Magellan Behavioral Health of Pennsylvania, Inc.*

Provider Handbook Supplement for HealthChoices' Program Providers for Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties

* Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Magellan Behavioral Health of Pennsylvania, Inc.; and their respective affiliates and subsidiaries are affiliates of Magellan Health, Inc. (collectively "Magellan").

Magellan HEALTHCARE

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*To access Appendix A "Forms and Processes" as well as Appendix B "County Specific Forms" please go to: http://www.magellanprovider.com/news-publications/state-plan-eap-specific-information/pennsylvania-healthchoices/supplement-appendices.aspx

SECTION 1: INTRODUCTION

Welcome

Welcome to Magellan Behavioral Health of Pennsylvania, Inc. (Magellan). This Provider Handbook Supplement is designed to give Magellan network providers specific information on the delivery of behavioral health care services to members of the HealthChoices' Program in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties in Pennsylvania. Only providers that are actively enrolled for the provider type and specialty at the appropriate service location are eligible to receive Medicaid reimbursement. If you are not contracted with Magellan and are accessing this handbook for information regarding a non-participating agreement, the requirement of active MA enrollment extends to all services and providers that are accessed by our members.

This handbook supplements the Magellan Health, Inc. National Provider Handbook, addressing policies and procedures specific to the HealthChoices' Program for members in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties. It should be used in conjunction with the national handbook. When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, policies and procedures in this supplement prevail.

It is important that providers review this supplement and follow its procedures when providing services to members in the HealthChoices' Program. This supplement provides information from Magellan on authorization procedures, clinical and administrative systems, and documentation requirements. It is to be used with the:

- Department of Human Services' (DHS') Medical Necessity Criteria (available at https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/2023%20Updated%20Documents/12.2022%20HC%20BH%20Appendices%201-1-23.pdf)
- Magellan supplemental Medical Necessity Criteria (available at https://www.magellanofpa.com/documents/2021/07/mnc-full-mnc-guidelines.pdf/)
- American Society of Addiction Medicine (ASAM) (Appendix A)
- Adolescent Patient Placement Criteria of the American Society for Addiction Medicine, Second Edition [ASAM-PPC-2])

Provider Orientation

Magellan has developed a comprehensive training webinar to give Magellan network providers specific information on the delivery of behavioral health care services to members of the HealthChoices' Program in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties in Pennsylvania. The training is intended to complement this Pennsylvania HealthChoices'

Program Provider Handbook Supplement and the Magellan Health, Inc. National Provider Handbook. The training provides information from Magellan in the following areas: network, contracting and billing; levels of care overview; authorization procedures; clinical and administrative systems; provider performance monitoring; complaints and grievances; customer service support; member eligibility; fraud, waste and abuse; documentation requirements and effective compliance programs. We designed it for providers who are new to Magellan; but it also has proven to be a helpful overview for more tenured providers who want to refresh their knowledge of Magellan's policies and procedures. We share it with providers during the contracting process. It can also be obtained at any time by contacting a member of our team. We also encourage you to visit our Pennsylvania-specific website at www.MagellanofPA.com, for additional information on Compliance, Training, and county-specific information.

We look forward to working with you in the delivery of quality behavioral health care services to HealthChoices' members in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties.

Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our provider website at www.MagellanProvider.com. You can update your specialty services and languages offered, in addition to completing other key provider transactions. We have designed our website for you to have easy and quick access to information and answers to questions you may have about Magellan. You can look up authorizations and verify the status of a claim through Availity Essentials. Additional information can be found at www.MagellanProvider.com/Availity.

You can also reach us at the Magellan Cambria, Yardley, and Lehigh Valley Pennsylvania Care Management Centers at the following numbers:

Bucks and Montgomery Counties Provider Services Line: 1-877-769-9779

Cambria County Provider Services Line: 1-800-424-3711

Lehigh and Northampton Counties Provider Services Line: 1-866-780-3368

***Members may contact Magellan at*:**

Bucks County Member Services Line
1-877-769-9784

Cambria County Member Services Line

1-800-424-0485

Lehigh County Member Services Line
1-866-238-2311

Montgomery County Member Services Line
1-877-769-9782

Northampton County Member Services Line
1-866-238-2312

For members who are deaf, hard of hearing, or have difficulty speaking, you may call the Pennsylvania Relay Operator at 711 to get help communicating with Magellan.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Network Provider Participation

Contracted providers for the Pennsylvania HealthChoices' network are required to be actively enrolled with the Pennsylvania Medical Assistance Program for their contracted provider type and specialty, at the approved OMHSAS service location. If you anticipate moving a contracted service location, please notify your Magellan network management specialist immediately, to discuss the appropriate actions needed to transition your contract and MA enrollment.

Medical Assistance Enrollment Procedures

- To be eligible to enroll, providers must be licensed and currently registered by the appropriate state agency.
- To enroll, you must complete a provider enrollment application and any applicable addenda documents, dependent on the provider type, prior to serving HealthChoices' members.
- Base Medicaid Applications are available at the following website address: https://provider.enrollment.dpw.state.pa.us/Home/.
- The Primary Contractor (County) or the Behavioral Health MCO (Magellan) may develop or purchase In Lieu Of or In Addition To services that are not State Plan Services. These In Lieu Of Medicaid services must be approved by Magellan and the appropriate county behavioral health office.
- If you move locations, you must complete a new application prior to starting services for the HealthChoices' population.
- If you are adding a new service to an existing location, you must complete a new application.
- To terminate association (fee assignment) with a provider group by an individual, you must complete a service location change request form.
- To add or terminate participation with a Provider Eligibility Program (PEP), you must complete a service location change request form.
- See the State's website for instructions for the PROMISe™ Provider Service Location Change Request. (Note: This is for a location change, not for adding a new service location.) You must complete a new Provider Enrollment Application or New Service Location Application, as applicable, to add a new service location where recipient services are provided.
- DHS requires that all providers re-enroll every five years by submitting a fully completed Pennsylvania PROMISe™ Provider Enrollment Application and any required additional

documentation/information, based on provider type, for every active and current service location.

- Please be sure to follow these procedures to avoid any interruption in reimbursement from Magellan. For assistance with provider types and required applications you should submit, please contact your local network management specialist.

Contracting with Magellan Health

To be eligible to accept referrals and to receive reimbursement for covered services rendered to HealthChoices' 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.

Existing contracted providers may not be eligible to expand services while they are under a corrective action plan, or the provider has a change in licensure status (e.g., a provisional status).

All new In Lieu Of and In Addition To Services require approval and letters of support from both Magellan and the Primary Contractor (County) prior to changing an approved program description.

Credentialing/Recredentialing

Magellan and its providers must adhere to credentialing requirements under the Pennsylvania Department of Health Regulations, Chapter 9, Managed Care Regulations, Subchapter G, Section 9.761 and 9.762. In establishing and maintaining the provider network, Magellan has established written credentialing and recredentialing criteria for all participating provider types.

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. Magellan's network providers are required to participate in Magellan's credentialing and recredentialing processes, and must meet Magellan's credentialing criteria (refer to the appendix in the Magellan National Provider Handbook). Some organizations and agencies for the HealthChoices' Program are credentialed pursuant to standards specific to the HealthChoices' Program.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Obligations of Provider

As outlined in your Magellan Medicaid Addendum

Provision of Covered Services to Enrollees

Provider shall be available to accept referrals of Enrollees from Magellan for Covered Services within the scope of Provider's practice. Provider shall render such services in accordance with the terms of the Agreement, this HealthChoices' Medicaid Addendum, any applicable provider manual and Magellan's Policies and Procedures. Provider agrees to render all Covered Services in his/her office or in such other facilities and locations as are mutually agreed to by the parties hereto. Provider shall not discriminate against Enrollees on the basis of health status or need for health care services or on the basis of race, color, gender identity, sexual orientation, or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color, gender identity, sexual orientation, or national origin.

Compliance with the Americans with Disabilities Act

Provider and Magellan agree to comply with The Americans with Disabilities Act (ADA) of 1990 (Pub. L. 101-336), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Justice (28 CFR 35.101 et seq.), to the end that in accordance with the Act and Regulation, no person in the United States with a disability shall, on the basis of the disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which the Contractor receives Federal financial assistance under your contract including, but not limited to, communication disabilities such as deafness, hard-of-hearing, blindness or low vision. Providers are additionally responsible to have accommodating service locations for members who have physical disabilities.

The ADA requires public accommodations to make reasonable modifications in policies, practices, and procedures for individuals with physical or intellectual disabilities, which includes facilitating effective communication with individuals who have vision and/or auditory limitations by providing appropriate auxiliary aids and services, such as sign language interpreters and alternative formats. The Pennsylvania Medical Assistance (MA) Program, which receives federal financial participation, pays enrolled providers for Medicaid services. MA enrolled providers are considered covered entities due to their receipt of federal Medicaid funds. As such, MA providers must comply with the regulations and requirements related to services to individuals with LEP, vision limitations, and/or auditory limitations, including providing interpretation and translation services free of charge to MA beneficiaries.

Hours of Operation

Network providers must offer hours of operation to Pennsylvania HealthChoices' members that are no less than the hours of operation they offer to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

Magellan's *e*MbraceCare Care Model

Magellan's branded, clinically driven care model, ***e*MbraceCare,** uses a **person-centered approach** that is designed to support an individual's achievement of improved personal health outcomes and wellness, **by encouraging positive living,** along with the provision of services that meet the individual's needs in a whole health manner. Positive living, the ultimate goal of *e*MbraceCare, is a lifelong process for individuals experiencing behavioral and substance use disorders that includes incorporating all of the **Substance Abuse and Mental Health Services Administration's (SAMHSA's) Eight Dimensions of Wellness**[1] into their lives. These *Eight Dimensions of Wellness* include the following:

- **Emotional** - Coping effectively with life and creating satisfying relationships.
- **Environmental** - Achieving good health by occupying pleasant, stimulating environments that support well-being.
- **Financial** - Satisfaction with current and future financial situations.
- **Intellectual** - Recognizing creative abilities and finding ways to expand knowledge and skills.
- **Occupational** - Achieving personal satisfaction and enrichment from one's work.
- **Physical** - Recognizing the need for physical activity, healthy foods, and sleep.
- **Social** - Developing a sense of connection, belonging, and a well-developed support system.
- **Spiritual** - Expanding a sense of purpose and meaning in life.

Through Magellan's **person-centered** and **predictive** clinical model, we address the care of the complete individual using *e*MbraceCare, which reflects our commitment to personalized care. This approach begins with the assurance that our clinical staff honors self-determination, direction, and control over an individual's recovery planning process, as part of the treatment paradigm.

Within this care model, the focal point is a service delivery system that takes into account the individual's strengths, in addition to his or her identified behavioral health, physical health, socio-economic, and communal needs. This model builds and improves upon the *Eight Dimensions of Wellness* at the time of entry into and throughout treatment.

*e*MbraceCare engages the individual in identifying and accessing a menu of services and supports that enable him/her to actively engage in and manage his/her own wellness and

[1] http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness

effectively navigate the system of care. Rather than a traditional utilization management model, Magellan's *e*MbraceCare model takes a proactive approach to wellness and recovery.

Magellan's ***e*MbraceCare team members** coordinate services and offer tools that tap into available supports, such as employment assistance programs, health and wellness programs, community services, and peer and parent support that enhance the individual's ability to achieve overall wellness. Services are customized to the individual and changed based on the individual's evolving needs.

At Magellan, we know that recovery is real. Our care management process fully supports and enables a tailored recovery experience, with the ultimate goal of helping each individual to achieve all dimensions of wellness and ***embrace positive living***.

Community Intensive Care Coordination (ICC)

Magellan and its partner counties of Bucks, Cambria, Lehigh, Montgomery, and Northampton offer an intensive care management program for adults, in which a plan is developed to organize treatment resources to better meet the needs of members with multiple needs. The purpose of the program is to identify and coordinate treatment services and other community supports so the member can have continuity of care, better address recovery goals, strive to achieve increased independence, and have better community integration. These goals are measured by increased community tenure, with no hospitalizations for at least 90 days. Although the criteria for admission into the program focuses mainly on the readmission of people with mental health disorders, people with co-occurring mental health and substance use disorders and people with mental health and intellectual disabilities (MH-ID) are also included. Also eligible for these services are:

- Members with two or more admissions to an acute inpatient or residential level of treatment within 60 days, with a diagnosis of schizophrenia or bipolar disorder
- Pregnant women with a substance use disorder.
- Members who are dually diagnosed with MH-ID, with two or more admissions to acute inpatient care or two or more crisis services within 30 days.
- Members who have 25 inpatient days in a rolling 12-month period.

Magellan and/or the County may identify additional members for consideration.

Components of the program include:

- More intensive care management involvement.
- Development of a support plan and a crisis plan.
- Intensive aftercare planning and member follow up through all levels of care.

- Frequent interactions with the blended case manager or identified team leader.
- Treatment planning conferences.

The Treatment Planning Conferences are an important component of the program. The conferences allow all those involved in the member's care to meet face-to-face or virtually to discuss the member's history and current treatment and to brainstorm, along with the member, for their next steps toward recovery. Treatment providers could share information, and the member has the opportunity to openly voice his/her goals, treatment choices and preferences.

Clinical Procedures

Member Referral and Preauthorization Procedures

Magellan is available for authorization and referral information for providers and members 24 hours a day, seven days a week. Magellan authorizes all 24-hour levels of care and some community-based levels of care, in order for the services to be eligible for reimbursement, excluding emergency services, which do not require preauthorization, and excluding services outlined below as Partners In Care models which do not require prior authorization. Magellan's Prior Authorization, Medical Policies and Peer-to-Peer Review Procedures can be accessed on our website at https://www.magellanofpa.com/documents/2024/03/helpful-tips-for-providers.pdf/. Magellan has established toll-free numbers for both members and providers to access care and obtain authorization for services.
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Care managers are available 24 hours a day, seven days a week. These numbers can also be used *after business hours* for members in crisis and for providers assisting members.

Magellan utilizes a telephonic interpreter service for those members who call for services but do not speak English. We also supply a list of providers who speak languages other than English (https://www.magellanofpa.com/for-members/find-a-provider/provider-directories). The list of providers is updated periodically and is subject to change. If you have any questions regarding the listing, please call Magellan.

Access Standards and Initial Authorization Determination Timelines

Magellan monitors members' ability to access care through Magellan, based on an individual evaluation of the level of urgency at the time of request. Members requiring services for what is determined to be an emergency are to be seen by a participating and appropriately credentialed provider within one (1) hour of the request for services. Members requiring services for what is determined to be an urgent need are to be seen by a participating and appropriately credentialed provider, within twenty-four (24) hours of the request for services. Members requiring services for what is determined to be a routine need are to be seen within five business days. Magellan adheres to the Program Standards and Requirements timeframes for authorization of care turnaround times as outlined below.

Level of Urgency	**Timeframe for Provider to Conduct Face-to-Face Assessment**
Emergent	Within 1 hour
Urgent	Within 24 hours
Routine	Within 5 business days

Magellan Decision	**Time Frame**
Pre-Service Urgent	Up to 3 hours
TRF/Written Review	2 business days
Urgent Concurrent Review	24 hours
Retro Review	30 days

You must notify Magellan of any circumstances that may affect your ability to meet required time/access standards. The Provider Access Form (*Appendix A*) must be faxed to the attention of the Network Department within one business day of your decrease in availability.

Partners in Care Program

The Partners in Care program is a collaboration between community provider agencies and Magellan to manage community-based behavioral health care services. The Partners in Care program replaced the traditional managed care authorization procedures with an active program of consultation. The Partners in Care programs are unique to each Magellan Care Management Center. Refer to the list below for level of care references. This program consultation model may include a review of management reports, treatment record reviews, case consultations, development of program improvement plans, and other quality

management activities designed to improve member outcomes and program efficiencies. The objectives of the Partners in Care program are to:

- Increase program efficiencies by reducing administrative requirements.
- Increase the quality and effectiveness of program services, including member outcomes.
- Develop and implement a payment system that pays for quality.

Partners in Care Services

- Routine outpatient mental health and drug and alcohol services (including individual therapy, group therapy, family therapy, psychiatric evaluation, and medication checks/medication management)
- Clozaril monitoring and support
- Methadone maintenance services
- Medication-assisted treatment (MAT) for substance use disorders
- Psychiatric rehabilitation services (PRS)
- Peer support services (PSS)
- Recovery support services (RSS)
- Crisis services
- Case management services
- Functional family therapy (FFT)
- Intensive outpatient services
- Multisystemic therapy (MST)
- Wellness recovery teams (WRT)
- Substance use disorder partial hospitalization

Magellan requires that providers conduct member eligibility verification through the Eligibility Verification System (EVS), and hard copies of the EVS printout are to be maintained in the member's medical record. Eligibility may change throughout a member's treatment history, so it is recommended that providers check eligibility prior to each appointment and/or monthly, at a minimum.

Authorization Processes

The member is to be placed in the most appropriate, least restrictive level of care necessary to meet his/her needs. The member's care is to be individualized and recovery/resiliency-focused, and the member is to be included in the treatment planning process. It is expected that all members will receive an integrated assessment to include assessment for co-occurring mental health and substance use issues.

Level of Care	Initial Authorization	Concurrent	Discharge
Psychological Testing	Paper*	Paper*	N/A
Family-Based Mental Health Services	Paper*	N/A	N/A
Intensive Behavioral Health Services (IBHS) including Individual, Group and ABA Services	IBHS Packet*	IBHS Packet*	Online submission
CTT/ACT	Telephonic	Telephonic	Telephonic
Crisis Residential Programs	Telephonic	Telephonic	Telephonic
Long Term Structured Residential (LTSR)	Telephonic	Telephonic	Telephonic
Mental Health Partial Hospitalization (Acute)	Paper*	Paper*	N/A
Mental Health Partial Hospitalization (School-Based/Subacute)	Telephonic	Telephonic	Telephonic
Acute Inpatient Mental Health	Telephonic	Telephonic	Telephonic
Extended Acute Care (EAC)	Telephonic	Telephonic	Telephonic
Residential Treatment Facility (RTF)	CASSP Meeting with Magellan Packet	RTF/CRR Packet*/**	Telephonic
CRR Host Home	CASSP Meeting with Magellan Packet	RTF/CRR Packet*/**	Telephonic
Inpatient Detox, Inpatient Rehab, Non-Hospital Detox, Non-Hospital Rehab and Halfway House	Telephonic	Telephonic	Telephonic
Dual Diagnosis Treatment Team (DDTT)	Packet	Telephonic	Telephonic

Level of Care	Initial Authorization	Concurrent	Discharge
Electroconvulsive therapy (ECT)	Telephonic	Telephonic	Telephonic

**Levels of care that require paper submissions should be submitted electronically via the online authorization tool.*

***Magellan's Care Manager will also complete concurrent telephonic reviews for any child/adolescent who is placed in RTF or CRR Host Home.*

For a complete list of services that can be submitted electronically or via paper submission, please see the website.

Concurrent Review

- For concurrent review of 24-hour levels of care, you must call the care manager; the review will be conducted telephonically. These telephonic reviews are to be conducted on the day prior to the end of your authorization, which is your last covered day.
- The continued need for a level of care is based on medical necessity and is reviewed on a regular basis. Some reviews are based on paper documentation, while other reviews are done telephonically.
- Continued stay reviews for mental health treatment are based on DHS Medical Necessity Criteria or Magellan's supplemental Medical Necessity Criteria which can be found at https://www.magellanofpa.com/for-providers/provider-resources/medical-necessity-criteria.
- Continued stay reviews for substance use disorder treatment are based on The ASAM Criteria (American Society of Addiction Medicine) Third Edition, 2013. The ASAM criteria is used for both Adults and Adolescents. You must complete an ASAM Summary Form (Appendix A) for all ASAM levels of care and keep it in the member's record. If you recommend that care be continued beyond the initial authorization, you must present clinical information (ASAM) to the assigned Magellan care manager.

Second Opinion

Each member has the ***right to request a second opinion*** from a qualified health care professional within the network. Magellan ***must provide for a second opinion*** from a qualified health care professional within the network or arrange for the member to obtain one outside the network, at no cost to the member.

Emergency Services

- HealthChoices' members may use ANY hospital or emergency service for emergency care.
- Magellan may not deny payment for treatment obtained when a representative of Magellan instructs the member to seek emergency services.
- Magellan may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Magellan may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention:
    - Would not have placed the health of the individual in serious jeopardy
    - Would not have resulted in serious impairment to bodily functions
    - Would not have resulted in serious dysfunction of any bodily organ or part.
- Magellan may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's behavioral health managed care organization of the member's screening and treatment within 10 calendar days of presentation for emergency services.
- The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Magellan.
- A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the patient.

Telehealth

Telehealth is the delivery of compensable behavioral health services using real-time, two-way interactive audio-video transmission. Telehealth per this definition does not include a voice only telephone conversation, text messaging, electronic mail messaging or facsimile (fax) transmissions between a health care practitioner and a member, or a consultation between two health care practitioners, although these activities may support or supplement telehealth services. Telehealth services, as defined by these guidelines, can be provided by licensed clinicians within their scope of practice, or unlicensed behavioral health staff including unlicensed master's level therapists, mental health targeted case managers, mental health certified peer support specialists, certified recovery specialists, and drug and alcohol counselors employed by, or working under contract for, licensed provider agencies (as defined in 28 Pa. Code §704.7(b)). There are no restrictions on the type of staff that can render telehealth if they are otherwise qualified to render that service in-person. Services delivered using telehealth must comply with all service specific and payment requirements for the service. Providers

should consult their licensing agencies for more specific requirements within their jurisdiction of practice.

Telehealth may be used when on-site services are not readily available due to distance, location, time of day, availability of resources, or other situations which would prevent or delay service delivery/treatment. Licensed practitioners or providers who deliver services through telehealth within their service area must ensure that they can arrange for services to be delivered in-person as clinically appropriate or as requested by the member served who resides within 60 minutes or 45 miles (whichever is greater) of the area served. All providers rendering telehealth services must use a Health Insurance Portability and Accountability Act (HIPAA) compliant telehealth platform. Providers may only utilize audio-only telehealth when the individual served does not have access to video capability or for an urgent medical situation. Rationale for audio-only telehealth must be documented in the record.

Members must consent to receive telehealth services. Effective Jan. 1, 2024, the telehealth signature flexibilities specific to consent to treat, service verifications and treatment plans have ended. As outlined in Medical Assistance Bulletin OMHSAS-22-02, as well as OMHSAS Interim Telehealth Guidance dated March 20, 2023, providers are expected to capture consent to treat, service verifications and approval of treatment plans in a manner that creates an auditable file and in accordance with the timelines outlined in the regulations. Providers must also allow members to elect to receive in-person service delivery at any time. The decision to use telehealth should be based solely on the best interest of the member and never based on the preference or convenience of the provider or behavioral health practitioner. The provider must assess the clinical appropriateness of utilizing telehealth for each member and situation.

Providers and practitioners should carefully consider the clinical appropriateness of telehealth delivery for such services, including, but not limited to: Partial Hospitalization, (Mental Health and Substance Use Disorder), Outpatient Groups and Intensive Outpatient Program Groups, Intensive Behavioral Health Services (IBHS), Family Based Mental Health, Assertive Community Treatment (ACT), or if the beneficiary is in a residential facility or inpatient setting.

Providers must also clearly document a telehealth session. In addition to the above guidelines, the following information must be included in the record for each rendered telehealth service:

- At intake, the documentation must include the member's consent to receive services in this manner.
- The documentation must indicate the mechanism for how services were delivered (i.e., telehealth, phone).
- The documentation must include the telehealth platform that was utilized, if applicable (i.e., Zoom).
- The documentation must include the member's phone number that was utilized, if applicable.
- Appropriateness/ rationale for audio-only telehealth, if applicable.

Magellan outlines additional expectations and guidelines in our Provider Performance Standards for Telehealth.

Additional Authorization Requirements

Intensive Behavioral Health Services (IBHS)

IBHS support children, youth, and young adults with mental, emotional, and behavioral needs. IBHS offers a wide array of services that meet the needs of these individuals in their homes, schools, and communities. IBHS has three categories of services: 1) Individual services which provide services to one child; 2) Applied Behavior Analysis (ABA) which is a specific behavioral approach to services; and 3) Group services which are most often provided to multiple children at a specific place. Evidence-based treatment (EBT) such as Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are also available within IBHS.

Written Order/Written Order Updates

A Written Order (WO) is based on a face-to-face interaction with the child, youth, or young adult. It needs to include a behavioral health diagnosis, specify the IBHS service, hours and setting(s), clinical information supporting the medical necessity of the order, and measurable improvements indicating when services may be reduced, changed, or terminated. A WO can be written by a licensed physician, licensed psychologist, certified registered nurse practitioner, or other licensed practitioner whose scope of practice includes diagnosis and treatment of behavioral health disorders and the prescribing of behavioral health services, including IBHS. The WO writer must be ORP (Ordering/Referring/ Prescribing) enrolled. Written Orders are valid for twelve (12) months.

Written orders can be updated within the 12 months of the original written order. Updates do not require a face-to-face interaction. They are based upon new clinical information from the assessment. Written order updates can only be completed by the original order writer. Updates cannot extend the time of the current authorization.

Assessments for IBHS

An initial face-to-face assessment is completed by a qualified staff within the timeframes specified in the regulations, 15 calendar days for Individual and Group and 30 calendar days for ABA services. Any barriers for meeting this requirement should be clearly documented in the member's medical record. Initial assessment documentation should clearly show the start and end date of the assessment process. A concurrent assessment is conducted during the authorization process and do not require an authorization except for Group Services. Assessments must include a summary of treatment recommendations which specify the hours per month per setting.

Individualized Treatment Plans (ITPs)

An ITP is developed within 30 calendar days for Individual and Group IBHS or 45 calendar days for ABA of the initiation of services. It must be reviewed and updated at least every 6 months.

Interagency Service Planning Team (ISPT) Meetings

ISPTs are only required for IBHS authorization or re-authorization when a Behavioral Health Technician (BHT) or BHT-ABA is requested in the school, daycare, preschool, afterschool, or camp setting. The meeting summary is required within the authorization packet and should reflect active collaboration around transfer of skills and titration planning.

Separate from authorization requests, Magellan will require that ISPTs be held for the following reasons:

- When IBHS is recommended for longer than one year. Annual ISPT meetings should be held for children still receiving IBHS (at the one-year, two-year, three-year mark, etc.).
- When a referral to a higher level of care is being considered.
- When requested by family member or team member.

Registration for Initial Individual, Group and ABA IBHS Assessments

Individual, Group and ABA providers will request authorization for the Initial Assessment utilizing the Magellan Behavioral Health of Pennsylvania, Inc. HealthChoices Treatment Authorization Cover Sheet for Intensive Behavioral Health Services (IBHS) Registration ONLY, along with a copy of the Written Order.

Initial Assessment Registration requests should be submitted via Magellan's online authorization request platform.

1. Magellan will authorize 15 hours (60 units) for the initial assessment for Individual and Group for 30 calendar days or 24 hours (96 units) for the assessment for ABA for 45 calendar days. As per the IBHS regulations, assessments should be completed within 15 calendar days (Individual/Group) and 30 calendar days (ABA).
2. Providers will have 7 <u>calendar</u> days to schedule first assessment appointment from receipt of the written order or from the initial call from the family with a verified written order. Providers should document any family cancellations or no-shows that impact the timeline.

Authorization for IBHS

Following the completion of the Assessment and development of the Individualized Treatment Plan (ITP), the authorization packet request should be submitted. For reauthorizations, packets may be submitted no more than 30 days before the current last covered day on the authorization. The start date of services, including reauthorization requests, cannot be more than 2 prior business days from the date it was submitted to Magellan.

The following documents are to be included in all IBHS initial and reauthorization packets:

- IBHS Treatment Authorization Request (TAR) Form
- Written order
- Assessment
- Individualized Treatment Plan (ITP)

- CANS summary report (For Individual and ABA services) – To be completed for all members 3 years of age and older
- ISPT summary note if BHT or BHT-ABA services are requested in school, daycare, preschool, afterschool, or camp setting.

If the Written Order and Assessment are not in agreement, either the original WO could be updated or a new WO could be completed. If the latter occurs, the provider must submit both Written Orders for review.

IBHS providers are required to utilize Magellan's online authorization request platform. If information is missing, Magellan will notify you of the missing information by fax within 48 hours. You must submit the required information to Magellan within two business days following notification. Magellan will notify the member or parent/guardian and provider in writing of any request for additional information, denial or modification of the services requested. Magellan also will notify the member or parent/ guardian and provider in writing of the right to file a grievance of any denial of requested services with Magellan and DHS, and/or request a DHS Fair Hearing.

IBHS Change of Prescription

If a member's needs change during an authorization, the IBHS prescription can be changed by following the change of prescription process. If the prescription needs to be increased beyond the current assessment recommendation but still within the written order recommendation, please submit via fax: Written Order, updated assessment, updated TAR. If a new service needs to be added to the IBHS prescription which is not currently in the written order/ assessment, please submit via provider portal: updated WO, Original WO, updated assessment, TAR (containing just the newly requested service(s)), updated ITP, ISPT meeting notes if adding BHT/BHT-ABA in school type setting. If needing to change the IBHS category (individual to ABA or vice versa), please submit via the provider portal: Updated WO, original WO, updated assessment, TAR, updated ITP, ISPT meeting notes if adding BHT/BHT-ABA in a school type setting.

IBHS Transfer Process

Once a receiving provider has been identified, the **currently** authorized provider should send the receiving provider:

- A copy of the approved packet.
- A statement on letterhead acknowledging the transfer of the member and noting the mutually agreed upon date of transfer.
- No Magellan discharge form needs to be submitted.

The **receiving** provider submits the following to Magellan via online provider portal:

- The letter from the current provider acknowledging the transfer of the member and noting the mutually agreed upon date of transfer.
- A letter from receiving provider on letterhead acknowledging the transfer of the member and noting the mutually agreed upon date of transfer.

- TAR to ensure accuracy of new authorization.

Family Based Mental Health Services for Children and Adolescents

PREAUTHORIZATION AND REAUTHORIZATION

Initial requests for Family Based Mental Health Services (FBMHS) in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties require the Initial Referral for Family Based Services form (*Appendix A*) and an evaluation recommending this service. The Initial Referral for Family Based Services form and a Life Domain evaluation recommending FBMHS and TAR should be faxed or electronically submitted to the Family Based Services Care Management department.

Components of an initial FBMHS referral packet include:

1. Magellan Treatment Authorization Request Cover Sheet (TAR).
2. Magellan FBMHS Referral Form.
3. Life Domain Evaluation.
    - Completed by a Psychiatrist/Psychologist/Certified Registered Nurse Practitioner/Other licensed Practitioner, whose scope of practice includes diagnosis and treatment of behavioral health disorders, along with the prescription of behavioral health services, including Family Based Services.
    - Evaluating practitioners must be Ordering Referring or Prescribing (ORP) enrolled [with an active Promise ID]
    - Evaluations are to be typed in the Life Domain format.
    - D. Evaluations can be submitted within 60 days from the date of the face-to-face evaluation but are considered expired after 60 days.

If a youth and family need initial Family Based Mental Health services urgently, an Expedited FBMHS referral can be used. In these situations, the staffing FBMHS provider submits a Magellan referral form. The form must be signed by a Psychiatrist/Psychologist/Certified Registered Nurse Practitioner/Other licensed Practitioner, whose scope of practice includes diagnosis and treatment of behavioral health disorders. The FBMHS provider must submit the full Family Based Authorization request as described above to Magellan, within 30 days of opening the expedited case.

Requests for extension of the existing FBMHS authorization require a telephonic review with the Family Based Services Care Management department as well as a Life Domain evaluation recommending a FBMHS extension. This evaluation should include a specific timeframe for the extension request. The request must be based on clinical need and not because adequate discharge planning did not occur during the routine course of the FBMHS work. An extension of the current authorization may be appropriate if the Magellan member and his or her family is

experiencing a new crisis, changes in caregiving, or an emergency situation requiring additional support.

Residential Treatment Facilities (RTF) and Community Residential Rehabilitation (CRR) Host Home

PREAUTHORIZATION

All residential treatment services require preauthorization. When a parent, provider or agency requests residential treatment facility services, an initial face-to-face psychiatric evaluation for the child or adolescent member is needed. Magellan can assist in identifying an in-network provider to complete the evaluation. If the evaluation results in a recommendation for Residential Treatment Facility services and the member and/or family are interested in pursuing this treatment, an ISPT or CASSP meeting is held to discuss the recommendation for residential treatment facility services. Magellan participates in the ISPT or CASSP meeting. The corresponding evaluation should be forwarded to Magellan. Additionally, for Cambria, Lehigh and Northampton Counties, the evaluation should be provided to the CASSP coordinator at the County prior to the ISPT meeting.

In addition to holding the CASSP meeting, the provider identified by the Children's Unit is responsible for completing and submitting the request package for Residential Treatment, which must include the following:

1. A Psychiatric evaluation recommending RTF in life-domain format that is based on a face-to-face (inclusive of telehealth) examination of the child/adolescent. The evaluation must be typed, signed, and dated. The evaluation is invalid after 60 days from the date of the signature. The recommendation for Residential Treatment Facility services cannot be made in an addendum to the original evaluation.
2. A proposed treatment plan for use in the requested service. The treatment plan must be signed by the Magellan member (14 years old or older) or the parent/legal guardian of the child (under 14 years old6). The signature on the treatment plan indicates that the Magellan member and his or her family are aware of the recommendation for Residential Treatment Facility services and agree with the request being submitted to Magellan.
3. The Plan of Care Summary (Appendix A); *For Bucks County, signatures of Bucks County Office of Mental Health/Developmental Programs' staff must be present.*
4. CASSP Sign In/Concurrence (*Appendix A*).
5. CASSP Meeting Notes.
6. Attachment 8 PA DHS Community-Based Mental Health Services - Alternatives to Residential Mental Health Form *(Appendix A).*

Submit these completed documents to Magellan, attention: RTF/CRR – HH Authorization Request, along with a cover letter and RTF Treatment Authorization Request Cover Sheet withing 7 days of the ISPTM *(Appendix A)*.

CONCURRENT REVIEW

Throughout the authorization, Magellan care managers will complete routine telephonic reviews with the RTF's clinical team. If continued stay is recommended by the Residential Treatment Facility, this recommendation must be made via an updated psychiatric evaluation and an ISPT meeting to review the recommendation. Residential Treatment Facility staff is responsible for scheduling and informing relevant team members of the next ISPT meeting for maximum participation. Magellan may participate in the discussion and explore other services that may help address the family and child's needs; however, the Magellan care manager will not make authorization decisions at ISPT meetings. The reauthorization packet needs to be submitted to Magellan, within seven calendar days from the date of the meeting.

Electroconvulsive Therapy (ECT)

- The provider may make a request for ECT through a Magellan care manager, via a telephonic review. The Magellan care manager will conduct a pre-service review with the provider and request any additional information needed to make a determination regarding the request, in consultation with a Magellan physician when needed.
- Both inpatient and outpatient ECT must be preauthorized. Outpatient ECT must be considered unless the member requires an inpatient level of care or there are other contraindications to receiving outpatient ECT.
- If a provider is requesting inpatient ECT treatment, the member must meet criteria for an inpatient level of care, in addition to meeting medical necessity for ECT. If the member no longer meets criteria for the inpatient level of care, then outpatient ECT shall be considered, unless medically contraindicated.
- Up to eight ECT treatments will be approved for an initial ECT request. If the member requires additional treatments, a subsequent request from the provider with information regarding response to treatments to date, any side effects from the treatments, and number of additional treatments that are planned should be provided to the Magellan care manager for determination of authorization.

Psychological Testing

Preauthorization is required for all psychological testing.

Any provider who wishes to refer a member for psychological testing must complete the Request for Psychological Testing Preauthorization Form *(Appendix A)* and fax the completed form to Magellan, at 1-866-667-7744 for all five counties.

A licensed psychologist or psychiatrist will review the request.

Court Ordered Evaluation/Treatment

- For court-ordered evaluation or treatment, Magellan may authorize **up to**:
  - Five days for an initial inpatient stay for any Section 302 commitment
  - 20 days for a Section 303 court order
  - 90 days for a Section 304 court order
  - 180 days for a Section 305 court order.
- All Section 306 orders are authorized according to the County's involuntary commitment procedures.
- When a commitment is changed to voluntary status after a 302, Magellan will continue to conduct concurrent reviews and monitor progress.
- Court-ordered treatments and evaluations will be considered, upon receipt of notification from the provider. Other than an involuntary commitment (302), all court-ordered treatment must meet Magellan's Medical Necessity Criteria for HealthChoices, in order to be authorized. Utilization reviews will be conducted for care monitoring and aftercare planning.

Note that preauthorization requirements apply to court-ordered treatment.

Discharge Summary

Magellan no longer requires providers to submit Discharge Summaries for Outpatient, Blended Case Management and Family Based Services levels of care. It is still required that providers conduct thorough discharge planning in collaboration with members, families, and identified care teams. Such processes are to be documented, made available to each member, and saved within each member record.

Magellan will continue to require Discharge Summaries for Intensive Behavioral Health Services (IBHS). These should be submitted electronically through the Magellan provider website. Magellan no longer accepts hard or paper copies of Discharge Summaries.

- For 24-hour levels of care, the care manager reviews the discharge plan telephonically with you on the day of discharge or within 24 hours of discharge.
- You must notify the assigned Magellan care manager, as soon as a treatment episode is complete or within 24-48 hours, especially in the case of Against Medical Advice (AMA) discharge and in administrative discharges, as there is a requirement to offer follow-up treatment. When you become aware of a potential AMA discharge, it is your responsibility to offer a discharge appointment to the member that is within the standard of seven calendar days of the date of discharge. Discharge planning is still important, even if the discharge is AMA. Magellan requires members discharged from a

24-hour level of care to be seen by the aftercare provider within five business days of discharge.

Retrospective Review

A retrospective review is an evaluation of the medical necessity of treatment services after the treatment has been rendered without preauthorization. Retrospective reviews may be requested under the following circumstances:

Emergency Services: Magellan performs retrospective reviews of emergency services performed without preauthorization. The review considers services performed from the time of the emergency until the member is in a safe setting. For services provided in an emergency situation, Magellan must receive a request for retrospective review within 180 days of the of the service date. Magellan may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.11(a) of the definition of emergency medical condition.

Member's medical condition precludes provider's ability to identify member's eligibility: Magellan will perform a retrospective review when a service is provided, and the member's medical condition precludes the provider from identifying the member's eligibility with Magellan. The review will consider services performed through the date that eligibility was reasonably discovered. Magellan must receive the retrospective review request within 180 days after the service was performed. Magellan will conduct the review using Magellan's Medical Necessity Criteria, DHS Medical Necessity Criteria, or ASAM criteria, as appropriate.

HealthChoices' eligibility is retroactively initiated: Magellan will perform a retrospective review when services are provided to a member whose eligibility is retroactively initiated by HealthChoices based on information in the Pennsylvania Department of Human Services' Eligibility Verification System (EVS). Magellan will review services from the date of eligibility through the date that eligibility was initiated or reinstated. For retrospective review requests due to a member's retroactive enrollment in HealthChoices, Magellan must receive the retrospective review request within 180 days after the service was performed. Magellan will conduct the review using Magellan's Medical Necessity Criteria, DHS Medical Necessity Criteria, or ASAM criteria, as appropriate.

Service was not covered by the member's primary insurer: Magellan will consider the services provided for any dates of service for which the member's primary insurer was believed responsible for coverage. For requests for retrospective review based on the service not being covered by the member's primary insurer, Magellan must receive the retrospective review request within 180 days after the service was performed, or within 180 days of the primary insurer's final decision notice. Magellan will conduct the review using Magellan's Medical Necessity Criteria, DHS Medical Necessity Criteria, or ASAM criteria, as appropriate.

To request a retrospective review, submit the following to Magellan:

- An electronically completed Magellan Retrospective Review Request Form (available on the Forms page of the Magellan of PA website at www.magellanofpa.com/for-providers/provider-resources/forms).

- Sufficient clinical information to establish medical necessity for the services provided. This may include information from the medical record or ASAM summary evaluations.

- For retrospective review requests due to a member's retroactive enrollment in HealthChoices, you must provide evidence that HealthChoices' eligibility was checked via the Eligibility Verification System (EVS) on each date of service (e.g., EVS printouts created during the period in which services were provided). EVS printouts created after the period for which coverage is requested are not evidence of retroactive enrollment and will not be considered.

- For requests for retrospective review based on the service not being covered by the member's primary insurer, you must include a copy of the Explanation of Benefit (EOB) form or final decision letter that demonstrates that the treatment rendered was not covered by the primary insurer.

Submit your request for retrospective review by facsimile to 1-888-656-2380 (preferred) or by mail to:

Magellan Behavioral Health of Pennsylvania, Inc.
790 Township Line Road
Suite 120, Yardley, PA 19067
Attention: Retrospective Review

Requests that do not include an electronically completed Magellan Retrospective Review Request Form or are missing required documentation cannot be processed.

Clinical Assessments and Care Reviews

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Magellan follows the Guidelines for Best Practice published by the Pennsylvania Department of Human Services, Office of Mental Health, Bureau of Children's Services, Department of Drug and Alcohol Programs (DDAP) Comprehensive Assessment Components and Comprehensive Assessment Components for Priority Populations. Magellan also emphasizes strengths-based and integrated co-occurring assessments. The information below is a general guide to some of the clinical information that is reviewed during the preauthorization and concurrent review processes:

- Current behaviors
- Precipitants to admission, "why now"
- Mental status and diagnosis
- Psychiatric and substance abuse treatment history and response
- Medical factors
- Medications, side effects, allergies, labs
- Risk factors related to functional impairment and dangerousness
- Treatment planning
- Discharge planning, including any barriers to remaining in the community
- Barriers to member's improvement
- Family and social supports and their level of involvement
- Education and treatment when co-occurring issues are present
- Consideration of alternate levels of care

Refer to the *Confidentiality* section of this handbook supplement (under Section 4) for information on limits of disclosure with substance abuse cases.

Substance Use Disorder reviews include a discussion of ASAM dimensions as outlined below:

- Dimension 1 – Acute Intoxication and/or Withdrawal Potential
- Dimension 2 – Biomedical Conditions and Complications
- Dimension 3 – Emotional, Behavioral or Cognitive Conditions or Complications (including assessment of mental health status)
- Dimension 4 – Readiness to Change
- Dimension 5 – Relapse, Continued Use or Continued Problem Potential
- Dimension 6 – Recovery/Living Environment

Treatment Planning

FOCUSED TREATMENT

Magellan supports a targeted and focused approach to member care. Providers should conduct a thorough diagnostic assessment and evaluation to understand the presenting clinical needs. Treatment planning must be informed by a comprehensive case formulation about what the treatment needs are. Treatment plans must be individualized and center around the member's goals for his or her treatment. When behavioral descriptions are incorporated, they must include information about the function of the behavior and describe the proposed replacement behavior. Treatment plans must be strengths-based and grounded in recovery concepts. Goals are to be concrete, specific, realistic, measurable, stage-of-change specific and based on the strengths of the member. Treatment Plans must include goals that are identified issues in the biopsychosocial assessment. Members must be actively involved in the development of their own treatment plans.

Magellan requires that treatment adhere to all applicable ethical standards. All providers, regardless of provider type and service that is being delivered, must have a treatment plan in place for all members. Level-of-care specific regulations dictate how often treatment plans must be reviewed and updated; as well as who is required to sign the treatment plan. At a minimum, all treatment plans must be reviewed and updated once every 180 days.

DISCHARGE PLANNING

Effective discharge planning begins at admission. Providers must clearly state the discharge criteria on the treatment plan. Discharge planning and aftercare monitoring are to be based on Child and Adolescent Services System Program (CASSP) and Community Support Program (CSP) intersystem guidelines and Treatment Principles for Alcoholism and Other Drug Dependencies (AODD). These principles are key components in the successful treatment of members. Magellan's care managers will work with you to coordinate discharge planning from all levels of care to continue treatment, care coordination and member satisfaction. We utilize the full continuum of care, so that the appropriate, least-restrictive level of care is obtained. Members must be actively involved in the development of their own discharge plan. Discharge plans should follow Magellan's Best Practice Guidelines for discharge outlined in Magellan's Provider Performance Standards, by level of care (https://www.magellanofpa.com/for-providers/quality-improvement/provider-performance/).

Recovery and Resiliency

Magellan values individuals and families as partners in treatment and believes that:

- All individuals and families have strengths.
- Hope is encouraged when someone really listens.
- Empowering is better than controlling.

Magellan is committed to the principles of recovery and resiliency for all members and believes that a participation within the community is possible for all individuals with access to appropriate services and supports. Magellan is committed to working together with members, families, providers, and counties to achieve this reality. Its philosophy of care also recognizes that full participation of the member and/or family members in the treatment process maximizes the likelihood of a successful clinical intervention. Magellan Care Managers and Recovery Support Navigators work together with providers and members, to address treatment, supports, and environmental factors impacting recovery and resiliency.

Magellan supports providers in ensuring that treatment for all individuals is recovery- and resiliency-oriented, stage-of-change specific, strengths-based, and member/family-centered. For children, treatment will be family-focused and, for adults, will involve natural supports to the extent desired by the member. Community-based treatment, using natural supports and extensive community supports, will be standard. Additionally, treatment will be multi-systemic in nature; culturally competent; flexible and accountable; coordinated; provided in the most appropriate, least-restrictive, and least-intrusive setting; evidence-based and reflective of best practices. Magellan supports providers' efforts to foster resilience through the promotion of protective factors and reduction of risk factors.

CASSP Principles

CHILD AND ADOLESCENT SERVICES SYSTEM PROGRAM (CASSP) PRINCIPLES

CASSP principles must be reflected in the care and coordination of treatment for children and adolescents. These principles are to be integrated into the interventions and practice and evidenced by active participation of the member and family in treatment.

Child-centered means that services are designed to meet the individual needs of the child, instead of the needs of the treatment provider. Child-centered means the services consider the child's family and community environment, are developmentally appropriate, child-specific, and build on the strengths of the child and family to meet the biopsychosocial physical needs of the child.

Family-Focused services recognize that the family is the primary support system for the child. The family participates fully in all stages of the decision-making and treatment planning process, including implementation, monitoring, and evaluation. A family may include biological, adoptive, and foster parents, siblings, grandparents, and any other adults who are committed to the child.

Community-Based means that services are delivered in the child's home community whenever possible. Services should draw on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health

professionals and provider agencies; but also social, religious, and cultural organizations and other natural community support networks.

Multi-System services draw on every child-serving system involved in the child's life. Representatives from all of these systems and the family collaborate to define the goals for the child, develop a service plan, including the necessary resources required to implement the plan, provide appropriate support to the child and family, and evaluate progress.

Culturally Competent services are provided by individuals with the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practice characteristics of the culture of a particular group of people.

Least-Restrictive/Least-Intrusive services take place in settings that are the most appropriate and natural for the child and family. They also are the least restrictive and least intrusive services available to meet the needs of the child and family.

Principles of Cultural Competence

Magellan commits to strong cultural competency practices. Magellan believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination. Magellan encourages network providers to uphold principles in cultural competence that maintain the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards):

- The system is strengths based, family friendly, culturally sensitive, and clinically sound. Behavioral health care is provided by valuing and recognizing the role each person's culture plays in their health and well-being.
- The system recognizes that ethnically diverse populations have unique needs that may present a unique set of mental health issues to which the system should be equipped to respond.
- Inherent in cross-cultural interactions are dynamics that should be acknowledged, adjusted to, and accepted.
- The system should sanction and, in some cases, mandate the incorporation of cultural knowledge into practice and policy making.
- Cultural competence involves working in conjunction with natural, informal support and helping networks within the minority community (e.g., neighborhoods, churches, spiritual leaders, healers, etc.).
- Cultural competence extends the concept of self-determination to the community. Only when a community recognizes and owns a problem does it take responsibility for creating solutions that fit the context of the culture.

- Community control of service delivery is essential to the development of effective services. This occurs through marginalized group member participation on boards of directors, administrative teams, and program planning and evaluation committees.
- An agency's staffing should reflect the makeup of the potential member population, be adjusted for the degree of community need, and make every effort to deliver effective services.
- Culturally competent services incorporate the concept of equal and non-discriminatory services; but go beyond that to include the concept of responsive services matched to the member population.
- Culturally competent providers practice diversity, equity, and inclusion in all aspects of their treatment deliver process.

Magellan supports the application of CLAS Standards to services throughout Magellan's behavioral healthcare network to promote equity in behavioral health care delivery system. Substance Abuse and Mental Health Services Administration (SAMHSA) collaborated with the OMH to develop the Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. This link provides a comprehensive guide for providers to inform development or analysis of organizational procedures. The Guide focuses on improving access to care, quality care, and reduction of disparities in behavioral health treatment for underserved populations.

As a contracted provider within the Magellan Network, Magellan may request that the organization conduct a self-assessment of the organization's cultural competency program as a quality improvement activity.

All network providers should have an annual training plan. It is Magellan's expectation and best practice that included in this annual training plan is a Cultural Competency Training for all provider staff. Providers may also choose to develop their own Cultural Competency Training or use other available resources. Regardless of what training curriculum a provider chooses to use, Magellan's expectation is that Cultural Competency Training is conducted annually. The Department of Human Services' HealthChoices Program Standards and Requirements stipulates that completion of this training be populated in our Provider Search tools. All providers must submit their training attestation annually.

Community Support Program in Pennsylvania

The Community Support Program (CSP) in Pennsylvania recognizes that people living with mental health diagnoses are to be treated with dignity and respect. They have the same needs,

rights, and responsibilities as other citizens and are to have access to the same opportunities, support, and services.

In addition to traditional mental health treatment, services such as housing, vocational training and employment, income maintenance, medical care, and rehabilitation are essential to help people live successfully in the community.

Providers are expected to demonstrate that the CSP principles are incorporated into all aspects of professional practice. Community support services are to:

- Be based on the needs of the individual.
- Empower members by encouraging them to have control over their lives by setting their own goals, deciding what services they will receive, and helping to plan and implement the delivery of services.
- Be culturally competent and available and acceptable to diverse racial, ethnic, gender, and religious groups.
- Be flexible enough for members to move in and out of the system, as needed.
- Focus on strengths and help members maintain a sense of identity, self-esteem, and dignity.
- Assist members in making a successful transition from inpatient treatment to the community, through natural supports in all aspects of living, working, learning, and leisure.
- Assist members in developing their potential for growth and movement toward independence and recovery.
- Meet the special needs of members with mental illness who also live with substance use disorder, physical disability, intellectual and/or developmental disability, homelessness, and/or involvement in the criminal justice system, etc.
- Be accountable to the members who access their services – members and families should help plan, implement, deliver, monitor, and evaluate services.
- Be coordinated through mandated linkages with members, families, and at the local and state levels – continuity of care for members discharged from hospitals to community-based services should be confirmed.

Substance Use Treatment

- **Substance Use Disorder Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for substance use disorders.** In therapy, members address issues of motivation, build skills to resist substance use, replace alcohol/drug-using activities with constructive and rewarding non-substance using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

- **12 Step groups, such as Alcoholics Anonymous, Narcotics Anonymous, Co-occurring Groups and community support groups can be essential adjuncts to the treatment process.** Attendance should be encouraged, when appropriate, but never mandated.
- **Medications are an important element of treatment for many members,** especially when combined with counseling and other behavioral therapies. Methadone, Subutex, and Suboxone are effective in helping individuals with an opioid use disorder stabilize their lives and reduce their opioid drug use. Naltrexone also is an effective medication for some patients addicted to opiates and some patients with co-occurring alcohol dependence. For persons with a nicotine use disorder, a nicotine replacement product (such as patches or gum) or an oral medication (such as Bupropion) can be an effective component of treatment. For patients with mental health disorders, both behavioral treatments and medications can be critically important.
- **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases,** and counseling to help members modify or change behaviors that place themselves or others at risk of infection. Counseling can help members avoid high-risk behavior. Counseling also can help infected individuals manage their illness.
- **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on their issues and needs. Treatment may include residential care followed by intensive outpatient care, or partial treatment followed by outpatient care, or any movement through the level-of-care continuum. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment, including the use of Motivational Interviewing strategies.
- **Recovery from chronic drug use can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. Individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Prolonged treatment does not imply continued stay in residential care. Treatment in various levels of care can result in positive outcomes. Participation in 12 Step or other community support programs during and following treatment often is helpful in maintaining long-term abstinence.
- **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. External motivations and enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates, and the success of drug treatment interventions. The use of Motivational Interviewing techniques is strongly recommended.
- **Persons recovering from substance use disorders are viewed as important resources in the statewide service system.** As representatives of the recovering community, persons in recovery serve as an inspiration to the active substance using person. Practicing professionals provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for patient advocacy.

Coordination of Care

Mental Health Advance Directives

Pennsylvania Act 194 became effective on January 28, 2005, and allows for Mental Health Advance Directives. All Magellan providers are required to comply with Act 194, as stated in the provider contract.

Mental Health Advance Directives allow members to plan for their future mental health care, in the event they can no longer make mental health care decisions on their own as a result of illness. This can be accomplished by creating a Mental Health Declaration or by appointing a Mental Health Power of Attorney, or both.

A Mental Health Declaration is a set of written instructions informing a provider of the member's:

- Type of treatment preference
- Treatment location preference
- Specific treatment instructions

A Mental Health Power of Attorney is a document that allows a member to name a person, in writing, to make mental health care decisions for the member, if the member is unable to make those decisions individually. The Mental Health Power of Attorney will make decisions about the member's mental health care, based on the member's written instructions.

If a member would like to have a Mental Health Declaration or a Mental Health Power of Attorney, or both, they can contact an advocacy organization such as the Mental Health Association in Pennsylvania, at 1-866-578-3659 or 717-346-0549; email: info@mhapa.org. The organization will provide the member with the forms and answer any questions. Providers should encourage members to share their written Mental Health Advance Directives with the organization, so that the Declaration can be followed. If a member does not have a Mental Health Declaration drafted, treating providers should ask if members want assistance developing one.

If a member believes that their provider has not handled their Mental Health Advance Directives properly, or if they have any other complaints about Mental Health Advance Directives, members can follow the standard complaint process in their Member Handbook.

Contact with PCPs and Other Providers

Magellan accepts referrals from primary care providers; however, HealthChoices' members do not need referrals from their primary care physicians (PCPs) to receive mental health, co-occurring, or drug and alcohol treatment.

As a behavioral health provider, you are expected to coordinate treatment with the member's PCP and respective Physical Health Managed Care Organization (PH-MCO) to maximize the integration, quality-of-care, and cost-effectiveness of the overall health care services provided.

After the member (or legal guardian/personal representative) signs the Authorization to Use and Disclose (AUD) Protected Health Information Form *(Appendix A)*, you are to notify the member's PCP of the initiation and progress of behavioral health care services by providing the following:

- Progress updates through the PCP Communication Form *(Appendix A)*
- A copy of the completed Discharge Summary

Each HealthChoices' PH-MCO maintains a "special needs" division to coordinate, and case manage medical and behavioral care. In addition, HealthChoices' PH-MCOs often provide specialty care management programs targeting those with higher risk medical conditions to provide enhanced support and encourage treatment compliance.

For members who have identified themselves as HIV-positive, you should coordinate treatment with the PCP and other health officials involved in the member's care, in accordance with applicable Pennsylvania confidentiality law.

You also are expected to coordinate care with other behavioral health providers involved in the member's care and to actively participate in interagency team meetings.

Coordination of Care with Collateral Agencies/Interagency Team Meetings

Behavioral health providers or other service agencies are expected to coordinate care with other providers or other agencies involved in the member's care including, but not limited to, the Office of Probation and Parole, Office of Intellectual Disability, Area Agency on Aging, and Children and Youth Services. Coordination of care is also expected with other treatment providers with whom member may be involved. This can include therapists, Assertive Community Treatment Teams, Psychiatric Rehabilitation or Peer Support Providers, and PCPs.

Behavioral Health Screening Programs

Magellan supports several screening programs for network providers. These are accessible on Magellan's website. Magellan offers the Autism Treatment Evaluation Checklist (ATEC), Blended Case Management (BCM) Outcomes Tool, CAGE, Child and Adolescent Needs and Strengths (CANS), Columbia-Suicide Severity Rating Scale (C-SSRS), Global Appraisal of Individual Needs-Short Screener (GAIN-SS), Modified-Family Assessment Form (M-FAF), Patient Health Questionnaire 9-item scale (PHQ-9), and SmartScreener tools for providers as screening programs.

New providers to the network receive information about these behavioral health screening tools in the new provider training. When providers attest to completion of this training, they

are also confirming that they are aware of the screening tools and where they can be located. The direct link to these tools is found on Magellan's website at this location. Contracted and existing providers are shared this information annually with distribution of the Provider Handbook.

The CAGE questionnaire is a screening tool predominately used in primary care and behavioral health settings to aid in the assessment of alcohol misuse. CAGE is an acronym for the four questions of the assessment where "C" stands for "cutting down", "A" stands for "annoyance by criticism", "G" stands for "guilty feeling", and "E" for "eye openers". This brief screening tool has a strong evidence base with respect to both validity and reliability.

A screening tool required for youth recommended for Intensive Behavioral Health Services (IBHS) is the Child and Adolescent Needs and Strengths (CANS) Assessment Tool. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS consist of domains that focus on various areas in a child's/youth's life, and each domain is made up of a group of specific items.

There are domains that address how the child/youth functions in everyday life: a) emotional or behavioral concerns; b) risk behaviors; c) strengths, and on skills needed to grow and develop; d) family's beliefs and preferences; and e) general family concerns/needs.

The CANS is intended to support care planning and level of care decision making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

CANS completion requires certification prior to use and annual re-certification. Providers using the CANS as part of IBHS monitoring are given pre-paid access to the CANS online training and certification site, which includes additional materials on using the CANS in treatment planning. Providers are encouraged to utilize this screening tool at admission to IBHS, at re-assessment and again at discharge. Magellan shares annually with IBHS providers an annual CANS Outcomes Report.

The Columbia-Suicide Severity Rating Scale (C-SSRS), can be administered to individuals ages six years and up, comprises of 2-6 questions to assess risk for suicide, determine the severity of risk, and identify appropriate interventions based on the level of severity. The tool was initially developed in 2007 by Columbia University, University of Pennsylvania, and University of Pittsburgh to assess suicide risk in teenage youth as part of a National Institute of Health Study.

The GAIN-SS can be utilized to detect the presence of psychiatric disorders, substance use challenges and crime and violence challenges. The screener helps identify those who would

benefit from further assessment or referral for these issues. Furthermore, the screener can also provide information regarding the absence of these challenges.

The PHQ-9 is a brief screening tool designed to assess the presence of depression symptoms, as well as the severity of depression symptoms over time. This screener can also provide information with respect to who would benefit from further assessment and interventions.

The SmartScreener was developed by Magellan using validated, reliable, and well-researched brief screens identified by SAMHSA. The screens were chosen to maximize identification of behavioral health and co-morbid substance use, with screened conditions making up more than 90% of behavioral health complaints. Each tool is available in English and Spanish.

The SmartScreener includes screening for insomnia (ISI-3), depression (PHQ-2), anxiety (GAD-2), alcohol (AUDIT-1), drugs (DAST-1), and pain (PEG- 3). The SmartScreener is "smart" because each tool expands to the longer versions of the tool when the minimum threshold for each one to three item brief screen is met. Specifically, the tools expand to the ISI- 7, PHQ-9, GAD-7, AUDIT-10, and DAST-10. The PEG is only a three-item screener.

All the aforementioned behavioral health screening tools are evaluated every two years, or more frequently when there are scientific and clinical updates made to these tools.

Transportation Services

Emergency transportation services are the responsibility of the member's PH-MCO. When a member needs emergency ambulance transportation, the Emergency Room or Crisis Center will facilitate the ambulance search. The Special Needs Unit (SNU) of the applicable PH-MCO is able to assist with any transportation barriers or to facilitate the ambulance search.

Requests for non-emergency transportation can be made to the following agencies. For administrative issues with non-emergency transportation, call Magellan and we will assist the member.

Bucks County Provider: Bucks County Transport (BCT)
Phone: 215-794-5554, Toll Free: 888-795-0740
https://www.bctransport.org/medical_assistance_transportation.htm

Cambria County Provider: Community Action Partnership of Cambria County
Phone: 814-535-4630, Toll Free: 888-647-4814
http://www.capcc.us/community-services/

Montgomery County Provider: Suburban Transit/TransNet
Phone: 215-542-7433, Toll Free: Same as Local #
https://www.suburbantransit.org/medical-assistance

Lehigh and Northampton Counties Provider: Lehigh and Northampton Transit Authority (LANTA)
Phone: 610-253-8333, Toll Free: 888-253-8333
https://www.lantabus.com/

Language Assistance Services

Interpreter services are not billed as a separate behavioral health service in the HealthChoices' Program. While it is the responsibility of network providers to accommodate the specialized needs of HealthChoices' members, including securing interpreter services, Magellan can offer assistance securing these services as needed. Network providers may not decline a member's access to treatment based on their need for language assistance. Providers should reference Medical Assistance Bulletin 99-17-11 which outlines these requirements.

Magellan offers language assistance services resources for network providers. These are located on Magellan's website at the following location. We can also assist in the coordination of translation services for members who need assistance. Please call the applicable provider services line to request assistance.

Pharmacy Services

With the exception of methadone, most pharmacy services are covered by the member's PH-MCO, including drugs prescribed by Magellan network physicians. Magellan is responsible for the coverage of medically necessary methadone.

As PH-MCO plans vary, you will need to be knowledgeable about the member's prescription plan. If a member goes to the pharmacy to fill a prescription and the prescription cannot be filled because it needs a prior authorization, the pharmacist will give the member a temporary supply. If a member has not already been taking the medicine, they will get a 72-hour supply. If the member has already been taking the medicine, they will get a 15-day supply. Encourage members to tell you if a prescription has been denied, so the appropriate action can be taken. To appeal pharmacy denials, members and providers are to follow the grievance procedures outlined by the designated PH-MCO. You may use the Medication Problem Report *(Appendix A)* to report problems with obtaining medications for members, **after** an attempt is made to resolve the issue with the PH-MCO.

You can obtain specific formulary information through the PH-MCO websites at:

AmeriHealth Caritas – www.amerihealthcaritaspa.com
Highmark Wholecare – www.highmarkwholecare.com

Geisinger Health Plan – www.ghpfamily.com
Health Partners Plans – www.HPPLans.com
Keystone First – www.keystonefirstpa.com
United Healthcare Community Plan – www.uhccommunityplan.com
UPMC for You – www.upmchealthplan.com

You can reach the PH-MCO Special Needs Units at:

AmeriHealth Caritas – 1-800-684-5503
Highmark Wholecare – 1-800-392-1147
Geisinger Health Plan – 1-855-214-8100
Health Partners Plans – 1-866-500-4571
Keystone First – 1-800-573-4100
United Healthcare Community Plan – 1-877-844-8844
UPMC for You – 1-866-463-1462

Transfer of Care

When a member requests a transfer from one provider to another, he or she will be encouraged to discuss this request and the reason for it with his or her current provider. The care manager will inform a treating provider by telephone, prior to transferring the member to another provider, for managed levels of care.

Member Rights and Responsibilities

You are expected to share with members their rights and responsibilities (below). Evidence that you have shared this information with members is expected to be in their record. Rights and Responsibilities also need to be posted in a visible area within your office.

Members have the right to get the care they need. They should expect to:

- Be treated with respect, recognizing their dignity and need for privacy, by Magellan staff and network providers.
- Have easy access to understand Magellan, its services, and the providers that treat them when they need it.
- Pick any Magellan network provider that they want for treatment. They may change providers if they are unhappy.
- Get emergency services when they need them from any provider without Magellan's approval.
- Get information that they can easily understand from their providers and be able to talk to them about treatment options, without any interference from Magellan.

- Make decisions about their treatment. If they cannot make treatment decisions independently, they have the right to have someone else help them make decisions or make decisions for them. They may refuse treatment or services unless they are required to get involuntary treatment under the Mental Health Procedures Act.
- Talk with providers in confidence and to have their information and records kept confidential.
- See and get a copy of their medical records and to ask for changes or corrections to your records.
- Ask for a second opinion.
- File a Grievance if they disagree with Magellan's decision that a service is not medically necessary for them (Information about the process can be found beginning on page 47).
- File a Complaint if they are unhappy about the care or treatment they have received (Information about the process can be found beginning on page 42.).
- Ask for a Department of Human Services Fair Hearing (Information about the process can be found beginning on page 52.).
- Be free from any form of restraint or seclusion used to force them to do something, to discipline them, or as a punishment.
- Get information about services that Magellan or a provider does not cover because of moral or religious objections and about how to get those services.
- Exercise their rights without it negatively affecting the way the Department of Human Services, Magellan, or network providers treat them.
- Request case files prior to any proceedings. There is no cost to file.
- Receive a list of advocacy organizations that can assist them.

Members also have responsibilities to Magellan staff and its providers. They are as follows:

- Provide, to the extent they can, information needed by their providers.
- Tell their provider the medicines they are taking, including over-the-counter medicines, vitamins, and natural remedies.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Take their medications as prescribed and tell their provider if there is a problem.
- Keep their appointments.
- Learn about Magellan coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless Magellan approves an out-of-network provider.
- Respect other patients, provider staff and provider workers.
- Report fraud and abuse to the Department of Human Services Fraud and Abuse Reporting Hotline.

Child Protective Services Law and Reporting Requirements

Child Protective Services Laws

According to the Pennsylvania Department of Human Services, "*Since 2013, legislation has been enacted, changing the manner in which Pennsylvania responds to child abuse. These changes will significantly impact the reporting, investigating, assessment, prosecution, and judicial handling of child abuse and neglect cases. These new laws expand and further define mandated reporters and the reporting process, increase penalties for those mandated to report suspected child abuse who fail to do so, and provide protections from employment discrimination for filing a good faith report of child abuse*." Additional information about these laws is available at https://www.pa.gov/en/agencies/dhs/resources/keep-kids-safe/about-keep-kids-safe/cps-laws.html.

Child Protective Service Law - Background Check/Clearance Requirements

Additional information about the clearance/background check requirements for persons who, in the course of their employment or occupation or in the practice of their profession, come into contact with children is available at https://www.pa.gov/en/agencies/dhs/resources/keep-kids-safe/child-abuse-clearances.html

Child Protective Service Law - Reporting Requirement

Magellan providers are mandated reporters under the Pennsylvania Child Protective Services Law. "*Mandated reporters are certain adults, who are legally required to report suspected child abuse if they have reasonable cause to suspect that a child is a victim of child abuse*. *Mandated reporters may report by telephone* (1-800-932-0313) *or electronically through the Child Welfare Portal*." Please review the information about the reporting requirements posted at Report Child Abuse | Department of Human Services | Commonwealth of Pennsylvania.

Elder Abuse - Reporting Requirement

Magellan providers also are required to report suspected abuse, neglect, exploitation and/or abandonment of County residents who are age 60 or older. If you suspect elder abuse, you are required to contact the following agencies:

Bucks County Area Agency on Aging Protective Services - 1-800-243-3767
Cambria County Area Agency on Aging - 1-877-268-9463
Lehigh County Aging and Adult Services - 1-610-782-3034 or 1-800-490-8505
Montgomery County Elder Abuse Hotline - 1-800-734-2020
Northampton County Aging and Adult Services - 1-610-252-9060

When abuse is sexual, results in serious physical or bodily harm, or when a death is suspicious, call the above agencies, the local police, or the Pennsylvania Department of Aging, at 1-717-783-1550.

Complaints and Grievances

Filing a Provider Complaint

Magellan provides a formal process for providers to express a complaint related to service provided by Magellan, to have their concerns or complaints investigated and resolved, and to receive a timely and professional response to those concerns.

Provider Complaint Definition:

A provider complaint is any written communication made by a provider to Magellan expressing dissatisfaction with any aspect of Magellan operations, activities, or staff behavior. If the concern is on behalf of a specific member, it will be classified as a "member complaint" and the member complaint policy will be followed.

To register a provider complaint, providers must submit the complaint in writing to:

Magellan Behavioral Health of Pennsylvania, Inc.
790 Township Line Rd, Suite 120
Yardley, PA 19067
Attn: Provider Complaints

The provider complaint process has two levels:

First Level

A Magellan staff member documents that a complaint has been received. The complaint is investigated and resolved within 30 calendar days of receipt. A written response is mailed to the provider within five business days of resolution. The response may include the results of the investigation, action(s) taken, and recommendations for additional actions or follow up, if needed.

All complaints involving potential harm to members or others are directed to the Magellan Care Management Center's medical director, or their respective designee, to determine an immediate course of action.

Second Level

If the provider is dissatisfied with the first-level resolution, he or she may register a second-level complaint. The provider is notified in the first-level resolution letter of the right to register

a second-level complaint. To register a second-level complaint, the provider must file a second-level complaint in writing, within 45 days of receiving Magellan's first-level decision.

The second-level complaint review will be conducted by the County through which the provider is contracted. The second-level complaint committee will include, at minimum, three persons – at least one County staff member, a Magellan representative, and, at the County's discretion, a representative from a network provider entity. No representative from Magellan previously involved with the issue will serve on the second-level complaint committee.

The provider will be notified of the right to appear before the second-level complaint committee. The provider may have other representation, to assist in the presentation of the complaint.

The second-level complaint committee must conduct the review, within 30 days of receipt of the second-level complaint. Magellan will send the provider the results of the second-level complaint decision in writing, within five business days following the second-level complaint review. The decision of the second-level complaint committee is final.

Member Complaints and Grievances

Information regarding the member complaint and grievance processes may be found on Magellan's website at: https://www.magellanofpa.com/for-providers/services-programs/complaints-grievances/

NOTE: *To ask for help or to request more details about the complaint, grievance and fair hearing processes, call Magellan's toll-free telephone number at 1-877-769-9784 for Bucks County members; 1-800-424-0485 for* Cambria County members; *1-866-238-2311 for Lehigh County members; 1-877-769-9782 for Montgomery County members; and 1-866-238-2312 for Northampton County members.*

Provider Responsibility in the Event of a Denial

In the event that a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review

of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

If the level of care being denied is inpatient, hospital staff is expected to communicate with the member, and the member's family if appropriate, on the same day that the non-authorization is issued. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Provider Initiated Grievances

In accordance with the Pennsylvania HealthChoices Program Standards and Requirements, in order for a provider to represent a member in the conduct of a grievance, the provider must obtain the written consent of the member and submit the written consent with the grievance. A provider may obtain the member's written permission at the time of treatment. Providers must not require a member to sign a document authorizing the provider to file a grievance as a condition of treatment. The written consent must include:

I. The name and address of the member, the member's date of birth, and identification number.
II. If the member is a minor, or is legally incompetent, the name, address, and relationship to the member of the person who signed the consent.
III. The name, address, and plan identification number of the Provider to whom the member is providing consent.
IV. The name and address of the plan to which the grievance will be submitted (Magellan).
V. An explanation of the specific service which was provided or denied to the member to which the consent will apply.
VI. The following statement: "The member or the member's representative may not submit a grievance concerning the services listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or member's representative has the right to rescind consent at any time during the grievance process."
VII. The following statement: "The consent of the member or the member's representative shall be automatically rescinded if the Provider fails to file a grievance or fails to continue to prosecute the grievance through the review process."
VIII. The following statement: "The member or the member's representative, if the member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The member or the member's representative understands the information in the member's consent form."

IX. The dated signature of the member, or the member's representative, and the dated signature of a witness.

All provider-initiated grievance requests, with written member consent, must be received by Magellan within 60 days from the date of denial notification. You may file your provider-initiated grievance by calling Magellan or writing to:

Magellan Behavioral Health of Pennsylvania, Inc.
790 Township Line Rd, Suite 120
Yardley, PA 19067
Attention: Complaints and Grievances
Fax (preferred): 1-888-656-2380

Upon receipt of acceptable member consent, Magellan will conduct the grievance review as outlined under the "member complaint and grievance" procedures.

Reminder: Per your provider contract with Magellan, members are not responsible for payment for services provided during the provider-initiated grievance.

SECTION 4: THE QUALITY PARTNERSHIP

Network Provider Participation

Magellan has collaborated with the Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members. Magellan has implemented processes and procedures to gather information that is used to improve the quality of care. When Magellan collects and evaluates information specific to you, Magellan will communicate the findings to you.

Our Quality Improvement Program includes the following:

Evaluation of quality of care through:

- Treatment record reviews
- Site visits
- Review of quality indicators (complaints, incidents, member experience or Consumer/Family Satisfaction Teams experience outcomes, and quality of care concerns)
- Specific quality initiatives
- Monitoring of implementation of clinical practice guidelines

Utilization of resources through:

- Utilization reports for all levels of care
- Monitoring readmission rates to 24-hour levels of care
- Custom reports to compare utilization to provider history and other providers

Outcomes of care through:

- The use of standardized measurement tools
- Satisfaction surveys
- Special outcomes studies
- Performance improvement plans
- Provider profiling
- Analysis of member and provider satisfaction survey results

Administrative procedures through:

- Assessment of compliance with credentialing, quality, and utilization program requirements
- Adherence to service standards, such as member's timely access to care

If it is indicated that improvement is needed as the result of our findings, we will collaborate with you to develop action plans geared toward improving the areas where deficiencies are

identified. This feedback, action and follow-up process is key to improving care and the quality of services for HealthChoices' members.

Incident Reporting

In accordance with the OMHSAS Community Incident Management and Report System Bulletin of 2015 (OMHSAS-15-01), providers are required to notify Magellan within 24-hours of the occurrence of a reportable incident involving a HealthChoices' member. Providers should access the electronic submission process on Magellan's website. This information is used to monitor and follow up on serious incidents. Incident data is also shared with Magellan's stakeholders and is utilized as a key quality indicator.

It is necessary to complete the Magellan Provider Incident Reporting Form in its entirety. For online incident reporting, the Provider MIS number and the Member's Medical Assistance Identification Number must be entered correctly. Indicate whether or not the incident meets the criteria for a Sentinel Event, provide a complete explanation of the event and what actions were taken in response to the incident. Response to requests for additional information and/or follow-up activity must be carried out in a timely manner.

Provider Preventable Conditions

Section 2702 of the Patient Protection and Affordable Care Act prohibits federal payments for Medicaid managed care expenditures on Provider Preventable Conditions. Providers are required to report the occurrence of Provider Preventable Conditions (PPCs) when submitting claims. PPC means a condition that meets the definition of a Health Care-Acquired Conditions (HCAC) or an Other Provider-Preventable Conditions (OPPC).

When a provider becomes aware of a PPC, the provider is required to report the information to Magellan through the Incident Reporting process. As outlined in the Department of Human Services PROMISe Provider Handbook, providers should complete the state's *OPPC Self Reporting Form* for all non-HCAC PPCs; or report all HCACs through the *UB-92 Claim Form.*

Accreditation and External Review of Quality

The Magellan Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the

National Committee for Quality Assurance (NCQA). Assessment of compliance with these requirements is integrated into our quality improvement activities. Reviewers for these accrediting bodies focus on compliance with standards and policies, as well as the effectiveness of our Quality Improvement Program in overseeing compliance with these standards.

NCQA's accreditation standards for managed behavioral health care organizations (MBHOs) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver, as well as the direct care you provide, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Strong emphasis also is placed on clear communication with members about:

- Their rights and responsibilities.
- Key components of the MBHO program, such as utilization review criteria and practice guidelines.
- Member and provider involvement in the MBHO's quality improvement program.

We have developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices' requirements. Specific activities include:

- Assessing accessibility to care for initial appointments, aftercare, and specialty care.
- Conducting site visits and treatment record reviews for assessment of quality of care and adequacy of the service site.
- Credentialing and recredentialing requirements for individual providers and organizations.
- With appropriate authorization from the member, communicating and coordinating care with PCPs and other providers.
- Promoting behavioral health screening programs.
- Conducting member satisfaction surveys.
- Facilitating complaint and grievance procedures.
- Reporting serious provider quality deficiencies to the appropriate authorities.

As part of our effort to provide timely access to members, you are asked to document the following:

- First appointment time offered to a member.
- First appointment time kept by a member.
- Appointments that are canceled or missed.
- Attempts to contact members who terminate treatment without notification.

Provider Performance Concerns

Magellan's Quality Improvement Program maintains oversight of Provider Performance Concerns () which are safety related in nature. Provider Performance Concerns (quality of care concerns), action plans, site visits and other collaborative performance improvement activities all fall within this monitoring activity.

Patient Safety

The Magellan Quality Improvement Program prioritizes a focus on patient safety that includes oversight of quality-of-care concerns that may occur at programs and facilities. This activity may support assessments of the provider performance concerns, and compliance with regulatory and Magellan standards of services delivered. Our staff may conduct administrative, compliance, and clinical reviews.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures. Providers shall permit access to any and all portions of the medical record which resulted from member's admission, or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

Treatment Record Reviews (TRRs) and/or on-site visits may be conducted at minimum:

- During initial credentialing for participation in the network.
- Within the first year of contracting for a new provider or program to assess successful implementation.
- On a routine basis, per selection via a statistically valid random sample.
- On other occasions, when Magellan determines it is necessary, including, but not limited to, clinical reasons, complaint investigations, and customer request.

We evaluate TRRs/site visit findings and may send a written report to the provider. This report may include 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.

These findings are reviewed by County representatives and the applicable Magellan Regional Network and Credentialing Committee (RNCC), as part of the provider's credentialing and recredentialing process.

Provider Performance Standards

Magellan's Provider Performance Standards are intended to serve as a tool to promote progression toward best practice, continuous quality improvement, and improvement of member outcomes. The Standards will add to current licensing guidelines and regulations and are not intended to replace regulations. Providers are encouraged to refer to these documents and utilize the Standards in the development of internal quality improvement and monitoring activities. These Standards will periodically be reviewed and revised. Provider feedback is welcome and, if appropriate, incorporated into the documents as revisions are made.

Member Satisfaction Surveys

Magellan utilizes several methods to assess the satisfaction of the members it serves. Magellan 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, or other ad-hoc surveys administered to assess HealthChoices funded member experiences.

Magellan contracted providers may be requested to assist with connecting members in care to peer-run organizations that support the HealthChoices requirement for member satisfaction through the Consumer/Family Satisfaction Teams (C/FST). It is Magellan's expectation that providers participate in these important outcome activities.

For providers that offer services for substance use treatment needs, Magellan may send to the provider location paper surveys to be administered directly to members that are receiving HealthChoices' funded services. The surveys will have return envelopes with postage applied for ease of return by the member. Magellan requests that all contracted providers that receive these survey administration packets provide Magellan members the surveys to help obtain member feedback across the network.

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. The survey findings are used to identify areas we need to work on and to develop and implement actions for improvement. We strongly encourage you to participate.

Confidentiality

Under the Pennsylvania HealthChoices' program, Bucks, Cambria, Lehigh, Montgomery and Northampton Counties, DHS and Magellan have access to all Medical Assistance member records.

Confidentiality of **all** information about a member receiving mental health and/or substance abuse treatment service is of paramount importance. Confidentiality is an ethical obligation of all treatment professionals, and a legal right for every member, regardless of the source or the format of the information. As a Magellan network provider, you are responsible for maintaining

the confidentiality of all member information. You must be knowledgeable of all applicable state and federal laws, including The Health Insurance Portability and Accountability Act (HIPAA), regarding confidentiality or having an impact upon a member's right to confidentiality. This also includes any applicable reporting requirements for child or elder abuse, and the common law or statutory duty-to-warn.

Any requirements under applicable federal and state laws regarding confidentiality must be followed regarding release of information with or without the member's authorization.

Informed Disclosure

During the first therapeutic communication, whether by telephone or in person, you must inform members of their right to confidentiality and the limits of those rights, so that the member may make an informed decision as to what he or she chooses to disclose to you. You will need to document in the member's medical record that a discussion regarding confidentiality took place and the member's response to this information.

You also must inform members that information will be shared with Magellan, DHS, and the County, and obtain the member's Authorization to Disclose Protected Health Information, to document that the member consents to such disclosures. The reasons you may need to share information with Magellan, DHS or the County may include the following:

- Medicaid program audits and evaluations
- Utilization review or claims review
- Investigation of complaints and grievances.

Specific to substance use disorder (SUD) records, Act 33 of 2022 made Pennsylvania's SUD confidentiality requirements consistent with federal law. Federally assisted programs for the diagnosis, referral, or treatment for SUD are covered by the federal regulations at 42 CFR Part 2. 42 CFR Part 2 requires that members provide written consent to release SUD information.

Proper coordination of care under the HealthChoices' program requires that a member's PCP be kept informed of any mental health or substance abuse services received through Magellan. This coordination of care is to be conducted in the member's best interest. Therefore, you must inform members of the need to communicate with their PCP and obtain authorization to release information to the PCP.

Finally, you are to inform the member of circumstances under which confidential information may be disclosed without his or her consent. These instances include, but are not limited to:

- Medical emergencies
- Responses to court orders
- Reporting requirements (such as abuse and duty-to-warn).

Guidelines for Establishing Office Protocol

You are expected to establish an office protocol, including processes, procedures, and systems, to maintain member confidentiality.

Communication with Members

In addition to informing each member of their right to confidentiality, and any limits on those rights, you should also explain to members your procedures regarding telephone contact. These would include obtaining phone numbers where the member may be reached and names of those with whom you may leave messages. When leaving messages, leave only your name and phone number. The purpose of the call must never be revealed. The procedures for phone contact should be noted in sufficient detail in the member's record.

Authorization to Use and Disclose Protected Health Information (AUD)

Except as otherwise permitted or required by law, Magellan does not use or disclose protected health information (PHI) for purposes other than payment, treatment, or health care operations without valid authorization from the member.

Except as otherwise permitted or required by law, Magellan does not use or disclose a member's PHI without first obtaining a valid Authorization to Use and Disclose Protected Health Information (AUD) Form from the member.

Magellan obtains a completed *AUD Form* prior to using PHI for purposes other than treatment, payment, or health care operations. Magellan uses a standard *AUD Form* consistent with applicable federal regulations. When presented with Magellan's standard *AUD Form,* approval must also be obtained before any PHI is used or disclosed pursuant to such form. If a non-Magellan release form is utilized for a member, prior approval must be obtained by Magellan before any PHI is used or disclosed pursuant to such form.

Members and providers should visit Magellan's website to access the *AUD Form* under Release Forms & Member Access Portal. Directions on how to complete it are available. Magellan recommends that members utilize the online submission option. Signed and completed *AUD Forms may also be faxed* to Magellan at 1-866-667-7744; or sent via e-mail to PAHC_AUD@MagellanHealth.com. If you are faxing an AUD form on behalf of a member, please include the name of the Magellan staff who you are working with and your contact information on the fax cover sheet. Providers should not submit multiple AUDs for different members in the same communication.

Member Records

If using paper records, you must maintain each member's record in a separate file. Include the member's identifying information in the file. Keep member charts in a locked file when not in use. Your office must also be locked when you are not on the premises. Providers utilizing an

Electronic Health Record (EHR) must ensure that the EHR software supports all Magellan and Pennsylvania Medicaid documentation requirements. Only you and authorized staff employed by you are to have access to member medical records.

Your office staff must be informed of the protocol for confidentiality and be made aware of their responsibility to maintain the confidentiality of members. Your staff may not talk about members or give out any information to anyone (including the member's spouse; or parent if the member is aged 14 and older) without the member's explicit written authorization. Office staff may not acknowledge, by telephone, in person, or in writing, that an individual is or was in treatment or is in the office. In fact, it is a good idea to instruct your staff not to release any verbal or written information before they check with the member, even with a signed authorization on file.

A system for keeping members' telephone calls and messages confidential should be established and your staff is to be informed of these procedures. Office staff should be sensitive to the need for maintaining confidentiality during phone conversations when others are in the reception area. Appointment books are to be treated as confidential and kept in a locked file when not in use. Separate entrances and exits, while not required, may help the effort to maintain confidentiality.

When mailing confidential information, label the document as confidential.

Records of Disclosures

All disclosures of member information by you or your staff must be documented in the member's clinical record. The documentation must indicate to whom disclosure was made, date of disclosure, purpose of disclosure and the information disclosed. The member is to be informed of any disclosures that are made.

NOTE: You are responsible for knowing, understanding and following all applicable laws regarding confidential patient information. In providing the information in this handbook supplement regarding confidentiality, Magellan is not furnishing legal advice. If legal or other professional advice is required, you are responsible for seeking the services of a professional.

Documentation

In addition to serving as a legal record of services rendered, the documentation within each member's health record serves many purposes. It allows health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time; facilitates communication and continuity of care among the physicians and other health care professionals involved in the patient's care; ensures accurate and timely claims review and payment; promotes appropriate utilization review and quality of care evaluations; can be used

for research and education; and finally, serves as evidence that the services were provided as billed to a payer.

Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by the responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as a final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as the treatment plan, must be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages, must be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's records require a notation to this effect.
- The record must indicate the progress at each visit, change in diagnosis, change in treatment, and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.

The documentation of treatment or progress notes for all services, at a minimum, must include:

- The specific services rendered.
- The date that the service was provided.
- The name(s) of the individuals(s) who rendered the services.
- The place where the services were rendered.
- The relationship of the services to the treatment/service plan - specifically, any goals, objectives, and interventions.
- Progress at each visit, any change in diagnosis, changes in treatment, and response to treatment.
- The actual time in clock hours that services were rendered. For example: The recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 a.m. to 11:00 a.m.

In addition to the above requirements, providers must follow the applicable MA regulations and bulletins for the services for which they are licensed and enrolled. Retractions may be pursued if documentation does not meet Magellan or the state's minimum expectations.

Encounter Forms

Encounter Forms offer an extra check and balance for an agency to ensure that services delivered are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services. Medicaid providers across the country surrender millions of dollars annually, due to staff persons falsifying claims and/or billing for services not rendered. Thus, securing and monitoring Encounter Forms can be viewed as a mutual aid for the battle against Fraud, Waste and Abuse.

In accordance with Medical Assistance (MA) Bulletin 99-89-05, a recipient signature is required for MA services unless the service is signature exempt (please reference details in the bulletin). If a provider is unable to obtain a signature on the encounter form (including refusal), it must be documented why, and attempts should be made to obtain a signature the following session.

Per MA Bulletin 99-89-05, the following information must be recorded on the encounter form:

- A certification statement: "I certify that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws."
- Provider name and MA ID number
- Recipient name and ID number
- Recipient's signature, or the signature of the recipient's agent
- Date of Service

Magellan also considers the inclusion of start and end times on telehealth encounter forms to be a best practice (this is a requirement for in-person community-based/ mobile services). PerOMHSAS-22-02, signatures for telehealth service verification may include hand-written or electronic signatures, unless prohibited by other laws. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Providers using electronic signatures must have systems in place to ensure that there is an audit trail that validates the signer's identity. Physical signatures may be obtained through a variety of different mechanisms including in-person with the member; US Mail; or e-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies.

Signatures can also include an audio recording of voice consent (i.e., the "sound") stored within a HIPAA-compliant telehealth platform. Recording means that the member's voice consent is stored within the medical record system. Signatures are to be obtained as soon as possible and no later than 90 days after the service.

If the billable face-to-face contact is collateral (the member is not present), then the identified individual who meets with the provider would sign the encounter verification form (i.e., school personnel/teacher). Magellan does permit encounter signatures on multiple dates of service, for example, a weekly/ monthly encounter form for all services rendered during the prior week/ month, as long as the minimum requirements outlined above are met. Signed encounter forms should be available at the time of a Magellan audit or review. The signed encounter form must match all other supporting documentation of the session (e.g., progress note).

If the billable face-to-face contact is collateral (the member is not present), then the identified individual who meets with the provider would sign the encounter verification form (i.e., school personnel/teacher).

Encounter Forms offer an extra check and balance for an agency to ensure that services delivered in the community are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services. Medicaid providers across the country surrender millions of dollars annually, due to staff persons falsifying claims and/or billing for services not rendered. Thus, securing and monitoring Encounter Forms should be viewed as a mutual aid for our battle against Fraud, Waste and Abuse.

Providers should not bill for services unless and until they meet the documentation and signature requirements. Sign and date records at the time of service or shortly thereafter. This ensures a fresh recollection of the details and facilitates a faster and more accurate note-writing process. Delays can make remembering essential details and events more difficult, which may result in incomplete or inaccurate notes. We encourage timely notetaking and recommend finishing the notes within 24 to 48 hours of the session if feasible.

Fraud, Waste, and Abuse

Magellan takes provider fraud, waste, and abuse very seriously. Magellan engages in considerable efforts and dedicates substantial resources to prevent these activities and to identify those committing violations. Our policies in this area reflect that both Magellan and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare Advantage, State Children's Health Insurance Program (SCHIP) and Medicaid), federally funded contracts, and private insurance. Magellan complies with all applicable laws, including the Federal False Claims Act, state false claims laws, applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010, and applicable state and federal billing requirements for state-funded programs, federally funded health care programs (e.g., Medicare Advantage, SCHIP and Medicaid), and other

payers. Magellan has 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 and Appendix J of our National Provider Handbook. Magellan Behavioral Health of Pennsylvania, Inc. also has a dedicated compliance and fraud, waste, and abuse page on our website: https://www.magellanofpa.com/for-providers/provider-resources/fraud-waste-and-abuse-compliance/.

All Magellan providers, regardless of size are expected to develop, implement, and maintain a written Compliance Plan which adheres to applicable federal and Pennsylvania 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 Pennsylvania Department of Human Services' (DHS's) Bureau of Program Integrity (BPI). 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.

The Pennsylvania HealthChoices' Behavioral Health Program Standards and Requirements (PSR) definitions are as follows.

Abuse

Abuse is defined as any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the Medical Assistance program, Behavioral Health Managed Care Organization, Primary Contractor, a Subcontractor, or Provider, or a practice that results in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations (including the Agreement, contracts, guidance issued in bulletins, and the requirements of State and Federal statutes and regulations) for health care.

Examples include:

- Services that are billed by mistake.
- Misusing codes: code on claim does not comply with national or local coding guidelines; not billed as rendered.
- Billing for a non-covered service.
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session).
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment; unpaid overpayments are grounds for program exclusion).

Fraud

Fraud is defined as any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State Law, made by an entity or person with the

knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting.
Examples include:

- Intentionally billing for services that were not provided.
- Falsifying signatures.
- Rounding up time spent with a member.
- Altering claim forms.

Waste

Waste means over-utilization of services, or other practices that, directly or indirectly result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

Examples include:

- Using excessive services such as office visits.
- Providing services that aren't medically necessary.
- Ordering excessive testing.

We encourage you to visit the Pennsylvania Department of Human Services' (DHS') Bureau of Program Integrity (BPI) website where you can find general information on fraud, waste, and abuse; information about the Medical Assistance Provider Self Audit Protocol; and information on how to report fraud, waste, and abuse.

The mission of BPI is to ensure that:

- The Medical Assistance Program is protected from provider fraud, waste, and abuse.
- Medical Assistance recipients receive quality medical services.
- Medical Assistance recipients do not abuse their use of medical services.
- Feedback is provided to the Department to enhance program performance.

Self-Auditing Protocol

Through Magellan's partnership with the Department of Human Services (DHS), The Bureau of Program Integrity (BPI), Primary Contractors and our provider network, we encourage the practice of **self-reporting** Fraud, Waste, and Abuse (FWA), with the common goal of protecting the financial integrity of the MA program. Magellan supports the notion that treatment providers have an ethical and legal duty to promptly return inappropriate payments that they have received from the MA program.

Magellan supports the Centers for Medicare and Medicaid Services' (CMS') Compliance Program Guidelines which include a component on provider self-auditing. All providers should develop a Claims Auditing Policy which includes a procedure and mechanism for oversight in this area. Self-auditing is a good tool to measure internal compliance and ensures compliance with MA regulations. A comprehensive Claims Auditing Policy should include (at a minimum):

the frequency with which audits are conducted; the number or percentage of records reviewed; how the sample is selected; whether audits are conducted prospectively (before claims are submitted) or retrospectively (after claims are submitted); the indicators that are measured; and the procedure/workflow regarding action steps to correct internal claims error findings. Magellan reviews providers' claims auditing policies during routine compliance audits and integrated audits.

In the event that a provider self-identifies inappropriate payment during the course of a self-audit or via another mechanism (e.g., Compliance Hotline), we encourage you to contact Magellan's Compliance Department immediately. Technical assistance may be provided at this time, as needed. Providers will be advised to conduct a more thorough and comprehensive self-audit to identify the full impact of the alleged FWA inquiry. The Bureau of Program Integrity (BPI) is also available for technical assistance in answering questions related to a self-audit. Upon completion of a comprehensive self-audit, providers should submit to Magellan the list of affected claims and an investigative report/summary including the corrective action taken by the provider/agency to address and mitigate the findings. All self-report information should be sent electronically to: PAHCSelfreport@MagellanHealth.com.

Regulatory Requirements

Providers and subcontractors are contractually obligated to comply with regulatory and HealthChoices' program requirements. These documents and procedures are in place to protect the integrity of the services provided under the HealthChoices' Program. Providers must be knowledgeable of and follow all applicable PA Medicaid regulations and bulletins for which they are licensed, enrolled, and contracted. In some cases, Magellan may implement or clarify a standard that exceeds the state's minimum regulatory requirements. This information is disseminated to providers by Magellan's Compliance Department through monthly e-mail alerts. These Compliance Alerts are posted on Magellan's website for ongoing access (See Compliance Alerts on the Magellan Provider Page: https://www.magellanofpa.com/for-providers/. Providers are responsible for reviewing Magellan's Compliance Alerts on a regular basis and maintaining adherence with the expectations that are outlined. To sign-up to receive the communications in your inbox, providers can submit a request to PAHCCompliance@MagellanHealth.com.

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

Under Pennsylvania law, providers whose provider agreements have been terminated by the DHS 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 this Commonwealth's Medical Assistance Program during the period of their termination.

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, vendors, contractors, service providers, and referral sources whose functions are a necessary component of providing items and services to MA recipients, and who are involved in generating a claim to bill for services or are paid by Medicaid (including salaries that are included on a cost report submitted to the Department). Providers are required to comply with this obligation, as a condition of enrollment as a Medicare or Medicaid provider.
- All the screening requirements are outlined in Medical Assistance Bulletin 99-11-05. Provider must screen all employees and contractors (both individuals and entities), at time of hire or contracting; and, thereafter, on an ongoing monthly basis.
- Search the HHS-OIG LEIE website at https://www.oig.hhs.gov/exclusions/exclusions_list.asp to capture exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Check the Pennsylvania Medicheck List (https://www.pa.gov/en/agencies/dhs/report-fraud/medicheck-list.html) a database maintained by the Department that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program. If an individual's resume indicates that he/she has worked in another state, providers should also check that state's individual list.
- 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 five percent or more controlling interest and subcontractors are not debarred, suspended, or otherwise excluded under the HHS-OIG LEIE at

https://www.oig.hhs.gov/exclusions/exclusions_list.asp, the General Services Administration's System for Award Management (SAM) Exclusion Database at https://sam.gov/content/exclusions, The Pennsylvania Medicheck List at https://www.pa.gov/en/agencies/dhs/report-fraud/medicheck-list.html or any applicable state exclusion list where the services are rendered or delivered.

- Immediately notify Magellan in writing of the debarment, suspension, or exclusion of you, your employees, subcontractors, directors, officers, partners, or owners with a five percent or more controlling interest.

The Effect of an Exclusion

The Pennsylvania Medical Assistance (MA) HealthChoices' Behavioral Health Program is funded by the state and the federal government. An exclusion from participation in state or federally 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:

- *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.*
- *No payment will be made by any state or federal health care program for any administrative or management services provided by excluded individuals/entities.*
- *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.*
- *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 Pennsylvania law, the DHS and managed care organizations *will not* pay for any services prescribed, ordered, or rendered by the providers or individuals listed on the Medicheck List, including services performed in an inpatient hospital or long-term care setting. In addition, subsequent to the effective date of the termination or preclusion, any entity of which five percent or more is owned by a sanctioned provider or individual will not be reimbursed for any items or services rendered to MA 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:

- Identity of *any perso*n 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.

- 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.
- 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.

Pennsylvania Law

Under Pennsylvania law (55 Pa. Code § 1101.75), an enrolled provider may not, either directly or indirectly, do any of the following acts:

- Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.
- Knowingly submit false information to obtain authorization to furnish services or items under MA.
- Solicit, receive, offer, or pay remuneration, including a kickback, bribe, or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.
- Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.
- Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.
- Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.
- Submit a claim or refer a recipient to another provider by referral, order, or prescription, for services, supplies, or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.
- Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.
- Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.
- Except in emergency situations, dispense, render, or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.
- Except in emergency situations, dispense, render, or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

- Enter into an agreement, combination, or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.
- Make a false statement in the application for enrollment or reenrollment in the program.
- Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

Please note that a provider or person who commits a prohibited act specified above, except paragraph (11), is subject to the penalties specified in §§ 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department; and restitution and repayment).

How to Report Suspected Fraud, Waste, and Abuse

1. 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

2. The Department of Human Services has established a hotline to report suspected fraud, waste, and abuse committed by any entity providing services to Medical Assistance recipients. If you have knowledge of suspected MA provider non-compliance, or of substandard quality of care for services paid for under the Pennsylvania Medical Assistance Program, please contact the MA Provider Compliance Hotline by:

   - Telephone (includes TTY service): **1-866-379-8477**
   - Electronically submitting the **MA Provider Compliance Hotline Response Form** at: https://forms.dhs.pa.gov/dhs-ma-provider-compliance/
   - Fax: 717-772-4655 ("Attention MA Provider Compliance Hotline")
   - U.S. Mail: Bureau of Program Integrity
MA Provider Compliance Hotline
PO Box 2675
Harrisburg, PA 17105-2675

   The MA Provider Compliance Hotline, established by and located in the DHS Bureau of Program Integrity is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in fee-for-service and managed care within the Pennsylvania MA Program. The hotline operates between the hours of 8:30 a.m. and 3:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-

English speaking interpreter services are available to provide assistance to callers and TTY services for persons with hearing impairment are also available. Additional instructions:

- Callers to the hotline are not required to identify themselves.
- If a caller does not wish to speak to a hotline representative directly, he or she should leave a message outside the regular hours of operation.
- Individuals can report suspected fraudulent and abusive practices through the DHS website, without disclosing their identity, by completing and submitting the MA Provider Compliance Hotline Response Form.

Please have the following information when you call:

- Provider's name and address.
- Description of the suspected fraudulent and abusive activity, including the time period, frequency of the events, recipient name, and recipient ID number.
- Telephone number where you can be reached, in the event that you want to be contacted.

County HealthChoices' Fraud and Abuse Hotline

You also can report fraud, waste, and abuse directly to your county's HealthChoices' Fraud and Abuse Hotline, listed below:

Bucks County: 1-844-347-8477
Cambria County: 1-844-347-8477
Lehigh County: 1-844-347-8477
Montgomery County: 1-844-347-8477
Northampton County: 1-877-235-3164

Value-Based Reimbursement

With increasing emphasis on value-based payment models in the behavioral healthcare industry, more specifically the Pennsylvania HealthChoices' state contractual requirements for Primary Contractors and MBHOs to demonstrate that reimbursement is aligned with value, it is with increasing importance that providers are able to demonstrate value through the achievement of quality, utilization, and cost metrics, along with collecting and reporting on member outcomes and healthcare indicators. To that end, Magellan Behavioral Health of Pennsylvania will continue implementing value-based reimbursement models that align reimbursement with member outcomes. Coupled with all value-based reimbursement models is the expectation that providers are accountable for quality of care and ownership of care outcomes by implementing best practices. Therefore, Value Based Payments will be the method for rate increases beyond county/market/level of care rates.

Submission of Claims

Timely Claims Submission

All claims for covered services provided to HealthChoices' members must be received by Magellan in accordance with the following timelines, **within 60 days of the date of service for most levels of care, except as provided below**:

- Within 60 days from date of discharge, for 24-hour levels of care.
- Within 60 days of the last day of the month or the discharge date, whichever is earlier, when billing monthly for longer treatment episodes of care at a 24-hour level facility.
- Within 60 days of the claim settlement for third-party claims. This date is based on the date of the other carrier's EOB, which must be attached to the claim you submit to Magellan.

If Magellan does not receive a claim within these timeframes, the claim will be denied for payment.

In accordance with applicable law, Magellan will pay clean claims within 45 days of the date of receipt. Interest of 10 percent per year, or the amount required by applicable law, will be paid on ***clean claims*** not paid within the 45-day timeframe. Interest is calculated beginning the day after the required payment date and ending on the date the claim is paid. In accordance with applicable law, Magellan will not pay any interest calculated to be less than $2. Clean claims are defined as claims that can be processed without obtaining any additional information from the provider or from a third party.

We strongly encourage all providers to submit claims to Magellan electronically, via our provider website (one claim at a time, or in bulk through EDI Direct Submit), or by enrolling with one of the claims clearinghouse vendors designated by Magellan. Call the Magellan provider line at 1-877-769-9779 or 1-800-686-1356 for more information or visit the Electronic Transactions/Claims section of the Magellan provider website.

If filing on paper, send claims to:

Magellan Health, Inc.
PAHC – **Bucks County**
P.O. Box **1715**
Maryland Heights, MO 63043

Magellan Health, Inc.
PAHC – **Cambria County**
P.O. Box **2157**
Maryland Heights, MO 63043

Magellan Health, Inc.
PAHC – **Lehigh County**
P.O. Box **2127**
Maryland Heights, MO 63043

Magellan Health, Inc.
PAHC – **Montgomery County**
P.O. Box **2277**
Maryland Heights, MO 63043

Magellan Health, Inc.
PAHC – **Northampton County**
P.O. Box **2065**
Maryland Heights, MO 63043

Third Party Liability

Medicaid is always the last payer; therefore, providers must exhaust all other insurance benefits first before pursuing payment through Magellan HealthChoices.

Claims for services provided to HealthChoices' members who have another primary insurance carrier must be submitted to the primary insurer first, in order to obtain an explanation of benefits (EOB). HealthChoices will not make payments if the full obligations of the primary insurer are not met. If an individual has a primary health insurance other than Medicare and that service is covered by the other insurance, members must get the service from a provider that is in both the network of the other insurance and Magellan's network.

As a Magellan provider, you are required to hold HealthChoices' members harmless and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.

All providers who submit claims must hold active medical assistance "PROMISe" enrollment specific to the level of service provided.

Act 62

The Pennsylvania Autism Insurance Act (Act 62) was a 2009 state mandate that requires private insurance companies to pay up to an annual limit per year for diagnostic assessments and treatment of covered individuals with autism spectrum disorders (ASD) who are under age 21 (the limit is subject to change annually). Autism related services may be covered by private health insurance, the Medicaid program and/or the Children's Health Insurance Program.

Federal law requires Medicaid be the payor of last resort whenever a member has primary coverage in addition to Medicaid. Magellan is responsible for ensuring that primary insurance coverage is billed, and benefits are coordinated. This must occur prior to Medicaid reimbursing for services that are otherwise a responsibility of a primary payor.

The Department of Human Services (DHS) has identified procedure codes that reflect services for the diagnostic assessment and treatment of ASD and may be subject to Act 62. This includes ABA and IBHS services, but other services are also included. If the Medicaid beneficiary has private health insurance, providers must:

- Identify the procedure codes that are on the private health insurer's fee schedule. Private health insurance may require specific procedures codes for billing purposes. Those codes should be utilized when billing the primary insurer to ensure proper processing and payment of the claim.
- Submit claims to the private health insurance prior to billing Magellan, even if a denial was previously received for that service or a similar service.
- Submit evidence of exhaustion of benefits or denials of coverage to Magellan.

Magellan will work with providers and primary payers to coordinate benefits, ensure member and family care continuity, and issue timely payment. Additional information on ACT 62 and what this means for members and providers can be found on the DHS website

Resubmitting Claims

Claims with *provider* billing errors are called "resubmissions." Resubmitted claims must be received by Magellan within 60 days of the date on Magellan's explanation of benefits.

Resubmitted claims can be sent electronically, via an 837 file. There is a specific indicator for an adjusted claim (please consult Magellan's companion guide or the EDI hotline for assistance). When resubmitting on paper, the claim must be stamped "resubmission" and marked with a "7" for replacement claim in box 22 of Form CMS-1500) and include the original claim number that is intended to be corrected

- Failure to do so will result in an automatic denial.

Corrections can also be made to claims submitted on Magellan's website on the same day, prior to 3 p.m. CST. Click *View Claims Submitted Online* and "Edit" by the appropriate claim.

For claims corrections on a different day than submitted, or after 3 p.m. CST, the following fields can be amended: Place of Service; Billed Amount; or Number of Units. This functionality is **only** available for claims with a status of *Received/Accepted*. Corrections to claims other than Place of Service, Billed Amount or Units can be submitted on hard copy corrected claim, via postal mail as noted above.

Ordering, Referring and Prescribing (ORP)

To be eligible for payment, services that require ORP on the claim as defined by OMHSAS need to be included on all claims submissions for dates of service starting January 1, 2018. All ORP practitioners that are reported on claims need to be **actively enrolled** in the State Medicaid program.

To access all of the information related to ORP including the link to the State's technical specifications for outpatient and institutional billing, please visit the ORP page on our website. www.MagellanofPa.com

Important considerations for every agency related to ORP:

- Are my ORP staff enrolled with PA Medicaid?
- Do I have the ORP 9-digit MA "Promise" ID # and their 4-digit service location ID #?
- Do I have the ORP 10-digit NPI #?

If you have any questions related to ORP, contact our provider question email box at: PAHCPQuestions@MagellanHealth.com.

Alternative Payment Arrangements

When appropriate and approved by the State, there is a procedure Magellan uses to contract with providers outside of the traditional Fee-for-Service unit definition defined by the State. In order to participate in this arrangement, you must:

- Submit all treatment encounters, per the assigned procedure/modifier combination as outlined in your contract.
- Apply a dollar amount to zero paid claims to ensure timely processing.
- Ensure that treatment encounter claims have been submitted before sending your invoice for consideration.

Magellan will process all invoices for the submitted treatment month once the encounters have been verified. Encounters must be submitted before the payment invoice can be submitted for that month.

Proper Claims Forms and Codes

For the proper procedure code and/or modifier(s) to use for claims, consult your Magellan agreement and reimbursement schedules. Form CMS-1500 or UB-04 (formerly UB-92) should be used, if submitting claims on paper. Please see "Elements of a Clean Claim" which is available on Magellan's provider website:
https://www.magellanprovider.com/media/11924/f_cleanclaim.pdf

Claims Review

Upon receipt of a claim, Magellan reviews the documentation and makes a payment determination. As a result of this determination, a remittance advice known as an Explanation of Payment (EOP) is sent to you. The EOP includes details of payment or the denial. It is important that you review all EOPs promptly. If you have questions about EOPs or claims submitted for HealthChoices' members, contact Magellan at 1-877-769-9779.

Claims Resolution

If you believe that Magellan has incorrectly processed or denied your claim, you may submit a **claim inquiry** to Magellan, for reconsideration of your claim.

If supporting documentation is not required for Magellan to review your claim or supportive documentation is not available, providers may contact the Magellan provider line, at 1-877-769-9779 or 1-800-686-1356, and speak to a customer service representative. If necessary, the customer service associate will submit a service request application (SRA) to Magellan's claims resolution team for further investigation.

If you have supporting documentation to support payment for your claim, you may submit a written claims appeal, with your supporting documentation, to Magellan at:

Magellan Behavioral Health of Pennsylvania, Inc.
790 Township Line Rd, Suite 120
Yardley, PA 19067
Attention: Claim Appeals

Or email: ClaimAppealsPAHC@MagellanHealth.com

Upon receipt of your claim appeal, Magellan will investigate the information presented and make a determination within 30 days. Please be advised that a claim appeal is a request for a claim to be reviewed; it is not a guarantee of payment.

No claim appeal will be considered past 365 days from the date of service. It is the provider's responsibility to manage all denials and rejections and follow up with the appropriate resubmission or appeal mechanism outlined above.

If you are dissatisfied with Magellan's response to your claim inquiry, you may pursue a **Provider Complaint**, as outlined in Section 3 of this manual.

Claims Submission – Helpful Tips

The following suggestions will help expedite the processing of your claims:

- Use the appropriate billing revenue codes, procedure codes, and modifiers provided on the HealthChoices' reimbursement schedules to your Magellan agreement. This also applies to third-party liability (TPL) claims submitted to Magellan.

- Submit claims in a timely manner (see "Timely Claims Submission").
- If submitting on paper, use the appropriate claim form (UB-04 [formerly UB-92] or CMS-1500).
- Complete **all** required data on the form, including the Tax ID/SS number and NPI number.
- Use the unit of service indicated on your Magellan contract.
- Submit the Usual and Customary Charges for the service (preferred).

The following are common claims errors that may result in a denial. Check all claims prior to submission to avoid delays due to these errors:

- Corrected claims are submitted without replacement code 7 and a reference to the original denied Magellan claim number
- Authorized units do not match billed units.
- More than one month of service is billed on one claim form.
- The recipient's Medical Assistance ID number is incorrect or not utilized.
- The recipient's date of birth is missing.
- Itemized charges are not provided when a date span is used for billing.
- An EOB is not attached to a third-party claim form.
- Revenue code, procedure code and/or modifier(s) are incorrect.
- Duplicate claim submissions are not identified as "duplicate."
- The diagnosis code is not an accepted code.
- Service and/or diagnosis billed is not permitted under the provider's license.

Electronic Funds Transfer (EFT)

Electronic funds transfer (EFT) is the industry standard and a secure method that allows payments to providers in a timely manner. EFT significantly reduces administrative burdens and ultimately benefits your practice.

How to Register for EFT

- Sign in securely to **www.MagellanProvider.com** (Click the Forgot Password? or Forgot Username? links, if you need to obtain your website sign-in).
- From your MyPractice page, click Display/Edit Practice Information.
- Click Electronic Funds Transfer.
- Click Add to enter your information, then **Submit.**

After you register, Magellan will conduct a transmission test with your bank, to make sure payments transfer properly. During this time, you will continue to receive paper checks, via U.S. mail. You can access and print EOB information, via the Check Claims Status application, after secure sign in on the provider website.

In accordance with your agreement(s) with Magellan and/or its affiliated companies, you should adhere to the policies and procedures outlined in the national handbook and any supplements that apply to states in which you practice or lines of business for which you are eligible to see members.

*The EFT requirement outlined in the Magellan National Provider Handbook currently does not apply to PAHC; however, EFT is available for PAHC payments.

Eligibility Verification System

Authorization for service is based on eligibility at the time of the treatment request and does not guarantee payment. Providers are responsible for verifying a member's eligibility for HealthChoices' coverage through the PA Medical Assistance (MA) PROMISe™ Eligibility Verification System:

- Prior to the first appointment
- Throughout the course of treatment
- Prior to submitting claims

For information regarding the different options for checking EVS, go to the following DHS website address: (https://promise.DHS.state.pa.us) or call 1-800-766-5387 for interactive (real-time) eligibility verification 24 hours a day, seven days a week.

National Provider Identifier (NPI)

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 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.

There are two different types of NPI numbers: Type 1 is for health care providers who are individuals, including physicians, psychiatrists, and all sole proprietors. An individual is eligible for only one NPI; Type 2 NPIs are for health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

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

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

Providers should submit their NPI to Magellan by signing in with their secure username and password on the provider website (www.MagellanProvider.com), selecting *Display/Edit Practice Information*, and completing the NPI request field. Providers can also submit their NPI by mail or fax, by sending us a copy of their NPI notification letter or email from NPPES: Magellan Health, Attn: Data Management, PO BOX 1899 Maryland Heights, MO 63043; fax number: 1-314-387-5584.

The following are claims submission procedures specific to the NPI:

- For claims submitted via the ASC X12N 837 professional health care claim transaction, place the Type 2 NPI in the provider billing segment, loop 2010AA; and the Type 1 NPI in loop 2310B.
- On the CMS-1500 paper form (version 08/05), insert the main or billing Type 2 NPI number in Box 33a. Insert the service facility Type 2 NPI (if different from main or billing NPI) in Box 32a. Group providers only must also insert Type 1 NPIs for rendering providers in Box 24J.
- On the UB-04 form, insert the main Type 2 NPI number in Box 56.
- For claims submitted to Magellan's website via Claims Courier: Organizations/Facilities should complete the "Billing/Pay-To Provider Information" section, using the NPI number associated with the rendering service location. Individual providers should complete the "Billing/Pay-To Provider Information" section with their own type 1 NPI number. The individual's NPI number should be entered in that section only. Group providers should complete the "Billing/Pay-To Provider Information" section with the Group's type 2 NPI number. The "Rendering Provider Information" section should be completed using the rendering provider's type 1 NPI.

National Correct Coding Initiative Edits

The CMS developed the National Correct Coding Initiative (NCCI), to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service.

For more information please visit: NCCI.CMS

HealthChoices' Specific Website

Magellan Behavioral Health of Pennsylvania, Inc. has a website specific to HealthChoices' accounts in Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties: www.MagellanofPA.com. Here, providers can find all the resources they need to provide care through the Pennsylvania HealthChoices' Program. At this Internet location is everything providers need to stay current about Magellan of Pennsylvania, including the latest updates, practice guidelines, and training links, as well as county-specific information. Providers and members also can search for a provider by ZIP code, or search by level of care. (The link to the page is https://www.magellanofpa.com/for-members/find-a-provider/provider-search-start/.) The Magellan of PA website also enables the provider to link to provider websites to complete transactions.

Provider Websites

Magellan's provider website, www.MagellanProvider.com, is our primary site for provider information and business transactions. We may also direct you to the sites of Magellan's contracted vendors to perform secure online transactions. We encourage you to use provider portals often as self-service tools for supporting your behavioral health practice. We require your use of our online tools to enter and maintain the accuracy of your provider practice data.