Magellan Healthcare, Inc.*

Provider Handbook Supplement for Virginia Behavioral Health Service Administrator (BHSA)

*Magellan Healthcare, Inc. and its respective affiliates and subsidiaries are affiliates of Magellan Health, Inc. (collectively “Magellan”).
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SECTION 1: INTRODUCTION

Welcome

Welcome to the Virginia Behavioral Health Services Administrator (BHSA) Provider Handbook Supplement. This document supplements the Magellan National Provider Handbook, addressing policies and procedures specific for the Virginia BHSA plan. This provider handbook supplement is to be used in conjunction with the Magellan National Provider Handbook (and Magellan organizational provider supplement, as applicable). When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, the policies and procedures in the Virginia BHSA supplement prevail.

Covered Benefits

Magellan administers the traditional and non-traditional behavioral health and substance use services for all members covered through any Virginia Department of Medical Assistance Services (DMAS) behavioral health fee-for-service program. Magellan also administers the residential behavioral health services for members enrolled with a Medicaid/FAMIS (Family Access to Medical Insurance Security) Managed Care plan.

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Therapeutic Group Home
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<td>Peer Support Services, Substance Use</td>
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Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our Virginia website at www.MagellanofVirginia.com and our Magellan provider website at www.MagellanProvider.com (or the sites of Magellan’s contracted vendors, as directed) to complete key provider transactions. We have designed our websites for you to have quick and easy access to information, and answers to questions you may have about Magellan.

You also can reach us at the Magellan of Virginia Care Management Center:
- Phone: 1-800-424-4046 Customer Service
- Phone: 1-800-424-4536 Provider Relations
- Email: VAProviderQuestions@MagellanHealth.com
- Email for Medicaid marketing materials: VAMarketing@MagellanHealth.com
Network Provider Participation

**Our Philosophy**
Magellan works with behavioral healthcare professionals, groups, agencies and facilities to provide member care and treatment across a range of covered services as defined by DMAS.

**Our Policy**
To be a network provider of clinical services under the BHSA program, you must be enrolled according to DMAS standards. Providers are subject to applicable licensing requirements. Out-of-state providers must also be enrolled with Virginia Medicaid.

**What You Need to Do**
Your responsibility is to:

- Provide medically necessary covered services to members whose care is managed by Magellan;
- Follow the policies and procedures outlined in this handbook, any applicable supplements, as well as DMAS policies and regulations;
- Provide services in accordance with applicable Commonwealth and federal laws and licensing and certification bodies. Enrolled providers with the Virginia Medicaid network are required to abide by DMAS regulations and manuals, and maintain active licensure for their enrolled provider type and specialty for community-based services as well as at each service location;
- Agree to cooperate and participate with all care management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures; and
- Make sure only providers currently enrolled with Virginia Medicaid render services to Magellan members.

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

- Provide assistance 24 hours a day, seven days a week; and
- Assist you in understanding and adhering to our policies and procedures, the payer’s applicable policies and procedures, and the requirements of our accreditation agencies including but not limited to the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC).
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Care Management Overview

Our Philosophy
Through our care management process, Magellan joins with our members and providers to make sure members receive appropriate services and experience desirable treatment outcomes.

Our Policy
Through the care management process, we assist members in optimizing their benefits by reviewing and authorizing appropriate services to meet their behavioral healthcare needs. We do not pay incentives to employees, peer reviewers (e.g., physician advisors), or providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-authorization or under-utilization of behavioral healthcare services.

What You Need to Do
Your responsibility is to:
- Participate in the care management processes, often necessary before beginning care, and at intervals during treatment, as required by the member’s benefit plan;
- Contact Magellan to register a service or request an initial authorization, when necessary, or concurrent review authorization of care, as required by the member’s benefit plan; and
- Contact Magellan within one business day of discharge from Inpatient or Residential facilities, or within a timely manner for all other levels of care to inform of a member’s discharge from service when the member has:
  - achieved maximum benefit from the identified level of care or
  - member’s level of functioning has not improved despite the length of time in treatment and interventions attempted or
  - member chooses to discharge from the provider.

What Magellan Will Do
Magellan’s responsibility is to:
- Provide timely access to appropriate staff to conduct care management reviews;
- Manage care with the least amount of intrusion into the care experience;
- Process referrals and complete the care management process in a timely manner;
• Manage care in accordance with the requirements, allowances and limitations of the member’s benefit plan;
• Conduct care management reviews and make determinations in accordance with Department of Medical Assistance Services (DMAS) Medical Necessity Criteria, Magellan Medical Necessity Criteria or other required clinical criteria based on the assessment information provided; and
• Require Magellan employees to attend company compliance training regarding Magellan’s policy to not provide incentives for non-authorization or under-utilization of care.
Contact Information

If you have questions, Magellan is eager to assist you. We encourage you to visit our Virginia website at www.MagellanofVirginia.com and our Magellan provider website at www.MagellanProvider.com (or the sites of Magellan’s contracted vendors, as directed) to complete key provider transactions. We have designed our websites for you to have quick and easy access to information, and answers to questions you may have about Magellan.

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- Email: VAProviderQuestions@MagellanHealth.com

Before Services Begin

Our Philosophy

When members contact Magellan for a referral, our philosophy is to offer choice of practitioners or providers who best fit their needs and preferences including provider location, service hours, specialties, spoken language(s), gender and cultural aspects.

Our Policy

Our policy is to offer a choice of providers to members who best fit their needs and preferences based on member information shared with Magellan at the time of the call. We also confirm member eligibility and conduct reviews for initial authorization requests for clinical services upon request.

