal.

- Extend the timeframe for completing appeals by up to 14 calendar days at the request of the member, the provider or Magellan.
- Notify you of the appeal decision, as well as the State Fair Hearing process. The member must exhaust all internal appeal processes prior to requesting a State Fair Hearing.
- All requests for a State Fair Hearing should be sent to:
  Division of Administrative Law
  Health and Hospitals Section
  P.O. Box 4189
  Baton Rouge, LA 70821-4189
- Staff all appeals with individuals who have the appropriate clinical experience and who have not been previously involved in the decision (for medical necessity appeals or appeals involving other clinical issues).
- Accept information from the member and his/her representative (generally including the facility and provider) to support the request for appeal and allow the member to examine his/her 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.
- Review services retrospectively as long as it is clear that the provider had no way of knowing that the member was eligible for services under Magellan. If eligibility is established retrospectively by the state, Magellan will complete a clinical review; however, that does not mean that services will be authorized, as it is required that the services be medically necessary. Requests for retrospective reviews should be submitted to Magellan no later than 365 days after the date of service.
SECTION 4: THE QUALITY PARTNERSHIP

Site Visits

Our Philosophy
The Magellan Quality Improvement Program includes site visits to programs and facilities to assess the quality of care and services delivered. Our staff conducts both administrative and clinical reviews. Licensed clinicians conduct all clinical aspects of the site visit.

Our Policy
Site visits may be conducted at minimum:
- During initial credentialing for participation in the network.
- At recredentialing, which occurs every three years.
- On other occasions when Magellan determines it is necessary, including, but not limited to, for clinical reasons.

Magellan evaluates site visit findings and sends a written report to the provider. The report includes the following information:
- The findings from the site visit.
- Recommendations for improvement, if needed.
- A request for a corrective action plan to improve care or services, if indicated.

Site visit findings are reviewed by the applicable Magellan Regional Network and Credentialing Committee (RNCC) as part of the provider’s credentialing and recredentialing process.

What You Need to Do
To comply with this policy 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 to you is to:
- Notify 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.
Our Philosophy

Member and provider satisfaction are part of Magellan’s core performance measures. Obtaining input from members and providers is an essential component of our quality program.

Our Policy

Member Satisfaction Surveys
Magellan utilizes a number of methods to assess the satisfaction of the members we serve. (See the Magellan National Handbook, Section 4, for information on the member survey process.) We may supplement the annual member satisfaction survey with a member office visit questionnaire administered to members who receive care from high-volume providers and organizations.

Provider Satisfaction Surveys
Our relationship with you, our providers, is crucial to the delivery of quality behavioral health care to our members. Therefore, Magellan also conducts an annual provider satisfaction survey. (See the Magellan National Handbook, Section 4, for information on the provider survey process.) The survey findings are used to identify areas we need to work on and to develop and implement actions for improvement. This survey is administered to network providers at least once a year. We strongly encourage you to participate.

What You Need to Do

To comply with this policy your responsibility is to:

- Encourage members to provide feedback on the care and services they have received.
- Complete Magellan provider satisfaction surveys, offering your feedback and suggestions.

What Magellan Will Do

Magellan’s responsibility to you is to:

- Share the results of member and provider satisfaction surveys with you.
- Use member and 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

Fraud, Waste and Abuse

Our Philosophy
Magellan takes provider fraud, waste and abuse very seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. We have 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. For definitions, corporate policies and more information, see the Fraud, Waste and Abuse section of our National Provider Handbook.

Our Policy
Magellan does not tolerate fraud, waste or abuse, either by providers, members 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 and abuse in government programs and private insurance.

What You Need to Do
Magellan providers are expected to develop, implement, and maintain a written Compliance Plan which adheres to applicable federal and Louisiana state law and any applicable guidance on such plans issued by the United States Office of Health and Human Services Office of the Inspector General (“HHS-OIG”) or the Louisiana Department of Health (LDH). All persons employed by or contracted with a Magellan-contracted provider will be governed under that provider’s Compliance Plan and the provider is responsible for the individuals’ actions.

LDH defines “fraud” as follows:

Fraud: As it relates to the Medicaid Program, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received.
Program Exclusion
Under Louisiana law, providers whose provider agreements have been terminated by the Department of Health (LDH) or a sub-agency thereof, or who have been excluded from the Medicare program or any other state’s Medicaid program, are not eligible to participate in Louisiana’s Medicaid Program during the period of their termination. LDH does not have a published list of Louisiana Medicaid excluded providers. However, the HHS-OIG maintains a list of excluded individuals who are unable to participate as providers in Medicare or Medicaid. Check the link:
http://exclusions.oig.hhs.gov/

The Effect of an Exclusion
The LDH Louisiana Coordinated System of Care (CSoC) is funded by the state and the federal government. An exclusion from participation in federally or state-funded contracts and programs means the excluded individual or entity cannot participate in any federally or state-funded health care program. It also means that:

1. No payment will be made by any state or federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity;
2. No payment will be made by any state or federal health care program for any administrative or management services provided by excluded individuals/entities;
3. Federally funded health care programs like Medicaid, Medicare, Medicare Advantage and other federal health care programs cannot pay excluded individuals/entities, or anyone who employs or contracts with excluded entities/individuals; and
4. Individuals and entities who are enrolled to participate in federally funded health care programs like Medicaid, Medicare, Medicare Advantage, and SCHIP, are prohibited from knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity’s equity who is debarred, suspended, or excluded.

Under Louisiana law, LDH and managed care organizations will not pay for any services prescribed, ordered, or rendered by the providers or individuals listed on the HHS-OIG List of Excluded Individuals, including services performed in an inpatient hospital or long-term care setting. In addition, subsequent to the effective date of the termination or preclusion, any entity of which 5 percent or
more is owned by a sanctioned provider or individual will not be reimbursed for any items or services rendered to CSoC recipients. Providers are required to disclose to Magellan any update regarding the information below within 10 days from when the provider becomes aware of the information. Disclosure includes the following information:

a. Identity of any person or entity having an ownership or control interest in the provider, and who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b. Identity of any person who is managing employee of the provider and who has been convicted of a crime related to federal health care programs.

c. Identity of any person who is an agent of the provider and who has been convicted of a crime related to federal health care programs.

Federal False Claims Act

Providers must be familiar and comply with the Federal False Claims Act. The False Claims Act (FCA) provides, in pertinent part, that:

a. Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a Member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages, which the Government sustains because of the act of that person.

b. For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in
reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

**Procedures Relating to Provider Exclusion from Federally or State-Funded Programs**

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

- Screen all employees 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/](http://www.oig.hhs.gov/) to capture 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 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, directors, officers, partners or owners with a 5 percent or more controlling interest and subcontractors are not debarred, suspended or otherwise excluded under the HHS·OIG LEIE at [http://www.oig.hhs.gov/](http://www.oig.hhs.gov/), the SAMS at [http://www.sam.gov/](http://www.sam.gov/) or any applicable state exclusion list where the services are rendered or delivered; and
- Immediately notify Magellan in writing of the debarment, suspension or exclusion of you, your employees, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.

**Disclosure Requirements**

Medicaid providers are required to disclose the following information regarding:

1) the identity of all individuals and entities with an ownership or control interest of 5% or greater in the provider including 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 individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or 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 (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.

How to Report Suspected Cases of Fraud, Waste and Abuse
Reports made to Magellan can be submitted via one of the following methods:

- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

Contact Information for Fraud and Abuse Reporting
If you have knowledge of suspected Medicaid provider noncompliance, or of substandard quality of care for services paid for under the Louisiana Medicaid Coordinated System of Care Program, there are four ways to report this information to the state:

1. Call toll-free 1-800-488-2917 for Provider Fraud Complaints or 1-888-342-6207 for Recipient Fraud complaints. Call long distance 1-318-487-5138 for Recipient Fraud complaints.

2. Complete the appropriate form online and submit it electronically.
   - Provider Fraud Form - http://ldh.la.gov/index.cfm/form/22
   - Member Fraud Form - http://ldh.la.gov/index.cfm/form/23

3. Print out the appropriate form (above), complete it, and mail it to Molina Healthcare Inc.
   - SURS Department
   - 8591 United Plaza Blvd
   - Baton Rouge, LA 70809

4. Fax the completed form (above) to 225-216-6129 for provider fraud complaint or 225-389-2610 for member fraud complaint
What Magellan Will Do

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

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste and abuse;
- Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct;
- Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations;
- Cooperating with law enforcement authorities in the prosecution of health care and insurance fraud cases;
- Verifying eligibility for members and providers;
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded health care programs;
- Provide individual Explanation of Benefit notices to a sample group of the members who received services in a manner that complies with 42CFR§455.20 and §433.116(e).
- Training employees annually on Magellan’s Corporate Compliance Handbook; and
- Making the Magellan Provider Handbook available to network providers.
SECTION 4: THE QUALITY PARTNERSHIP

Network Monitoring

Our Philosophy
Magellan is committed to ensuring providers meet licensing rules and are compliant with requirements for providing services as outlined in the Medicaid Behavioral Health Services Provider Manual.

Our Policy
It is Magellan’s policy to verify the provider’s physical environment, human resource records, policies and procedures, and member records for compliance with Medicaid’s and Louisiana Department of Health’s requirements, including but not limited to:

- Licensing Rules
- Unlicensed Direct Care Staff Qualifications and Training Requirements
- Appointment Availability Standards
- Home and Community Based Setting (HCBS) Rule Requirements (waiver services providers only)
- Claims Coding Requirements (waiver services providers only)

What You Need to Do
To comply with this policy your responsibility is to:

- Ensure compliance with licensing rule and requirements established in the Medicaid Behavioral Health Services Provider Manual, including but not limited to appointment availability and unlicensed direct care staff requirements.
- Ensure the human resources records include all qualifications and training requirements as outlined in the Medicaid Behavioral Health Services Provider Manual and are:
  o Accurate and legible
  o Safeguarded against loss, destruction, or unauthorized use and is maintained in an organized fashion for all staff rendering direct care to members, and is accessible for review and audit
  o Readily available for review
  o Compliant for all requirements
- Participate in all audit requests and complete all remedial activities timely as prescribed by Magellan.
  o Refusal to participate in any aspect of the monitoring process (e.g., not sending information timely, not responding to requests for corrective actions, not implementing remedial activities, etc.) will be considered provider non-compliance with their contract.
Program Exclusion
Under Louisiana law, providers whose provider agreements have been terminated by the Department of Health (LDH) or a sub-agency thereof, or who have been excluded from the Medicare program or any other state’s Medicaid program, are not eligible to participate in Louisiana’s Medicaid Program during the period of their termination. LDH does not have a published list of Louisiana Medicaid excluded providers. However, the HHS-OIG maintains a list of excluded individuals who are unable to participate as providers in Medicare or Medicaid. Check the link: http://exclusions.oig.hhs.gov/.

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

- Conduct monitoring reviews to ensure compliance with Medicaid requirements.
- Provide verbal and written feedback of results and ensure remedial activities are implemented to achieve compliance when deficiencies are identified.
- Follow Medicaid guidance and recoup Medicaid monies for services rendered by unlicensed providers and unlicensed direct care staff that do not meet qualification and training requirements as defined by the Medicaid Behavioral Health Services Provider Manual.
  - Medicaid defines any claim submitted for Medicaid reimbursement by an unlicensed direct care staff that does not meet qualification and training requirements as a false claim.
  - For dates of service on February 2, 2018 or after, Magellan will be required by the Louisiana Department of Health and Medicaid to recoup false claims as delivered by unlicensed direct care staff not meeting requirements.
SECTION 5: PROVIDER REIMBURSEMENT

Submission of Claims for Professional Services

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 addiction treatment providers in accordance with reimbursement schedules for professional services. 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 at 1-800-424-4489 prior to initiating care to check eligibility and obtain appropriate authorization for service. You may check member eligibility via http://www.lamedicaid.com or by calling 1-800-424-4489.
- Consider submitting claims electronically and signing up for electronic funds transfer (EFT).  
- Submit a clean claim form for the services that you have provided, through the Magellan provider website, through an accepted clearinghouse, or via paper claim.
- The postal address for CSOC claims is:
  Magellan Healthcare, Inc.
  P.O. Box 1286
  Maryland Heights, MO 63043
- Submit your claim for reimbursement within the limits required by the state. Magellan requires providers to submit claims within 365 calendar days of the 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.
- Not bill members for missed appointments.
- Contact the Care Management Center at 1-800-424-4489 if you are not certain which services require pre-authorization, what your reimbursement rate is, or for any questions that you have concerning claims payment.
• Refund any overpayments that you may identify, by mailing a check and documentation of the member identification number and date of service to:
  
  Magellan Healthcare, Inc.
  
  Recoveries Lockbox
  
  P.O. Box 785346
  
  Philadelphia, PA 19178-5346

**What Magellan Will Do**

Magellan’s responsibility to you is to:

• Process your claims promptly.
• Provide a toll-free number for you to call for provider assistance: 1-800-424-4489.
• Respond to your claims questions and help resolve issues.
• Review our reimbursement schedules periodically in consideration of Medicaid changes.
• Include all applicable reimbursement schedules as exhibits to your contract.
• Communicate changes to reimbursement rates in writing prior to their effective date.
• Notify you in writing with instructions for refunds when Magellan identifies that an overpayment has been made.
SECTION 5: PROVIDER REIMBURSEMENT

Claims Disputes

Our Philosophy
Magellan is committed to ensuring that providers have an avenue for redress of denied claims or payment matters. This further enhances our ability to accurately reimburse providers.

Our Policy
Magellan reviews provider-initiated disputes regarding payment of a claim, the denial of a claim, the recoupment of a payment of a claim and the imposition of sanctions.

What You Need to Do
Your responsibility is to:

- Timely file a claim dispute (appeal), if you are not satisfied with the payment of a claim, denial of claim, and recoupment of payment for a claim or the imposition of sanctions.
- Submit your claim dispute in writing within the required timeframe. Magellan requires providers to submit claim disputes within 180 calendar days of the date of the Explanation of Benefits. All claim disputes should be mailed to:
  
  Magellan Healthcare, Inc.
  Appeals and Grievances
  P.O. Box 83680
  Baton Rouge, LA 70884-3680
  1-888-656-4102 (fax)  LACSoCAppeals@MagellanHealth.com

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

- Allow you to file a claim dispute after receiving the Explanation of Benefits.
- Resolve and notify you in writing within 30 calendar days of receipt of your claim dispute.
- Extend the timeframe for completing the review by up to 30 calendar days at the request of the member, provider or Magellan.
- Notify you of the dispute resolution. We will also notify you of the next steps, which is the external administrative hearing process. All requests for an administrative hearing should be mailed directly to Division of Administrative Law, Health and Hospitals Section, P.O. Box 4189, Baton Rouge, LA 70821-4189.
SECTION 5: PROVIDER REIMBURSEMENT

National Provider Identifier (NPI) Numbers

Our Philosophy
Magellan complies with the Health Insurance Portability and Accountability Act (HIPAA) and its regulations regarding standard interface between health care organizations and providers. This includes provider attainment and use of the National Provider Identifier number.

Our Policy
The National Provider Identifier (NPI) is a 10-digit identifier that has been required on all HIPAA standard electronic transactions since May 23, 2008. NPIs replaced all separately issued identifiers, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI was put in place so that each provider has one unique, government-issued identifier to be used in transactions with all health plans with which the provider conducts business. An NPI does not replace a provider’s Taxpayer Identification Number (TIN). TINs continue to be required on all claims – paper and electronic. The NPI is for identification purposes, while the TIN is for tax purposes. **Important: claims that do not include a TIN will be rejected.**

What You Need to Do
You must apply for and use your National Provider Identifier (NPI) on all electronic transactions submitted to Magellan. There are two different types of NPI numbers: Type 1 is for health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. An individual is eligible for only one NPI; Type 2 NPIs are for health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

Organizations can choose to enumerate subparts by taxonomy/specialty, TIN or site address; however if you are an organization with a single-site address and multiple TINs, we prefer that you enumerate subparts at the TIN level. If you are an organization with multiple site addresses, we prefer that you enumerate subparts at the site address level. In other words, organizations should have
one unique NPI for each rendering service location for billing purposes. An individual practitioner is assigned only one NPI (Type 1) regardless of the number of places where he/she may practice.

How to Apply
To apply for an NPI number, there are two different options:

- For the most efficient application processing and the fastest receipt of an NPI, use the web-based NPI application process. Log on to the National Plan and Provider Enumeration System (NPPES) and apply online at: [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do).

- Or you may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) by contacting the Enumerator by phone at 1-800-465-3203 (TTY 1-800-692-2326); email [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com); or mail at NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

How to Submit
Providers should submit their NPI to Magellan by signing in with your secure username and password on the Magellan provider website ([www.MagellanProvider.com](http://www.MagellanProvider.com)), selecting Display/Edit Practice Information, and completing the NPI request field. You can also submit your NPI by mail or fax, by sending us a copy of your NPI notification letter or email from NPPES: Magellan Healthcare, Inc., Attn: Data Management, 14100 Magellan Plaza, Maryland Heights, MO 63043, Fax number: 314-387-5584.

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

- Be compliant with HIPAA’s standard coding requirements;
- Accept only compliant codes in covered electronic transactions;
- Accept only covered electronic transactions that include an NPI; and
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions.