Magellan Healthcare, Inc.

Provider Handbook Supplement for the Louisiana Coordinated System of Care

Revised November 2024

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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 (or the sites of Magellan's contracted vendors, as directed) to complete 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 may also reach us at the Magellan Baton Rouge Louisiana Care Management Center at the following number:

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

Or you may call our Magellan National Provider Services Line at 1-800-788-4005.

CSoC members can contact Magellan toll-free at: 1-800-424-4489

For members who are deaf or hard of hearing, call 7-1-1 to use the Louisiana Relay Service.

For reporting fraud and abuse contact any of the following:

- Magellan's Corporate Compliance Hotline at 1-800-915-2108 or email Compliance@MagellanHealth.com
- Magellan's Special Investigations Unit Hotline at 1-800-755-0850 or email SIU@MagellanHealth.com

Or you may report directly to:

Provider Fraud
Gainwell
SURS Department
8591 United Plaza Blvd
Baton Rouge, LA 70809
Call: 1-800-488-2917
Fax: 225-216-6129

Recipient Fraud
Louisiana Department of Health
Customer Service Unit
P.O. Box 91278
Baton Rouge, LA 70821-9278
Call: 1-833-920-1773
Fax: 225-389-2610

SECTION 1: INTRODUCTION

About the Louisiana Coordinated System of Care Program

The Coordinated System of Care (CSoC) is designed to provide services and support 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 integrates resources from all of Louisiana's child-serving agencies, including the Louisiana Department of Health (LDH), Office of Behavioral Health (OBH), Office for Citizens with Developmental Disabilities (OCDD), Louisiana 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 (WAA). 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 Medicaid Behavioral Health Service Provider Manual.

About the Louisiana Coordinated System of Care Program, cont'd

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.

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 usedin 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 Reviews

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 Medicaid Behavioral Health Services Provider Manual for services they render and should maintain proof of completion of these trainings in their personnel records on-site. For more required training information, go to the Medicaid Behavioral Health Services Provider Manual, Appendix D. Magellan is required to perform provider reviews for the Louisiana Coordinated System of Care network. The purpose of this review is to monitor compliance with licensing and training requirements, and qualifications for unlicensed direct care staff, 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.
    - Ensure agency staff completes all required trainings.
- Complete required trainings and attestation prior to service delivery.
- Understand the obligations and comply with the review request.
- Supply the requested documentation at the time of the review:
    - Prior to hire and monthly thereafter – Review the Office of Inspector General (OIG) list of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions websites to ensure employees have no exclusions.

Network Provider Training, cont'd

- Drug Screen – according to agency's policy.
- Prior to hire – LA Criminal Background Check.
- Prior to hire – Tuberculosis (TB) test, if applicable.
- Motor Vehicle Screen if staff transports members.
- Within 90 days of hire date and at least every two years or as recommended by the AHA – CPR, First Aid, and Seizure Assessment.
- Training Requirement Attestation
    - OBH required training for unlicensed direct care staff.
    - Crisis Intervention Training.
    - Cultural Competency Training.

Covered Benefits

Magellan manages the provision of clinically necessary services, pursuant to the Medicaid Behavioral Health Services Provider Manual that is available on the Department of Health website. Providers should furnish clinically necessary services in the amount, duration, and scope, as indicated on the plan of care, which 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. Provider shall render such services in accordance with federal and state regulations, law, rules, waivers, Medicaid provider policy manuals and any additional applicable provider manuals as well as Magellan policies and procedures.

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

Providers who file claims with Louisiana Medicaid and are invited to enroll, are required by federal laws to enroll in Medicaid's web-based Medicaid provider enrollment portal. 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 Handbooks).

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.
- Recredential providers every three years.

Updating Practice Information

Our Philosophy

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

Our Policy

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

Providers are required to notify Magellan and/or confirm any changes in administrative practice information using the online portal at www.MagellanProvider.com (or the sites of Magellan's contracted vendors, if directed). Providers who do not update their data when changes occur, or do not attest to data accuracy as required, may be put "on hold" for new referrals until review and attestation of data accuracy is completed.

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

What You Need to Do

Your responsibility is to:

- Promptly update changes in your administrative practice information listed below using our online form by signing in to www.MagellanProvider.com (or the sites of Magellan's contracted vendors, if directed).
- Notify us within two business days if you are unable to accept new referrals along with the associated reason. Associated reasons include, but not limited to:
    - Illness or maternity leave.
    - Practice at capacity for new patients.
    - Professional travel, sabbatical, vacation, leave of absence, etc.
- Promptly notify us of any changes to information reviewed during the credentialing process, including but not limited to:
    - Licensure or certification, including state licensing board actions on your license.
    - Denial, loss of, or any negative change in accreditation status.
    - Board certification(s).

Updating Practice Information, cont'd

  - Hospital privileges.
  - Insurance coverage.
  - New information regarding pending or settled malpractice actions.
- Promptly respond to us regarding member or other inquiries about the accuracy of your practice information, including but not limited to the information listed above. Failure to respond to inquiries regarding the accuracy of your information may impact your network participation status.
- See the Magellan Organizational and Facility Provider Supplement to this Provider Handbook for submitting changes in facility/organizational practices.
- Contact your assigned Network Management Specialist if directed to do this by the online application – some changes may require a contract amendment before you can initiate or bill for services.
- Update and maintain your Provider Profile information (enables you to enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.).
- Each time you make any changes noted above using the online PDCF or in response to any request from Magellan, it is important to attest that your data is current and accurate.
- Even if you have no changes, *Magellan requires that you review your practice information and attest that your information is correct, including appointment availability, at least quarterly.* Failure to update administrative practice information may impact your network participation status.

What Magellan Will Do

Magellan's responsibility for provider data changes is to:

- Maintain an online form for providers to review/update practice information.
- Contact you for clarification, if needed.
- Notify you when Magellan members tell us that they believe your provider data is incorrect.
- Monitor and follow up on the completion of required quarterly provider data accuracy attestations.
- Notify you if your change in information impacts your referral and/or network participation status.
- Provide a hard copy provider directory for members at their request.

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.
- 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 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. If 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. Magellan does not delegate the credentialing of CSoC providers.

What You Need to Do

Your responsibility is to:

- Complete your enrollment and screening—See Provider Enrollment Information.
- Sign a Magellan provider agreement.
- Complete Medicaid Disclosure form at MagellanProvider.com (or the sites of Magellan's contracted vendors, if directed).
- 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.
- 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.
- 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.

- Ensure completed applications and committee decision does not exceed 60 calendar days.
- Provide a copy of the executed agreement via an email notification.

Medicaid Behavioral Health Services Provider Manual

The Louisiana Department of Health (LDH) strives to make the information in the manual as accurate, complete, reliable, and as timely as possible. Providers are responsible for ensuring services are delivered in accordance with the manual and compliant with any authorities in effect on the date of service.

All mental health services must be medically necessary and the necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of their professional license and applicable state law.

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

- Medicaid Behavioral Health Services Provider Manual
- Louisiana Coordinated System of Care Medical Necessity Criteria

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 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 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 they were not present.
- Notify Magellan immediately if your site does not meet these requirements or if you have questions regarding compliance.
- Not deliver services to members in restrictive settings. The exceptions for service delivery are as follows:
  - WAA facilitation, which can be delivered for up to a 90-day period for the purposes of discharge and transition planning.
  - Parent Support and Training, which can be delivered while a member is admitted to an acute inpatient facility and/or
  - As specified in accordance with federal/state requirements or regulations.
- Participate in annual training on the home and community-based setting rule requirements, including the settings that are prohibited.
- Per LDH Health Standards Section HCBS Rule, home and community-based agencies must supervise the direct service workers (DSWs) that provide the care recipients receive. The requirement is for the supervisor of the DSW to make an onsite visit to the recipient's home to evaluate the following:
  - The DSW's ability to perform their assigned duties to determine whether recipient is receiving the services that are written in the plan of care.
  - To verify that the DSW is reporting to the home according to the frequency ordered in the plan of care.
  - To determine recipient's satisfaction with the services the recipient is receiving.

What Magellan Will Do

Magellan's responsibility 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 define cultural competency as a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions, and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

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 to refer members to providers appropriate for 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.
- Collect member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class.
- Ensure supervision of direct care staff is provided in a culturally sensitive manner that represents the cultural needs and characteristics of the staff, the service area, and the

- population being served.
- Involve the member throughout the planning and delivery of services. Ensure services are delivered in a culturally and linguistically competent manner; respectful of the member receiving services; appropriate to members of diverse racial, ethnic, religious, sexual and gender identities and other cultural and linguistic groups; and appropriate for age, development, and education.
- Participate in training on cultural competence, and obtain proof of attendance at trainings, for a minimum of three hours per year. Proof of participation should be maintained in the staff record.

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.
- Monitor cultural competence and linguistic needs, including the member's prevalent languages(s) and sign language.
- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs by collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served.
- Annually assess the cultural competence of the providers.
- Annually assess member satisfaction of the services provided as it pertains to cultural competence.

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 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.

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 period 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 or 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	1-866-430-1101
AmeriHealth Caritas	1-888-913-0364
Louisiana Healthcare Connections	1-855-369-3723
Humana Healthy Horizons in Louisiana	1-800-448-3810
United Healthcare Community Plan	1-866-726-1472

Member Access to Care, cont'd

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.

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 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 Coordinated System of Care Medical Necessity Criteria and ASAM-PPC-2R for Addiction Services.
- Prior to delivery of services, verify member eligibility via: http://www.lamedicaid.com.
- 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, 52 outpatient psychotherapy (individual, family, and/or group) sessions (contingent on eligibility), and 12 medication management sessions per year without needing prior authorization.
- Be aware that members may receive psychological testing without needing prior authorization.
- Not require a primary care physician (PCP) referral from members.
- Not require pre-certification of members for emergency services.
- Understand and comply with requirements when rendering service via telehealth as bulleted below.
    - Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician, LMHP, or other qualified professional, as determined in the Medicaid Behavioral Health Services Manual, and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.
    - The originating site means the location of the member at the time the telehealth services

are provided. There is no restriction on the originating site, and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided.

- Assessments, evaluations, individual psychotherapy, family psychotherapy, medication management, and Community Psychiatric Support and Treatment (CPST) services may be provided via telecommunication technology when the following criteria is met:
  - The telecommunication system used by physicians, LMHPs, and other qualified professionals must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
  - The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice.
  - The member's record includes informed consent for services provided using telehealth.
  - Services provided using telehealth must be identified on claims submission by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement.
  - Assessments, evaluations, and treatment planning conducted by an LMHP through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent.
  - Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services.
    - Provider must document the member's preference for in-person or telehealth.

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.

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
- Crisis Stabilization

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.

Concurrent Review, cont'd

- 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.

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 an advance directive has been executed.

Coordination of Care—Medications and Medication Screening

Our Philosophy

Magellan believes it to be imperative to provide coordination of physical and behavioral health care, including medications.

Our Policy

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.

What You Need to Do

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.

What Magellan Will Do

Coordination is monitored through the care management process and through on-site and off-site retrospective reviews of treatment records.

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 can search for a provider in several ways including but not limited to: ZIP Code, level of care, specialty, ethnicity, race, and gender.

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

- Magellan's National Provider Handbook
- *Provider Focus* Newsletter
- Provider education opportunities
- Provider demographic updates
- Roster staff updates

What You Need to Do

Review the Magellan of Louisiana website on a regular basis for updates, and sign into the provider website (or the sites of Magellan's contracted vendors, if directed) to perform secure transactions.

What Magellan Will Do

Magellan's responsibility to you is to:

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

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

Magellan maintains an internal Quality Assurance Process Improvement (QAPI) program that complies with state and federal standards specified in 42 CFR §438.200, the Medicaid State Plan and waiver applications relative to the CSoC, and any other requirements as issued by LDH. 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 their 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 laws, regulations, waiver and Medicaid State Plan requirements, the contract, and all other quality management requirements, including a procedure for formal review with site visits.
- Adhere to clinical practice guidelines as appropriate.
- Provide feedback and recommendations to improve Magellan's performance.
- Support members and their families/caregivers to submit grievances, appeals, feedback, and recommendations to improve Magellan's performance.
- Participate and cooperate fully in any monitoring and site reviews conducted by Magellan to ensure they provide services in settings that are home and community-based, as applicable.
- Participate in quality reviews and/or quality improvement activities as requested by Magellan and LDH.

What Magellan Will Do

Magellan's responsibility to you is to:

- Operate a toll-free telephone line to respond to provider questions, comments, complaints, and inquiries. That number is 1-800-424-4489.
- Establish a Quality Improvement program based on a model of continuous quality improvement using clinically sound, nationally developed, and accepted criteria.

A Commitment to Quality, cont'd

- Form a QAPI committee that meets the following requirements:
    - Be chaired or co-chaired by Magellan's Medical Director.
    - Include the appropriate Magellan staff representing the various departments of the Magellan organization including but not limited to grievance and appeal staff and Program Integrity Compliance Officer responsible for fraud, waste, and abuse activities.
    - Implement a written QAPI program description and work plan, which complies with LDH requirements as specified in our contract and is reviewed and approved by LDH annually.
    - Ensure written QAPI work plan includes:
        - Objectives for the contract year, inclusive of associated action steps and timelines.
        - Metrics and associated benchmarks for the wraparound agency scorecard.
        - A plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with NWI standards inclusive of best practice indicators approved by OBH.
    - Submit an annual QAPI evaluation to LDH that includes but is not limited to, result of QAPI activities and findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care.
- Ensure that QI processes are data-driven, including the continual measurement of clinical and non-clinical processes. These are driven by the measurement and the re-measurement of effectiveness and continuous development and implementation of improvements as appropriate.
- Have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to members with special healthcare needs.
- Collect data on race, ethnicity, primary language, gender, age, and geography (e.g.) urban/rural).
- Identify and address health disparities between population groups, such as but not limited to, quality of care, access to care, and health outcomes.
- Detect and address under-and-over-utilization of services.
- Verify members' receipt of services.
- Monitor subcontracted provider activities to ensure compliance with federal and state laws, regulations, waiver and Medicaid State Plan requirements, the contract, and all other quality management requirements, including a procedure for formal review with site visits. Site visits shall be conducted according to a periodic schedule determined by the Contractor and approved by LDH.
- Conduct peer reviews to evaluate the clinical competence, quality, and appropriateness of care/services provided to members.
- Increase the alignment of assessment and treatment with best practice standards through policies, such as increasing the use of evidence-based behavioral therapies

as the first-line treatment for attention deficit hyperactivity disorder (ADHD) for children younger than six years of age, or other methods to increase alignment with best practices for ADHD care for all children and particularly for children under age six (6).

- Support the Building Bridges initiatives aimed at increasing coordination between children's behavioral health residential programming and home and community-based services, in alignment with national best practice standards. The Contractor shall participate in planning and implementation of the Building Bridges initiative with LDH and the Integrated Medicaid Managed Care Program Plans and collaborate to develop an implementation monitoring plan and provide assistance to providers in collecting and reporting on best practice-related performance indicators. Performance indicators may include six (6) – 12 (twelve) month post-discharge outcomes data regarding successful integration into the home and community.
- Develop a performance scorecard (wraparound scorecard) for each wraparound agency to include comprehensive data on a variety of measures.
- Take appropriate action to address service delivery, provider, or other QAPI issues as they are identified.
- Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontractors, members and their families/caregivers, and providers and use the feedback and recommendations to improve performance.
- Disseminate information about findings and improvement actions taken and their effectiveness to LDH, the CSoC Governance Board, and other participating agencies, members and their families/caregivers, providers, committees, and other key stakeholders and post the information on the Contractor's website in a timely manner.
- Ensure that the ultimate responsibility for the QAPI is with the Contractor and shall not be delegated to subcontractors or network providers.
- Participate in the LDH quality committee meetings and other meetings as directed by LDH.
- Participate in the review of quality findings and act as directed by LDH. The Contractor shall submit requested materials to LDH at least three business days prior to the scheduled meeting date.
- Have systems in place to measure and improve performance in meeting the 1915 (c) waiver assurances that are set forth in 42 CFR §441.301 and §441.302, and collect data, perform data analysis, and report data for the performance measures as specified by LDH.
- Collect data, perform data analysis, and report data for the performance measures identified in the CSoC Quality Improvement Strategy (QIS) prepared by LDH and in accordance with the frequency identified in said document and the methodology approved by LDH.
- Establish and implement an ongoing program of Performance Improvement

Projects (PIPs) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240.

- Have systems in place to measure and improve performance in meeting the 1915 (c) waiver assurances that are set forth in 42 CFR §441.301 and §441.302. The Contractor shall collect data, perform data analysis, and report data for the performance measures, including direct care staff and facilities, to ensure quality of care and compliance with waiver requirements.
- Ensure that an appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.
- Submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for specialized behavioral health services.
- Survey members on an annual basis to assess member satisfaction with quality, availability, and accessibility of care and experience with his/her providers and Magellan.
- Cooperate fully in quality reviews conducted by LDH or its designee and ensure full cooperation of our network providers.
- Use quality review findings to improve the QAPI program and take action to address identified issues in a timely manner, as directed by LDH.

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.

Provider Complaint Process

Our Philosophy

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 a Provider Complaint System for providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Magellan defines a provider complaint as any verbal or written expression originating from a provider and delivered to any employee of Magellan that voices dissatisfaction with a policy, procedure, payment, or any other communication or action by Magellan. Please note member grievance and appeals filed by providers on behalf of a member are processed using our member grievance and appeals policies as outlined in this section.