What You Need to Do

Your responsibility is to do the following when a member presents for care:

- Verify eligibility through a DMAS-approved method and ensure the member has active Medicaid eligibility and Service Request Authorization is submitted to the correct health plan.
- Contact Magellan as soon as possible following the delivery of emergency services to coordinate care and discharge planning.
- Contact Magellan to either register a service or request an initial authorization, except in an emergency. See Appendix A for which services require registration or service authorization.
  - When a registration or service authorization is required, follow Magellan’s service authorization process by using the Service

Please note that registration and/or authorization is necessary for claims to be paid.

- Specifics regarding service authorization requests are found in full at [www.MagellanofVirginia.com](http://www.MagellanofVirginia.com).

- To receive authorization and reimbursement of Therapeutic Group Home or Psychiatric Residential Treatment Facility, The Independent Assessment, Certification and Coordination Team (IACCT) process must be completed, and the provider must submit additional forms (ex.: Certificate of Need) to Magellan. Full details of this procedure including all required submissions, timeframes and process for submission are described on the SRA form used when submitting a request for Therapeutic Group Home or Psychiatric Residential Treatment Facility.

- For certain service authorization requests, additional documentation may be required to be submitted along with the service request application. If these documents are not included, an Administrative non-authorization may be issued.

- Contact Magellan if, during the course of treatment, you determine that services other than those authorized are required; or you discharge a service.

### What Magellan Will Do

Magellan’s responsibility is to:

- Contact you directly to arrange an appointment for members needing emergent or urgent care. *Note: those needing emergent care are referred to network facility providers as appropriate, according to State law.*

- Identify appropriate referrals based on information submitted by our providers through the credentialing process;

- Make an authorization determination based upon the information provided by the member and/or the provider;

- Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

- Communicate the authorization determination by telephone, online and/or in writing to you as required by regulation and/or contract;

- Offer you the opportunity to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested services based on the medical necessity criteria review.
• After receiving a completed (which includes all required and necessary clinical information) request form for authorization of services, issue an authorization or adverse determination within the following timeframes:
  - One business day for hospitalization initial stay; One calendar day for ARTS ASAM 4.0, 3.7, 3.5 and 3.3;
  - Three calendar days for ARTS ASAM 2.1, 2.5 and 3.1;
  - Five business days for Therapeutic Day Treatment (TDT); and.
  - Three business days for all other initial authorization decisions, including Mental Health Services, Project BRAVO services and Residential Treatment services.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Psychological Testing

Our Philosophy

Magellan’s philosophy is that treatment should be rendered at the most appropriate, least intensive level of care necessary to provide safe and effective treatment that meets the individual member’s biopsychosocial needs. Psychological testing is reimbursed when it meets the medical necessity criteria for this service.

Our Policy

Our policy is to reimburse psychological testing when the clinical interview and/or behavioral observations alone are not sufficient to determine an appropriate diagnosis and treatment plan.

What You Need to Do

Your responsibility is to:

- Conduct and fully document a complete, comprehensive member assessment;
- Be knowledgeable about the current psychological testing medical necessity criteria and be able to apply accordingly to individual service requests;
- If the testing occurs over a period of more than one day, bill all procedure codes on the last day that testing occurred;
- A base code should only be submitted for the first unit of service of the evaluation process, and only add-on codes be used to capture the services provided during subsequent days of service.

What Magellan Will Do

Magellan’s responsibility is to:

- Reimburse in accordance with applicable federal and state regulations.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Continued Stay

**Our Philosophy**
Magellan believes in supporting the most appropriate services to improve healthcare outcomes for members. We look to our providers to notify us if additional services beyond those initially authorized are needed, including a second opinion for complex cases.

**Our Policy**
Continued stay utilization management review is required for various covered services, including but not limited to:
- Inpatient
- Residential
- Mental Health Services (MHS) Addiction and Recovery Treatment Services (ARTS)

A complete list of services requiring continued stay review is found in Appendix A.

**What You Need to Do**
If after evaluating and treating the member, you determine that additional services are necessary:
- Verify eligibility through a DMAS-approved method and ensure the member has active Medicaid eligibility and the Service Request Authorization is submitted to the correct health plan.
- Magellan recommends that providers submit the appropriate service request form or call the designated Magellan care management team member at least one day before the end of the authorization period for inpatient, and at least three business days before the end of the authorization period for all other services.
- For most service types, providers are required to submit service requests to Magellan on the requested start date or within the 30-day period prior to the requested start date.
- For information about submission guidelines for each service type, please consult Appendix B and the DMAS Provider Manual that governs the service type requested. The most recent version of these manuals can be found online at: [https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual](https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual).
- Be prepared, for certain service requests, to provide Magellan with supporting materials such as CANS or Plan of Care, in addition to completing the service authorization form associated with the request.
What Magellan Will Do

Magellan’s responsibility to you is to:

• Be available 24 hours a day, seven days a week, and 365 days a year to respond to requests for authorization of care.

• Promptly review your request for additional days or visits in accordance with the applicable medical necessity criteria.

• Have a physician advisor available to conduct a clinical review in a timely manner if the care manager is unable to authorize the requested services.

• Respond in a timely manner to your request, verbally and/or in writing as the timeframe and situation warrants for additional days or visits.

• After receiving a completed (which includes all required and necessary clinical information) request form for authorization of services, issue an authorization or adverse determination within the following timeframes:
  - One business day for hospitalization continued stay;
  - One calendar day for ARTS ASAM 4.0, 3.7, 3.5 and 3.3;
  - Three calendar days for ARTS ASAM 2.1, 2.5 and 3.1;
  - Five business days for Therapeutic Day Treatment (TDT); and
  - Three business days for all other continued stay authorization decisions, including All Mental Health Services, Residential Treatment Services and Project BRAVO Services.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Appealing Care Management Decisions

Our Philosophy
We support the right of members and their providers acting on the member’s behalf to request a reconsideration of adverse clinical determinations.

Our Policy
DMAS and applicable federal and state laws impact the clinical reconsideration and appeals process. Therefore, the procedure for requesting a reconsideration of a clinical determination and appeal is outlined fully in the notification of denial or partial approval letter(s).

What You Need to Do
Your responsibility is to:

- Refer to the notification of denial or partial approval letter for the specific procedures for requesting a reconsideration of a clinical determination.

- Providers must request a reconsideration with Magellan prior to filing a formal appeal with DMAS. Members may appeal clinical denials or partial approvals to DMAS without requesting a reconsideration with Magellan. Members can submit reconsiderations with Magellan and an appeal to DMAS simultaneously.

- Request for reconsiderations must be received within 30 calendar days from the date of the written notice of adverse determination.

What Magellan Will Do
Magellan’s responsibility is to:

- Regarding inpatient stays: notify you verbally of any adverse determination and of the reconsideration and of the appeal process for you according to the member’s benefit plan. Verbal notification to be followed up by a written adverse determination letter.

- Notify you in writing of an adverse determination and the reconsideration and appeal process for your state and/or the member’s benefit plan; and

- Notify you of the reconsideration decision and any further appeal rights with DMAS.

- No recoupment of previously paid claims shall occur during the provider’s appeal through the Magellan Clinical Reconsideration Process or the DMAS appeals process set forth above.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Member Access to Care

Our Philosophy
Members are to have timely access to appropriate mental health, and/or substance use services from an in-network provider 24 hours a day, seven days a week.

Our Policy
Our Access to Care standards enable members to obtain behavioral health services from an in-network provider within a timeframe that reflects the clinical urgency of their situation.

What You Need to Do
Your responsibility is to:

- Provide access during regular business hours and instructions on how to obtain access to services 24 hours a day, seven days a week that includes:
  - Inform members of how to proceed, should they need services after business hours,
  - Provide coverage for your practice when you are not available, including, but not limited to, an answering service with emergency contact information;
- Respond to telephone messages in a timely manner;
- Provide immediate emergency services (including complying with Virginia Code regarding ECO/TDO procedures) when necessary to evaluate or stabilize a potentially life-threatening situation.
  “Emergency” is defined as: Any medical or behavioral condition of recent onset and severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his/her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing his/her health in serious jeopardy, cause serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or (in the case of a behavioral condition), place the health of such person or other in serious jeopardy.
- For non-crisis services, the facility or provider shall provide covered services to the extent such covered services are offered by facility, and its staffing levels allows them to be rendered.
- For continuing care, continually assess the urgency of member situations and provide services within the timeframe that meets the clinical urgency.
- Follow the access to service standards for the following situations:
### What Magellan Will Do

Magellan’s responsibility is to:

- Communicate the clinical urgency of the member’s situation when making referrals; and
- Assist with follow-up service coordination with a selected provider for members transitioning to another level of care from an inpatient stay.

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<tr>
<td>Emergency</td>
<td>Immediately assist with access to emergency care (such as 9-1-1 call or Emergency Room).</td>
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<tr>
<td>Non-life-threatening emergency</td>
<td>Appointment within 6 hours of the call</td>
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<tr>
<td>Urgent care</td>
<td>Appointment within 48 hours of the call</td>
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<tr>
<td>Routine care</td>
<td>Appointment within 10 business days of the call</td>
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SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Continuity, Coordination and Collaboration

Our Philosophy
Magellan appreciates the importance of the therapeutic relationship and strongly encourage continuity, collaboration, and continuation of care. Whenever a transition of care plan is required, whether the transition is to a higher or less intensive level of care, the transition is designed to allow the member’s treatment to continue without disruption whenever possible. We also believe that collaboration and communication among providers participating in a member’s healthcare is essential for the delivery of integrated quality care.

Our Policy
Our commitment to continuity, collaboration and continuation of care is reflected in a number of our policies including but not limited to:

- **Ambulatory follow-up** - This policy requires that members being discharged from an inpatient stay have a follow-up appointment scheduled prior to discharge, and that the appointment occurs within seven calendar days of discharge; inpatient facilities are expected to communicate with the Community Services Board (CSB) to which the member is returning.

- **Timely and confidential exchange of information** - Through this policy, it is our expectation that, with written authorization from the member, you will communicate key clinical information in a timely manner to all other healthcare providers participating in a member’s care, including the member’s primary care physician (PCP), as well as the local CSB, when applicable.

- **Timely access (as determined by clinical need) and follow-up for medication evaluation and management** - Through this policy, our expectation is that members receive timely access and regular follow-up for medication management.

What You Need to Do
Your responsibility is to:

- Notify Magellan within one business day when a member discharges from Inpatient, ARTS ASAM 3.3-4.0, or Residential facilities;

- Collaborate with Magellan’s care management team and/or the member’s managed care organization (MCO), dependent upon member’s eligibility, to develop and implement discharge plans prior to the member being discharged from an inpatient setting or;
• Cooperate with follow-up verification activities and provide verification of kept appointments when requested, subject to applicable federal, state and local confidentiality laws; *
• Work with Magellan and/or MCO to establish discharge plans that include a post-discharge scheduled appointment within seven days of discharge;
• Notify Magellan immediately if a member misses a post hospital-discharge appointment;
• Promptly complete and submit a claim for services rendered confirming that the member kept the aftercare appointment;
• Explain to the member the purpose and importance of communicating clinical information with other relevant healthcare providers;
• Obtain, at the initial treatment session, the names and addresses of all relevant healthcare providers involved in the member’s care;
• Obtain written authorization from the member to communicate significant clinical information to other relevant providers; and
• Subject to applicable law, include the following in the Authorization to Disclose (AUD) document signed by the member:
  - A specific description of the information to be disclosed,
  - Name of the member(s), or entity authorized to make the disclosure,
  - Name of the member(s), or entity to whom the information may be disclosed,
  - An expiration date for the authorization,
  - A statement of the member’s right to revoke the authorization, any exceptions to the right to revoke, and instructions on how the member may revoke the authorization,
  - A disclaimer that the information disclosed may be subject to re-disclosure by the member and may no longer be protected,
  - A signature and date line for the member, and
  - If the authorization is signed by the member’s authorized representative, a description of the representative’s authority to act for the member.
• Upon obtaining appropriate authorization or AUD, communicate in writing to the PCP, at a minimum, at the following points in treatment:
  - Initial evaluation,
- Significant changes in diagnosis, treatment plan, or clinical status,
- After medications are initiated, discontinued or significantly altered, and
- Termination of treatment.

- Collaborate with medical practitioners to support the appropriate use of psychotropic drugs; and
- Provide suggestions to Magellan’s regional medical or clinical directors on how Magellan can continue to improve the collaboration of care process.

What Magellan Will Do

Magellan’s responsibility is to:

- Work with you, the member, and the member’s family to make any necessary transition of care as seamless as possible;
- Facilitate timely communication with the member’s PCP whenever possible including providing you with the name and address of member’s PCP, if the information is available and the member is unable to do so;
- Work with the facility provider’s treatment team to arrange for continued care with outpatient care providers, ARTS, and CMHRS providers, after discharge;
- Review medical records to measure compliance with this policy;
- Actively solicit your input and consider your suggestions for improving the collaboration of care process;
- Confirm that aftercare appointments have been established within seven days for members who have been discharged from psychiatric inpatient facilities; and
- Provide an MCO Liaison to coordinate care between physical health and behavioral health services.

*Health Insurance Portability and Accountability Act (* HIPAA) Privacy Rule includes these ambulatory follow-up activities within its definition of healthcare operations. The Privacy standards allow providers to disclose members’ Protected Health Information (PHI) to Magellan in support of Magellan’s operations without an authorization from the member.
Advance Directive

The Commonwealth of Virginia allows individuals to make an “advance directive” for mental health decision-making in accordance with Virginia’s revised Health Care Decisions Act. Providers shall ask each member whether or not they have a psychiatric advance directive and document this information accordingly in the member’s record.

**Our Philosophy**

An advance directive for mental health decision-making (advance directive) is a legal form. It describes how members want to be treated if they are not able to speak for themselves. Advance directives are a valuable decision support tool that promotes self-direction and choice, consistent with recovery-oriented systems of care.

**Our Policy**

Magellan will provide information about advance directives for mental health decision-making to providers and to members in the appropriate handbook, other member materials, and through educational outreach events.

**What You Need to Do**

Your responsibility is to:

- Ask whether or not a member has an advance directive. This must be noted in the member’s treatment record.
- If a member has an advance directive for mental health decision-making, ask the member if they would like to include their advance directive in their treatment record.
- Offer information about advance directives and assistance to the member in creating an advance directive if the member chooses.
- You must be familiar with the requirements relevant to honoring advance directives except in circumstances detailed in the Virginia revised Health Care Decisions Act.

**What Magellan Will Do**

Magellan’s responsibility is to:

Provide information and education about advance directives to members as part of initial orientations, ongoing educational activities, in the member handbook, and on the Magellan of Virginia website. This includes information about the National Center on Psychiatric Advance Directives at [http://www.nrc-pad.org/](http://www.nrc-pad.org/), Virginia-specific information at [www.virginiaadvancedirectives.org](http://www.virginiaadvancedirectives.org), as well as the Virginia Department of Health Advance Health Care Directive Registry at [https://www.connectvirginia.org/adr/](https://www.connectvirginia.org/adr/), where members may store their advance directives.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Medical Necessity Criteria

**Our Philosophy**

Magellan is committed to the philosophy of promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member’s biopsychosocial needs. Medical necessity criteria are applied based on the member’s individual needs including, but not limited to, clinical features and available behavioral healthcare services.

**Our Policy**

Magellan uses DMAS, American Society of Addiction Medicine (ASAM), and Magellan medical necessity criteria for making service authorization decisions. DMAS criteria are mainly based on Virginia Administrative Code, the DMAS Mental Health Services Manual, the DMAS Psychiatric Services Manual, the DMAS ARTS manual, and the Residential Treatment Services Manual. Magellan medical necessity criteria (which is available on www.MagellanofVirginia.com) are used for determining medical necessity for Inpatient Psychiatric requests.

**What You Need to Do**

Your responsibility is to:

- Review and be familiar with DMAS, ASAM, and Magellan’s current medical necessity criteria (MNC);
- If you have questions about which MNC apply to which services, refer to Appendix A or contact Magellan’s Care Management Center; and
- Submit suggestions for revisions to the MNC using the contact information located at www.MagellanofVirginia.com, or by submitting your feedback in writing to the applicable Magellan Care Management Center’s medical director.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Make the specific service MNC available to you free of charge, as appropriate;
- Invite and consider your comments and suggestions for revisions to the MNC; and
- Monitor the use of the MNC to make sure they are applied consistently.
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Clinical Practice Guidelines

IMPORTANT NOTE: This section has been left in as a placeholder, for your information. This section is included in the Magellan national provider handbook; any sections that are identical in content are not duplicated within this handbook supplement. Providers will use the national handbook in conjunction with this supplement.

REFER TO NATIONAL HANDBOOK FOR THIS SECTION
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Clinical Monographs

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
NEW TECHNOLOGIES

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
Provider Website

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

Our Policy
Magellan’s site specifically for VA Medicaid/FAMIS providers at www.MagellanofVirginia.com, along with Magellan’s corporate provider website at www.MagellanProvider.com, are Magellan’s primary portals for provider communication, information and business transactions. These websites are continually updated to provide easy access to information and greater convenience and speed in exchanging information with Magellan. Magellan encourages providers to use these websites (or the sites of Magellan’s contracted vendors, as directed) often as self-service tools for supporting the provider’s behavioral health practice.

What You Need to Do
To realize the benefits of the Magellan provider websites, you should:
• Have access to a personal computer, Internet service provider and current web browser software;
• Securely sign in to Magellan’s provider website (or the sites of Magellan’s contracted vendors, as directed) to access applications (e.g., eligibility, authorizations and claims);
• Visit our websites frequently to take advantage of new capabilities and access resources; and
• Provide us with feedback on any difficulties you may experience in using our online resources or on ideas you have for enhancements.

*For group or Organization practices, the first individual to sign in will be designated “Group Administrator.” The Group Administrator is responsible for providing access to Magellan online applications to appropriate group practitioners.

What Magellan Will Do
Magellan’s responsibility is to:
• Maintain operation of online services on a 24 hours a day, seven days a week basis;
• Inform users of service problems if they occur;
• Use your feedback to continually improve our website capabilities; and
• Provide online access to the following applications via a Magellan portal or those of a contracted vendor:
- Request for initial and subsequent authorization;
- Authorization inquiry and report download;
- Authorization approval letters;
- Claims submission (for professional services only for which Magellan is the designated claims payer);
- Claims inquiry and online explanation of payments (EOPs);
- Electronic funds transfer (EFT) signup;
- Cultural competency tools;
- Online demos to help providers navigate website applications;
- Comprehensive library of clinical practice information; and
- Other tools and information beneficial to providers serving Magellan members.
A Commitment to Quality

**Our Philosophy**
Magellan is committed to Continuous Quality Improvement (CQI) and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.

**Our Policy**
In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards and apply them in clinical work with members in order to provide safe, effective, patient-centered, timely, efficient, and equitable care in a culturally sensitive manner.

**What You Need to Do**
Your responsibility is to:

- Follow the policies and procedures outlined in the What You Need to Do sections in this handbook;
- Meet treatment record standards as outlined in the Treatment Documentation Worksheet in the appendix of the national handbook;
- Participate in treatment plan reviews, site visits and other quality improvement activities;
- Use evidence-based practices;
- Adhere to principles of patient safety;
- Attend or log onto provider training sessions;
- Participate in the completion of a remediation plan if quality of care concerns arise;
- Complete and return provider satisfaction surveys;
- Consider incorporating the use of secure technology into your practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, and online access to personal health record information;
- Assist with transition of care if a member’s benefits have been exhausted, you leave the Medicaid provider network, or you receive a referral of a member whose provider has left the Medicaid provider network, a member wants to change providers, or stop services prior to service authorization expiration;
- Assist in the investigation of member complaints and adverse incidents, if necessary;
Attend meetings of our quality committees and provider advisory groups, if requested;

- Review member-specific clinical reports, when available; and
- Be knowledgeable in quality improvement methods and tools including NCQA’s HEDIS® measures.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Consider your feedback on clinical practice guidelines, medical necessity criteria, prevention programs, patient safety policies, and new technology assessments;
- Consider your feedback in our quality committees;
- Develop methods to compare treatments, outcomes, and costs across the Medicaid provider network in an effort to diminish the need for case-by-case review of care;
- Provide member-specific clinical reports, when available;
- Monitor provider satisfaction with our policies and procedures as they affect you and your practice;
- Pay claims within applicable timeframes;
- Provide detailed information about how we will assess your practice during site visits and treatment record reviews;
- Join with you to develop a clear remediation plan to improve quality of care when necessary; and
- Resolve grievances and reconsiderations within applicable timeframes.
Cultural Competency

Our Philosophy
Magellan is committed to embracing the rich diversity of the people of Virginia. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who are visually and hearing impaired. All people entering the behavioral healthcare system must receive equitable and effective treatment in a respectful manner, recognizing the role that individual spoken language(s), gender, and culture plays in a person’s health and well-being.

Our Policy
Magellan staff is trained in cultural diversity and sensitivity, in order to refer members to providers appropriate to their needs and preferences. Magellan also provides cultural competency training, technical assistance and online resources to help providers enhance their provision of high quality, culturally appropriate services.

What You Need to Do
Your responsibility is to:
- Report information on languages you speak and specialties you provide during your initial enrollment or revalidation with DMAS.
- Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to members. Members must be provided with information instructing them how to access these services. Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages. In general, any document that requires the signature of the behavioral health member, and that contains vital information regarding treatment, medications, or service plans must be translated into their preferred/primary language if requested by the behavioral health member or his/her guardian.

What Magellan Will Do
Magellan’s responsibility is to:
- Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities;
• Provide language assistance, to Magellan call-center callers using interpreter services, to those with limited English proficiency during all hours of operation at no cost to the member.

• Assist providers in locating interpreters for our members when requested by the member or when requested by the provider;

• Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area; and

• Monitor gaps in services and other culture-specific provider service needs.
SECTION 4: THE QUALITY PARTNERSHIP

Member Safety

Our Philosophy
Magellan believes in the delivery of high-quality, safe behavioral healthcare services. We reinforce this commitment by embedding objective and systematic monitoring mechanisms into our policies and procedures.

Our Policy
Magellan monitors the safety of members receiving treatment from our providers. Monitoring includes, but is not limited to, member feedback, performance indicator reviews, site visits, treatment record reviews and surveys.

What You Need to Do
Your responsibility is to:

• Have a written member safety plan;
• Enhance and monitor the safety of members as related to their treatment while in your care;
• Be familiar with Magellan clinical guidelines related to member safety and use them in treatment decisions and management;
• Communicate to Magellan your plan and outcomes related to member safety when requested; and
• Complete the annual Member Safety Survey.

What Magellan Will Do
Magellan’s responsibility is to:

• Provide information about the data being requested and the rationale, methods, and standards employed in the review process;
• Work closely with you to improve performance on indicators that are below standard; and
• Communicate the results of member safety monitoring to our providers, customers, and members.
SECTION 4: THE QUALITY PARTNERSHIP

Accreditation

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
SECTION 4: THE QUALITY PARTNERSHIP

Prevention/Screening Programs

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SECTION 4: THE QUALITY PARTNERSHIP

Outcomes

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SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

**Our Philosophy**

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

**Our Policy**

Magellan obtains provider input on our programs and services through provider satisfaction surveys, participation in Magellan quality committees as appropriate, our provider website (or the sites of Magellan’s contracted vendors, as directed), and through special requests for feedback, such as for our clinical practice guidelines and prevention program development.

**What You Need to Do**

Your responsibility is to:

- Provide feedback on our clinical practice guidelines, medical necessity criteria, prevention programs, new technology assessments, and other guidelines and policies, if requested;
- Return completed provider satisfaction surveys, if requested;
- Attend committee meetings, if requested;
- Provide feedback on special projects, including research studies, as requested; and
- Provide feedback/lodge grievances through the Magellan provider website or by contacting your local Care Management Center staff for investigation and resolution of the issue.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Advise you of the forums available for your feedback;
- Actively request your input in the development and/or update of our policies and procedures; and
- Consider your input while developing or reviewing new and established policies, procedures, programs, and services.
Member Rights and Responsibilities

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SECTION 4: THE QUALITY PARTNERSHIP

Confidentiality

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
Site Visits

Our Philosophy
Magellan may conduct site visits with providers to assess the quality of care and services provided, evaluate adherence to policies and procedures, and support various quality improvement activities.

Our Policy
Magellan conducts site visits at individual and group practices, and at facilities and organizations, to directly assess the physical appearance of the facility/office, adequacy of waiting and treatment room space, physical accessibility, appointment accessibility, staffing, and treatment record-keeping practices. Magellan may also conduct unannounced site visits in situations where there is a potential risk to member safety. Magellan Provider Network staff conducts administrative aspects of site reviews, while Magellan licensed clinicians and Quality Improvement (QI) staff review specific clinical documents, as needed. Provider site visits may be conducted on other occasions as determined by quality or clinical reviews. Site visits may include, but not be limited to, a review of the following:

- Routine appointment availability, and procedures for access;
- Availability of care in emergencies and after-hours situations;
- Procedures to maintain confidentiality of member information;
- Procedures for disclosure of member information;
- Physical site environment, including appearance, accessibility, etc.;
- Staff orientation, training, and supervision (as appropriate);
- Treatment record-keeping practices;
- Documentation in member records;
- Documentation of contact with PCP, Community Services Board or other providers as clinically indicated (when authorized by the member);
- Credentials verifications of licensed clinical staff; verification and other human resources procedures for direct care staff; and
- Quality improvement and safety management programs.

What You Need to Do
Your responsibility is to:

- Comply with requests for site visits;
• Provide information in a timely manner, including files as requested by the site visit reviewer;
• Be available to answer questions from the reviewer; and
• Participate in developing and implementing a corrective action plan if required.

**What Magellan Will Do**

Magellan’s responsibility is to:

• Advise the provider if a site visit may occur (if there is no potential risk to member safety);
• Advise you of what you need to do to prepare for the site visit (only in cases where there is no potential risk to member safety);
• Notify you of the results of the site visit in a timely manner;
• Provide education or assistance in meeting the standard of care, Magellan policy, and regulatory requirements.
• Work with you to develop a corrective action plan, if required.
SECTION 4: THE QUALITY PARTNERSHIP

Treatment Record Reviews

Our Philosophy

In support of our commitment to quality care, Magellan requests that providers maintain organized, well-documented member medical records that reflect continuity of care for members. Magellan expects that all aspects of treatment will be documented in a timely manner, including face-to-face encounters, telephone contacts, clinical findings, and interventions.

Our Policy

For quality improvement purposes, Magellan reviews a random sample of treatment records from participating providers who render services to Magellan members.

What You Need to Do

Your responsibility is to:

• Follow the detailed instructions provided if you are selected for a review;
• Make the records requested available for our review;*
• Cooperate with Magellan in developing and carrying out a quality improvement plan if opportunities for improvement are identified; and
• Implement quality improvement plans if established.

What Magellan Will Do

Magellan’s responsibility is to:

• Provide detailed information prior to the review concerning the rationale, methods and standards employed in the review process;
• Request the minimum necessary protected health information to perform medical record reviews;
• Recommend and require steps to be taken to improve quality of treatment record documentation; and
• Work closely with you in carrying out a corrective action plan, if required.

* When the HIPAA Privacy Rule is applicable, it allows Magellan and providers to use and disclose PHI for treatment, payment, and healthcare operations activities.
SECTION 4: THE QUALITY PARTNERSHIP

Member Satisfaction Surveys

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
SECTION 4: THE QUALITY PARTNERSHIP

Provider Satisfaction Surveys

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SECTION 4: THE QUALITY PARTNERSHIP

Adverse Outcome Reporting

Our Philosophy
In our quest for our members to receive quality behavioral healthcare services, we routinely review quality of care concerns and adverse outcome occurrences to identify opportunities for improvement.

Our Policy
We initiate a quality of care review for known incidents in which an individual, who is a Magellan member at the time of the incident and who has been in treatment within six months of the incident, completes a suicide or homicide and/or engages in another type of serious incident that results in serious harm to the member or others.

What You Need to Do
Your responsibility is to:

• Within one (1) business day, contact the Magellan care management center to report any of the following incidents involving a Magellan member currently in treatment, or a member who was discharged from treatment within 180 days prior to the occurrence of:
  - Death;
  - Suicide or serious suicide attempt;
  - An incident of violence initiated by the member; or
  - Other incident resulting in serious harm to the member or others, that includes but is not limited to serious complications from a psychotropic medication regimen that required medical intervention.

• Please provide the following information via fax (888-656-5396) or online via the Adverse Outcomes submission form located on www.MagellanoofVirginia.com when notifying Magellan of an Adverse Outcome:
  - Member’s name and Medicaid number;
  - Facility/Provider name, address, and National Provider Identifier (NPI) number;
  - Name(s) of staff involved (if applicable);
  - Detailed description of the incident, including the dates and location of the incident;
Virginia BHSA Provider Handbook Supplement

- Outcome, including the person(s) notified;
- Current location and status of the member; and
- Steps taken to ensure continued member safety.

If additional clinical support is needed, please contact our care management center via the customer service phone number.

**What Magellan Will Do**

Magellan’s responsibility is to:

- Serve as a resource to manage the clinical situation presented by the adverse incident or potential adverse incident; and
- Investigate all adverse incidents in a timely manner.
SECTION 4: THE QUALITY PARTNERSHIP

Inquiry and Review Process

Our Philosophy
Magellan is committed to developing and maintaining a high-quality provider network.

Our Policy
Magellan maintains a process for inquiry, review, and action when concerns regarding provider performance are identified.

What You Need to Do
Your responsibility is to:
Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Virginia Medicaid provider network.

What Magellan Will Do
Magellan’s responsibility is to:
• Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised;
• Advise you if an on-site and/or treatment record review is required;
• Review all inquiries for adequate resolution of any performance concerns;
• Provide you with an opportunity to respond to quality of care or service concerns before taking further action (unless there is the belief that there is an immediate threat to the health, welfare, or safety of members);
• Advise you when a corrective action plan and follow-up are required;
• Advise you to contact DMAS when there is a change in the conditions of your network participation, if determined to be required; and
• Advise you, in writing, if any action is taken as a result of the inquiry and review process.
SECTION 4: THE QUALITY PARTNERSHIP

Fraud, Waste and Abuse

Our Philosophy

Through comprehensive Fraud, Waste, and Abuse (FWA) management practices, we incorporate effective approaches to discover potential FWA issues with all provider types. Magellan maintains written policies and procedures to guide the application of the anti-fraud practices, and to operate a comprehensive FWA prevention and detection program.

Fraud means making false statements or misrepresentations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person’s own benefit or for the benefit of another party. In order to be considered fraud, the act must be performed knowingly, willfully, and intentionally.

Abuse describes practices that, either directly or indirectly, result in unnecessary costs, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse is similar to fraud except that one is not required to prove or demonstrate that abusive acts were committed knowingly, willfully and intentionally. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Waste means activities involving payment or the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, but the outcome or poor or inefficient billing or treatment methods cause unnecessary costs.

Our Policy

Magellan will fully cooperate and assist Virginia’s Department of Medical Assistance Services and any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. Magellan will provide records and information, as requested.

What You Need to Do

Your responsibility is to report any suspected, perceived or actual cases of fraud, waste or abuse.

- To report suspected provider fraud to Magellan:
  - 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
To report suspected recipient fraud to Virginia’s Department of Medical Assistance Services:

**Department of Medical Assistance Services**
Recipient Audit Unit
600 East Broad Street
Suite 1300
Richmond, VA 23219

Phone: 1-800-371-0824
Email: Recipientfraud@DMAS.virginia.gov
Website: [http://dmasva.dmas.virginia.gov](http://dmasva.dmas.virginia.gov)

**What Magellan Will Do**

Magellan has the responsibility to assess the merits any allegation of fraud, waste, or abuse. Magellan performs all necessary investigations and coordinates with the Department of Medical Assistance Services to prevent, investigate, and recoup any funds paid for claims arising from fraud, waste or abuse.
SECTION 4: THE QUALITY PARTNERSHIP

HIPAA Transaction Standards

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REFER TO NATIONAL HANDBOOK FOR THIS SECTION
Claims Filing Procedures

Our Philosophy
Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to avoid administrative denials that delay payment and require resubmission of claims.

Our Policy
Magellan reimburses Virginia Medicaid/FAMIS providers for mental health and substance use treatment services using DMAS fee schedules and rates. Magellan’s professional reimbursement schedules include the most frequently billed services. Claims must be submitted within 365 days of the provision of covered services. Magellan will deny claims not received within 365 days. A claim must contain no defect or impropriety, including a lack of any required substantiating documentation, HIPAA compliant coding or other particular circumstance requiring special treatment that prevents timely payments from being made. If the claim does not contain all required information, it may be denied.

What You Need to Do
Your responsibility is to:
• Contact the Magellan of Virginia Care Management Center prior to rendering care, for services requiring authorization or registration;
• Complete all required fields on the claim submission accurately;
• Submit claims for services delivered in conjunction with the terms of your agreement with Magellan;
• Use only standard codes sets as established by the Centers for Medicare and Medicaid Services (CMS) or DMAS for the specific claim form (UB-04 or CMS-1500) you are using;
• Submit claims within 365 days of the provision of covered services;
• Submit claims only for services rendered within the time span of the authorization;
• Contact Magellan for direction if authorized services need to be used after the authorization has expired;
• Not bill the patient for any difference between your Magellan contracted reimbursement rate and your standard rate – this practice is called “balance billing” and is not permitted by Magellan;
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- Contact the Magellan of Virginia Care Management Center managing the member’s services if you are not certain which reimbursement rate applies to the member in your care;
- Refer to claims filing information on www.MagellanProvider.com;
- Submit BHSA claims electronically (the preferred method) or to:

  Magellan Healthcare – VA DMAS
  P.O. Box 1099
  Maryland Heights, MO 63043

What Magellan Will Do

Magellan’s responsibility is to:

- Provide verbal notice, send an authorization letter and/or provide electronic authorization when we authorize services;
- Process your claim promptly upon receipt, and complete all transactions within regulatory and DMAS standards;
- The Magellan claims system processes continually as claims are received from providers and the funds are approved by DMAS. The billing cycle for Virginia BHSA claims will follow this sample timeline:
  - Week 1-Provider submits claims to Magellan.
  - Week 2-Magellan submits claims to DMAS for review/payment on a weekly basis.
  - Week 3-DMAS releases funds to Magellan for provider reimbursement.
- Apply National Correct Coding Initiative (NCCI) claim edits to claim submissions. The NCCI claim edits module is a group of system edits defined by CMS to assure correct coding;
- Inform you of any reasons for administrative denials and action steps required to resolve the administrative denial;
- Send you or make available online an explanation of payment (EOP) or other notification for each claim submitted including procedures for filing reconsideration request;
- Provide appropriate notice regarding the reason for the claim denial, listing any missing claim information that is required, when appropriate. Claims Resubmission Process - Magellan will process corrected claims upon receipt of requested information from the provider. To be timely, corrected claims must be received within 13 months from the date of the initial denied claim as long as the initial claim was filed within 12 months from the date of service.
Any claims submitted 13 months or beyond the date of service would need to be submitted by the provider through the reconsideration process.

- Adjudicate claims (submissions or resubmissions) based on information available. If the information requested is not received within 365 days, the claim may be denied for insufficient information, subject to applicable state and federal law;
- Include all applicable reimbursement schedules as exhibits to your contract;
- Comply with applicable DMAS and federal regulatory requirements regarding claims payment; and
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

Claim Reconsideration Process

For claims submitted within timely filing: Providers that disagree with the action taken by Magellan may request a reconsideration of the process by submitting a request for reconsideration * online at www.MagellanofVirginia.com, by fax at 1-888-656-0399 or to the following mailing address:

Magellan Healthcare of Virginia
Attn: Quality Department
P.O. Box 5879
Glen Allen, VA 23058

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation will not be considered. Reconsideration* requests received after the 30-day time limit will be denied as untimely.

*Note: Reconsideration requests are different from the resubmission of corrected claims. Magellan will process corrected claims upon receipt of requested information from the provider. To be timely, corrected claims must be received within 13 months from the date of the initial denied claim, as long as the initial claim was filed within 12 months from the date of service. Any claims submitted 13 months or beyond the date of service must be submitted by the provider through the reconsideration process.
Reconsideration for claim payment beyond timely filing:

Federal Timely Filing Regulations - In accordance with Federal Regulations [42 CFR § 447.45(d)], Magellan must require the initial submission of all claims (including accident cases) within 12 months from the date of service. Federal financial participation is not available for claims that are not submitted within 12 months from the date of the service. Submission is defined as actual receipt by Magellan. In cases where the actual receipt of a claim by Magellan is undocumented, it is the provider’s responsibility to confirm actual receipt of a claim by Magellan within 12 months from the date of the service reflected on a claim.

Requests for claim payment beyond timely filing must be submitted to Magellan by the provider through the reconsideration process. Magellan is not authorized to make payment beyond timely filing, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Magellan the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Magellan may make payment for services billed more than 12 months from the date of service in certain circumstances. Magellan denials may be overturned or other actions may cause eligibility to be established for a prior period. Magellan may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider’s obligation to verify the patient’s Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the “signed and dated” letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied Claims - In order for a denied claim to be considered for payment beyond timely filing, providers must send the claim through
the reconsideration process. This includes new or resubmitted claims beyond 12 months of the date of service. The maximum timeframe for consideration of resubmitted claims is 13 months from the date of the initial denied claim, where the initial denied claim was received within the 12-month timely filing limit. In these circumstances, the provider must also include documentation to reflect efforts to resolve claim issues (through resubmission) within 6 months of the date of the last claim denial. No (resubmitted) claims will be considered for payment beyond 13 months from the date of the initial denied claim (i.e., where the initial claim was received within the 12-month timely filing limit).