What You Need to Do

To comply with this policy, your responsibility is to:

- Submit complaints to Magellan using one of the five available mechanisms:
    - Call Magellan at 1-800-424-4489 to report a complaint to any Magellan staff.
    - Fax a written complaint to 888-656-3857.
    - Access the Magellan of Louisiana website and complete the online complaint form.
    - Email a written complaint to LACSoCQI@MagellanHealth.com. If emailing protected health information to the Health Plan or (LDH), use secure e-mail.
    - Mail a written complaint to:

      Magellan of Louisiana
      Grievance and Appeals Department
      P.O. Box 83680
      Baton Rouge, LA 70884
- Notify us if you or your representatives want the opportunity to present your complaint(s) in person. We will assist you with next steps.
- Provide pertinent information to assist in investigating your complaint, such as relevant contact information (e.g., name, provider name, phone number, email, etc.), the subject of the complaint, and a description of the complaint.
- Follow procedures for escalating a complaint or contact LDH directly. This process is in place for both in-network and out-of-network providers to dispute Magellan's policies, procedures, or any aspect of Magellan's administrative functions. Additionally, you may file a complaint directly with LDH for any decision that is not unique to Magellan or if you feel you have exhausted Magellan's provider complaint system. The escalation procedures are also accessible via the Magellan of Louisiana website in the Issue Escalation and Resolution section. Procedures include:
    - Seek resolution with Magellan of Louisiana using the two-tier process that has been developed for escalation and resolution,

        - Tier 1: Contact your Network Management Specialist by phone or email, or by calling the toll-free provider line at 1-800-424-4489.
        - Tier 2: Contact your Network Management Specialist by phone or email, or by calling the toll-free provider line at 1-800-424-4489, and request to speak to our Network Management Director.
    - Document the name of the representative(s) with whom they speak or communicate along with the time and date and provide that information as issues are escalated.

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.
- Have a designated Magellan staff person, with authority, to administer and oversee the Provider Complaint System.
- Have authorized, dedicated provider support staff, called Network Management Specialists, for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint, and resolve problems. Magellan will ensure our Network Management Specialists are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf.
- Allow providers 30 days to file a written complaint and provide a description of how providers can file complaints with Magellan and the resolution timeframe.
- Allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual members or payment claims included in the bundled complaint.
- Provide written acknowledgement of provider complaint within three business days of receipt.
- Thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying Magellan's written policies and procedures.
- Resolve and provide written notification of the resolution to the provider within 30 business days of receipt. If unable to resolve in 30 business days, Magellan will provide written notification to the provider for the reason the issue has not been resolved; however, the issue must be resolved within 90 calendar days.
- Ensure a Magellan executive with the authority to require corrective action is involved in the provider complaint escalation process, as necessary.
- Give providers (or their representatives) the opportunity to present their cases in person if requested.
- Operate a system to capture, track, and report the status and resolution of all provider complaints, which includes all associated documentation, whether the complaint is received by telephone, in person, or in writing.
- Submit a monthly report of all provider complaints to LDH including the issue in the complaint.

- Address any aberrant trends identified, either internally or by LDH, which require corrective action by Magellan.

Member Grievance Process

Our Philosophy

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 a grievance system that complies with LDH contractual requirements and in accordance with state and federal law and regulation and ensures the prompt internal resolution of all grievances in accordance with all applicable state and federal laws and the Medicaid State Plan, 1915(b), and 1915(c) waivers. A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination and includes a member's right to dispute an extension of time proposed by Magellan to make an authorization decision. Examples of grievances include:

- Dissatisfaction with quality of care.
- Dissatisfaction with quality of services provided.
- Aspects of interpersonal relationships such as rudeness of a provider or a network employee or failure to respect a member's rights regardless of whether remedial action is requested.
- Dissatisfaction with network administration practices. Administrative grievances are generally those related to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

What You Need to Do

To comply with this policy your responsibility is to:

- Assist members in filing a grievance in one of the following ways:
    - By calling Magellan anytime at 1-800-424-4489. You can call 711 to use the Louisiana Relay Service.
    - Tell the person who answers the phone at Magellan that you want to assist a member to file a grievance.
    - Faxing the grievance to 1-888-656-4102.
    - Mailing the member's grievance to: Magellan of Louisiana Attention: Appeals & Grievances P.O. Box 83680 Baton Rouge, LA 70884.
    - Help the member to file the grievance at www.MagellanofLouisiana.com. Click on "For Members" and then "Member Materials." Click on "Grievances and Appeals." A form is provided on the website. Enter your information in the boxes and click "Submit" when you are finished.

What Magellan Will Do

- Ensure Magellan staff are educated concerning the importance of the grievance and appeal procedures, the rights of the member, and how to instruct a member to file a grievance/appeal.
- Assist members in completing forms and taking other procedural steps. This includes, but is

not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

- Refer all members who are dissatisfied with Magellan, its subcontractors, or its network providers in any respect to the Magellan staff authorized to review and respond to grievances and appeals and require corrective action.
- Maintain a website in which a grievance can be submitted electronically.
- Not create barriers to timely due process, which can include but are not limited to:
    - Labeling grievances as inquiries or complaints to be funneled into an informal review.
    - Failure to inform members of their due process rights.
    - Failure to log and process grievances and appeals.
    - Failure to issue a proper notice including vague or illegible notices.
    - Failure to inform of continuation of benefits.
    - Failure to inform of right to State Fair Hearing following the exhaustion of Magellan's internal appeal process.
- Allow the member or a representative or provider acting on the member's behalf, with the member's written consent, to file a grievance either orally or in writing, including online through the Magellan of Louisiana website. Grievances can be filed at any time.
- Once a grievance is received, Magellan will:
    - Acknowledge the grievance in writing within three business days from date of receipt, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, Magellan will report the grievance on our grievance log.
    - Make a good faith effort to resolve the concern at the time of the initial call or involve a supervisor or designee to resolve the issue.
    - Thoroughly investigate each member grievance using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties.
    - Resolve the grievance and provide written notification of the resolution to the grievant within 30 calendar days. Written notice to the member of the resolution of a grievance via a letter to the originator of the grievance containing, at a minimum:
        - Sufficient detail to foster an understanding of the quality-of-care resolution if grievance was a quality-of-care issue.
        - A description of how the member's behavioral healthcare needs will or have been met.
        - A contact name and telephone number to call for assistance or to express any unresolved concerns.
    - Make every effort to ensure that no punitive action will be taken against any member that files a grievance.
- When a grievance involves a quality of care (QOC) concern, Magellan will:

- Conduct follow-up with the member, family/caregiver, and/or custodial state agency, if applicable, to determine whether the immediate behavioral healthcare needs are met, which include follow-up after discharge from inpatient levels of care within 72 hours.
- Refer grievances with quality-of-care issues to the Magellan's peer review committee, when appropriate.
- Refer or report the grievance quality of care issue(s) to the appropriate regulatory agency, child, or adult protective services, and LDH for further research, review, or action, when appropriate.
- Notify LDH and the appropriate regulatory or licensing board or agency when the provider agreement with a network provider is suspended or terminated due to quality-of-care concerns.

Adverse Incident Reporting

Our Philosophy

In CSoC, an adverse incident is defined as an unexpected occurrence in connection with services provided by Magellan, or its subsidiaries, or affiliates, that led to or could have led to serious unintended or unexpected harm, loss, or damage, such as death or serious injury, to an individual receiving services through Magellan or a third party that becomes known to Magellan staff. Magellan is committed to accomplishing early identification of potential or existing risk to eliminate or mitigate risks to members and Magellan.

Our Policy

Magellan requires providers to provide written notification within 24 hours of becoming aware of the occurrence of a reportable adverse incident, including the use of restraints and/or seclusions.

What You Need to Do

To comply with this policy your responsibility is to:

- Complete Adverse Incident training as part of new provider orientation.
- Know the definitions of reportable incidents. Definitions and instructions on how to file adverse incidents are accessible on the Magellan of Louisiana website.
- Ensure all provider staff comply with state and/or federal regulations for mandated report of child or adult abuse, neglect, exploitation, and extortion.
- Comply with the member's right to be free of restraints and seclusions during the delivery of waiver services. Magellan does not permit or prohibits the use of restraints during the delivery of waiver services.
- Notify Magellan within 24 hours of the discovery of a reportable incident involving a Louisiana CSoC member, whether it occurs at the provider's location or at another location.
- Report any incidents of child or adult abuse, neglect, exploitation, and extortion to Magellan and the appropriate regulatory body (e.g., Department of Child and Family Services (DCFS), Office of Aging and Adult Services, police, etc.) within 24 hours of the discovery.
- Participate in the investigation of any adverse incident and complete corrective actions as needed.

Providers can use the Magellan Adverse Incident Reporting Form located on our website or a form of your choice if 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.
- Report individual-level remediation actions taken for critical incidents involving substantiated abuse, neglect, exploitation, and death to LDH.

Treatment Record and 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 the behavioral health record documentation of providers 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 that record keeping practices are fully compliant with all requirements outlined in the Medicaid Behavioral Health Services Manual.
- Maintain administrative, personnel, and member records for whichever of the following time frames is longer:
    - Until records are audited, and all audit questions are answered; or
    - Six years from the date of the last payment period.
    - NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements, and copies of the required documents transferred to the new agency.
- Ensure all records, including administrative and member records, must be the property of the provider and secured against loss, tampering, destruction, or unauthorized use.
- Safeguard the confidentiality of member records and any information that might identify the members or their families.
- Make all administrative, personnel and member records available to LDH, or its designee, and appropriate state and federal personnel always.
- Have a separate written record for each member served by the provider.
- Have adequate documentation of services offered and provided to members they serve for the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received. This documentation should be an on-going chronology of activities undertaken on behalf of the member.
- Ensure the organization of individual member records and the location of documents within the record is consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.
- Ensure that all entries and forms completed by staff in member records is legible, written in ink (not black) and include the following:
    - The name of the person making the entry.
    - The signature of the person making the entry.

  - The functional title, applicable educational degree and/or professional license of the person making the entry.
  - The full date of documentation.
  - Reviewed by the supervisor, if required.
- Maintain a behavioral health record for each member served which includes, minimally, the following:
  - Member Rights - reviewed, signed by, and given to the member and/ or responsible party, if applicable:
    - Psychiatric advanced directive and Medical advanced directive.
    - Consent for treatment/Informed consent.
    - Informed consent to deliver telemedicine/telehealth services. The consent form must include the following:
      - Rationale for using telemedicine/telehealth in place of in-person services.
      - Risks and benefits of the telemedicine/telehealth, including privacy-related risks.
      - Possible treatment alternatives and those risks and benefits.
      - Risks and benefits of no treatment.
- Rights to confidentiality must be reviewed, signed by, and given to the member and/or responsible party, if applicable.
- Name and date of birth of the member (Note: Each page of the record shall have a member identifier such as member name, member initials, member's client ID number, etc.).
- Primary language spoken by the member and any translation needs of the member.
- Documentation of freedom of choice (e.g., Freedom of Choice form), particularly regarding choice between institutional and waiver services.
- Social security number of the member.
- Address of the individual.
- Dates and time of service.
- Assessments, including the member's most recent Independent Behavioral Health Assessment (IBHA) and Child and Adolescent Needs and Strengths (CANS) evaluation (as retrieved from the member's Wraparound Agency).
- Documentation of referrals including follow-up and outcome of referrals.
- Documentation of emergency and/or after-hours encounters and follow-up.
- Other member assessments as required by LDH.
- Treatment plans or Plan of Care (if required), based on and consistent with the assessment, which include at a minimum:
  - Indication if treatment plan is an initial or an updated treatment plan.
  - Goals and objectives, which are specific, measurable, action oriented, realistic, and time-limited.
  - Specific interventions.
  - Service locations for each intervention.
  - Staff providing the intervention.
  - Estimated frequency and duration of service.
  - Signatures of the licensed mental health professional (LMHP), member, and

responsible party, i.e., guardian/caregiver, if applicable.
    - Updated when there are significant life changes, achieved goals, or new problems identified.
    - Progression made towards all goals.
- Progress notes.
- Units of services provided.
- Crisis plan.
    - Crisis plan must be directed by the member and/or the responsible party, i.e., guardian/caregiver, if applicable. Crisis plan must include signatures of the member and/or the responsible party, i.e., guardian/caregiver, if applicable.
- Continuity and coordination of care:
    - The record includes the primary care physician (PCP) name, address, phone number, and documentation of continuity and coordination of care between PCP and the member's treating provider.
    - The record includes the member's Wraparound Agency (WAA), any other treating behavioral health clinician's name, address, phone number, and documentation of continuity and coordination of care between any other treating behavioral health clinician's and the member's treating provider.
    - The record includes documentation of any referrals made on behalf of the member, if applicable.
    - The record must include a signed Release of Information form by the member and/or responsible party, i.e., guardian/caregiver, if applicable, for communication and coordination of care with the member's Wraparound Agency and PCP, at a minimum, to occur; if member and/or responsible party refuses, then this refusal must be noted within the record.
- Medication management, if applicable:
    - The record must indicate the following:
        - Medication name.
        - Medication type.
        - Medication frequency of administration.
        - Medication dosage.
        - Person who administered each medication.
        - Medication route.
        - Ordered lab work that has been reviewed by the clinician ordering the lab work as evidenced by date and signature of clinician.
        - Evidence of member education on prescribed medication including benefits, risks, side effects, and alternatives of each medication.
        - Signed consent for psychotropic medications by the member and/or responsible party, i.e., guardian/caregiver, if applicable; if member and/or responsible party refuses, then this refusal must be noted within the record.
        - AIMS (Abnormal Involuntary Movement Scale) preformed when appropriate (e.g., member is being treated with antipsychotic medication).
        - Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs, and

chronic conditions to document ongoing monitoring.
    - Documentation of monitoring medication adherence, efficacy, and adverse effects.
- Discharge plan.
    - Appointment date and/or time period of follow up with transitioning behavioral health provider and/or primary care physician, if medical comorbidity is present, must be documented on the discharge plan.
    - Provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care.
    - Provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication.
    - Provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care.
    - Medication profile, if applicable, provided to outpatient provider and to member during transition of care. Provider must document any barriers while reviewing the transition of care with member or while providing the medication profile to the outpatient provider.
- When a member signs the assessment and treatment plans electronically, ensure the member's electronic signature will be deemed valid under federal law if it is authorized by state law. Under the Louisiana Uniform Electronic Transactions Act, La. R.S. 9:2601 et seq. ("LUETA") an electronic signature is valid if:
    - Signer intentionally, voluntarily agrees to electronically sign the document.
    - Electronic signature is attributable to signer (i.e., be sure to have patient's printed name under signature).
    - Appropriate security measures are in place which can authenticate the signature and prevent alteration of the signature (i.e., date and signature cannot be modified in the electronic health record).
- Ensure service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered. The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:
    - Name of member.
    - Name of provider and employee providing the service(s).
    - Service provider's contact telephone number.
    - Date of service contact.
    - Start and stop time of service contact.
    - Content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement.
- Ensure a sample of the service/progress notes for each member seen by a non-LMHP is reviewed by an LMHP supervisor at least monthly or more if needed. The signature of the LMHP attests to the date and time that the review occurred.
- Provider's treatment record documentation must match all submitted claims and align with

service billed on the claim (e.g., diagnosis, DOB, procedure code).

- Ensure service/progress notes clearly document that the services provided are related to the member's goals, objectives, and interventions in the treatment plan, and are medically necessary and clinically appropriate.
- Ensure each service/progress note documents the specific interventions delivered including a description of what materials were used when teaching a skill, including each member's response to the intervention, noting if progress is or is not being made – e.g., observed behaviors, if applicable and a plan for the next scheduled contact with the member.
- Ensure each service/progress note includes sufficient detail to support the length of the contact, with sufficient specificity so a third party will understand the purpose of the contact and supports the service and claims data.
- Ensure the only staff who complete a service/progress note are the staff who delivered the service. It is not permissible for one staff to deliver the service and another staff to document and/or sign the service notes.
- If required, provide a progress summary that synthesizes all activities and services for a specified period (at least every 90 days or more often if required by Magellan) which addresses each member's assessed needs, progress toward the member's desired personal outcomes, and changes in the member's progress and service needs. Progress summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. Progress summaries must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.
- Provide one (1) free copy of any part of member's record upon member's request.

What Magellan Will Do

Magellan's responsibility to you is to:

- Conduct Treatment Record Reviews or reviews of member medical and treatment records using a Licensed Mental Health Professional to:
    - Verify that services for which reimbursement was made were provided to members.
    - Identify and overcome barriers to care that a member may encounter.
    - Ensure that providers render high-quality healthcare that is documented according to established standards.
- Ensure that treatment record reviews address the following:
    - Quality of care consistent with professionally recognized standards of practice.
    - Adherence to clinical practice guidelines.
    - Member rights and confidentiality, including advance directives and informed consent.
    - Cultural competency.
    - Patient safety.
    - Compliance with waiver requirements.
    - Compliance with adverse incident reporting requirements.
    - Appropriate use of restraints and seclusion, if applicable.

Treatment Record and Documentation, cont'd

  - Treatment planning components, including criteria to determine if the treatment plan includes evidence of implementation as reflected in progress notes and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member.
  - Continuity and coordination of care, including adequate discharge planning.
  - Adherence to SAMHSA Peer Worker Core Competencies for FSO peer staff (applicable for the Family Support Organization Only).
- Ensure that appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes are made in a timely manner.
- Submit quarterly reports which summarize results of treatment record reviews and corrective actions taken for specialized behavioral health services.

Appeal Procedures

Our Philosophy

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

Our Policy

Magellan maintains an appeal process and access to the State Fair Hearing system once Magellan's appeal process has been exhausted in accordance all applicable federal, state, and contract requirements. Magellan defines an adverse benefit determination as the denial, reduction, suspension, delay, or termination of a request for admission, availability of care, continued stay or other health care service upon review by Magellan of the information provided that the requested service does not meet Magellan's requirements for medical necessity, appropriateness, health care setting, and/or level of care or effectiveness. An appeal is defined as a review by Magellan of an adverse benefit determination. Specific examples include:

- The denial or limited authorization of a requested service, including the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service not including claims denied in whole or in part due to not meeting the definition of a clean claim.
- The failure to provide services in a timely manner as defined by the LDH.
- The failure of Magellan to act within the timeframes provided regarding the standard resolution of grievances and appeals.

What You Need to Do

To comply with this policy your responsibility is to:

- Have knowledge of Magellan's procedures for filing an appeal.
    - Support members in filing an appeal on their behalf. Appeal by phone, fax, email, or mail as detailed below:
        - Call Magellan at 1-800-424-4489.
        - Fax the Request for Appeal form to 1-888-656-4102.
        - Email the Request for Appeal form to LACSoCAppeals@MagellanHealth.com
        - Mail the Request for Appeal form to:

          Magellan of Louisiana
          Grievance and Appeals Department
          P.O. Box 83680
          Baton Rouge, LA 70884
        - Submit the request for appeal online through the Magellan of Louisiana website via an electronic appeal form.
- Obtain and submit the member's written consent when filing an appeal on behalf of the

member. Magellan will only process an appeal filed by a provider on behalf of the member if they have obtained and submitted the member's written consent with the appeal request. Refer members to their Notice of Appeal Resolution for information on how to ask for a State Fair Hearing if Magellan upholds the original adverse benefit determination. A State Fair Hearing must be requested by the member within 120 calendar days from the date of the Notice of Appeal Resolution. In addition to the Notice of Appeal, providers can direct members to their Member Handbook for information on when and how they can request a State Fair Hearing.

What Magellan Will Do

Magellan's responsibility to you is to:

- Ensure Magellan's staff are educated concerning the importance of the appeal procedures, the rights of the member, and how to instruct a member to file an appeal.
- Not create barriers to timely due process, which can include but are not limited to:
    - Labeling grievances as inquiries or complaints to be funneled into an informal review.
    - Failure to inform members of their due process rights.
    - Failure to log and process grievances and appeals.
    - Failure to issue a proper notice including vague or illegible notices.
    - Failure to inform of continuation of benefits.
    - Failure to inform of right to State Fair Hearing following the exhaustion of Magellan's internal appeal process.
- Allow the member, a representative acting on the member's behalf, or network provider, with the member's written consent, to request an appeal either orally or in writing. To process an appeal:
    - The appeal must be requested within 60 calendar days from the date on the Notice of Action.
- Maintain a website in which an appeal can be initiated via an electronic appeal form.
- Assist members in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
- Send a written acknowledgement of the appeal request within three business days of receipt.
- Provide the member reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Provide the member an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process, and any new or additional evidence considered, relied upon, or generated by Magellan in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the date by which Magellan must resolve the appeal.
- Ensure that the individuals who make appeal decisions:
    - Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.

    - Have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease.
- Consider all comments, documents, records, and other information submitted by the member or member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Not take any punitive action against any provider that requests or supports an appeal.
- Resolve an appeal and provide written notice, as expeditiously as the member's health condition requires, but no later than the timeframes established below:
    - For standard resolution of an appeal and notice to the affected parties, the timeframe is 30 calendar days from the day the appeal is received.
    - For expedited resolution of an appeal and notice to affected parties, the timeframe is 72 hours after receipt of the appeal.
- At the request of the member or if Magellan believes that there is need for additional information and the delay is in the member's interest, Magellan will extend the timeframe for completing appeals by up to 14 calendar days.
- Provide written notice to the member of the resolution of the appeal, which complies with all state, federal regulations, and LDH requirements and includes the results of the resolution process and the date it was completed. When the appeal is not resolved wholly in favor of the members, the written notice will also include:
    - The right to request a State Fair Hearing, and how to do so.
    - The right to request to receive benefits while the hearing is pending, and how to do so.
    - Notice that the member may be held liable for the cost of those benefits if the hearing decision upholds Magellan's action.
- Allow an expedited review process when the member or the treating provider, on behalf of 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. The member, the member's representative, or the member's provider acting on their behalf and with the member's prior written consent, may file an expedited appeal either orally or in writing. Expedited appeals will be completed, and written notification sent within 72 hours of the request. In addition, Magellan will make reasonable efforts to provide oral notice to the member within 72 hours of the request. In cases in which Magellan denies a request for expedited resolution of appeal, Magellan will:
    - Resolve the appeal within 30 calendar days from the day after appeal is received and inform all parties of Magellan's resolution in writing.
    - Make reasonable efforts to give the member prompt oral notice of the denial of request for expedited resolution and follow up within two calendar days with a written notice.
    - Not record the denial of a request for expedited resolution of appeal as an adverse benefit determination or require a Notice of Adverse Benefit Determination.
    - Allow the member to file a grievance in response to the denial of a request for

expedited resolution of an appeal.

- Continue the member's benefits while an appeal request is being reviewed as bulleted below. A provider may not request continuation of benefits for the member.
    - The member files the appeal timely in accordance with 42 CFR §438.420(c)(1)(ii) and (c)(2)(ii).
    - The appeal involves the termination, suspension, or reduction of previously authorized services.
    - The services were ordered by an authorized provider.
    - The period covered by the original authorization has not expired.
    - The member timely files for continuation of benefits.
- If the member's benefits, at the member's request, are continued or reinstated by Magellan while the appeal is pending, the benefits will continue until one of following occurs:
    - The member withdraws the appeal or request for State Fair Hearing.
    - The member fails to request a State Fair Hearing or continuation of benefits within 10 calendar days after Magellan mails the notice of adverse resolution to the member's appeal.
    - A State Fair Hearing Officer issues a hearing decision adverse to the member.
- Authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination when Magellan or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.
- Pay for those services when Magellan or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.
- Provide the information specified in 42 CFR §438.414 about the grievance and appeal system to all Subcontractors and network providers at the time they enter a provider agreement or subcontract.
- Make retrospective review determinations within 30 calendar days of receipt of sufficient medical information necessary to decide if the provider had no way of knowing that the member was eligible for services under Magellan. If the 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 must be submitted to Magellan no later than 180 days after the date of service.
- Not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission, or the provider misrepresented the member's health condition.

Site Visits

Our Philosophy

Site reviews are a joint responsibility of Network Management and Quality Improvement staff depending on the cause of the site visit. Administrative reviews may be conducted by non-clinicians while treatment record reviews evaluated for clinical care and services conducted are performed by licensed clinicians.

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 quality reasons or non-accreditation, as applicable based on provider type.

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.
- 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.
- Work with you to develop a corrective action plan, if required.

Member and Provider Satisfaction

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 several 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.

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.
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, after 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 U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database and the LDH Adverse Action website located at https://adverseactions.ldh.la.gov/SelSearch, or HHS-OIG LEIE website at 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 U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database, HHS-OIG LEIE at http://www.oig.hhs.gov/, the SAMS at https://www.sam.gov/SAM/ and the LDH Adverse Action website located at https://adverseactions.ldh.la.gov/SelSearch.
- 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.
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 1-833-920-1773 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
   Provider Fraud Complaint
   Gainwell-SURS Department
   8591 United Plaza Blvd
   Baton Rouge, LA 70809

   Member Fraud Complaint
   Louisiana Department of
   Health Customer Service Unit
   P.O. Box 91278
   Baton Rouge, LA 70821-9278

4. Fax the completed form (above) to 225-216-6129 for provider fraud complaint or 225-389-2610 for member fraud complaint. You can report anonymously.

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.
- Providing 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, and policies and procedures for compliance with Medicaid's and Louisiana Department of Health's requirements, including but not limited to:

- Licensing Rules.
- Licensed Mental Health Professionals and Unlicensed Direct Care Staff Qualifications and Training Requirements.
- Crisis Mitigation Plan.
- Accreditation, if applicable, core staffing requirements and regularly scheduled supervision of unlicensed staff by Licensed Mental Health Professional.
- Appointment Availability Standards.
- Policies and procedures for supporting compliance with HIPAA privacy and confidentiality requirements for Protected Health Information (PHI), drug testing and transporting of members.
- Home and Community Based Setting (HCBS) Rule Requirements (waiver services providers only).
- Policy for direct service worker supervisor to conduct onsite visits to recipient's home in accordance with licensing requirements and evidence of adherence. (Short Term Respite providers only).
- Initial and monthly review of the Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), including licensed and unlicensed staff.
- Initial and monthly review of the LDH State Adverse Actions website, including licensed and unlicensed staff.

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 and Provider Handbook Supplement for the Louisiana Coordinated System of Care.
    - Drug Screens according to agency's policy.
    - Prior to hire, conduct a LA Criminal Background Check.
    - Prior to hire, obtain a Tuberculosis (TB) Test, as applicable.
    - Motor Vehicle Screen according to transportation policy.
- Within 90 days of hire date and at least every two years or as recommended by AHA – CPR, First Aid, and Seizure Assessment.
- Ensure LMHP and unlicensed direct care staff all meet requirements.

Network Monitoring, cont'd

- Review and become familiar with the required provider trainings, by going to https://www.magellanoflouisiana.com/for-providers/training-and-events/provider-training-requirements/.
- Ensure agency staff completes all required trainings.
- Complete required trainings and attestation prior to service delivery.
- Ensure the human resources records include all qualifications and training requirements as outlined in the Medicaid Behavioral Health Services Provider Manual and are:
    - Accurate and legible.
    - 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 monitoring review.
    - Readily available for review.
    - Compliant for all requirements.
- Participate in all Network Monitoring requests and complete all remedial activities timely as prescribed by Magellan.
    - 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.
    - Provider non-compliance will lead to actions including being placed on a hold from receiving new referrals and termination for cause from the network. It should be noted that termination for non-compliance will be made with the approval of Magellan's Medical Director. This type of provider termination does not require the oversight and approval of Magellan's Regional Network Credentialing Committee (i.e., the provider peer committee).

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 payments for services rendered by 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 a direct care staff that does not meet qualification and training requirements as a false claim.
    - Magellan is required by the Louisiana Department of Health and Medicaid to recoup false claims as delivered by direct care staff not meeting requirements.

SECTION 5: PROVIDER REIMBURSEMENT

Submission of Claims

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:

- Check Medicaid member eligibility via http://www.lamedicaid.com.
- Verify member CSoC eligibility via Log In to Availity®.
- Contact the Magellan Care Management Center at 1-800-424- 4489 for Hospitalization, Crisis Stabilization and Crisis Intervention Follow Up.
- Obtain Authorizations for Multi-Systemic Therapy (MST), Assertive Community Treatment (ACT), CPST, PSR, FFT, Homebuilders, IOP Substance Abuse, Independent Living Skills Building, and Short-Term respite through the Plan of Care. Additional information can be found here: New Provider Orientation.
- Regular Routine Outpatient Therapy, Medication Management, and Psychological Testing will not require an authorization until the fifty-two (52) pass through service limits have been utilized.
- Consider submitting claims electronically and signing up for electronic funds transfer (EFT).
- Ensure services provided using telehealth are identified on claims submission by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement. For additional information on claim specific information, refer to the New Provider Orientation.
- Submit a clean claim form for the services that you have provided, through the Magellan provider website (or the sites of Magellan's contracted vendors, if directed), through an accepted clearinghouse, or via paper claim. *Note:* A clean claim is a claim that has no defect or impropriety (including any lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment of the claim. For additional claims submission guidance and examples, refer to the New Provider Orientation and Getting Paid. 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. Providers must submit claims within 365 calendar days of the date of service or discharge.

- Bill using your contracted Taxpayer Identification Number.
- Submit claims with agency NPI as the billing provider and licensed or unlicensed staff NPI as the rendering provider.
- Maintain up-to-date roster staff to avoid claim processing delays and/or denials.
- 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.
- Do not bill members for missed appointments.
- Contact Magellan 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.
- Pay or deny 90% of clean claims within 15 business days of claim receipt and by 30 days of receipt 99% of all clean claims will be paid.
- 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.

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 30 calendar days of the date of the Explanation of Benefits. All claim disputes should be mailed to:

  Magellan of Louisiana 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.
- Provide a second level appeal option to request binding arbitration, within 30 days of first level appeal notice of determination, for claims that have denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that providers training and certification in alternative dispute resolution. The arbitrator will conduct a hearing and issue a final ruling within 90 calendar days of being selected unless an extension is agreed upon. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.
- Submit your second level appeal to:

  Magellan of Louisiana, Inc. Appeals and Grievances
  P.O. Box 83680

Baton Rouge, LA 70884-3680
1-888-656-4102 (fax)
LACSoCAppeals@MagellanHealth.com (email)

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 healthcare 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. All staff providing Outpatient Therapy, Medication Management, Multi-Systemic Therapy (MST), Assertive Community Treatment (ACT), Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Crisis Intervention, Functional Family Therapy (FFT), Homebuilders, Independent Living Skills Building and Short-Term respite must have an NPI to render services.

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 they 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.

National Provider Indentifier, cont'd

- 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/TDD 1-800-692-2326); email customerservice@npienumerator.com; or mail at NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

How to Submit

Providers can submit their NPI to Magellan by signing in securely at www.MagellanProvider.com (or the sites of Magellan's contracted vendors, if directed), and entering it into the practice data information form.

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, PO BOX 1899, 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.
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions.