

Magellan Healthcare, Inc.*

Provider Handbook Supplement for California

Revised February 2021



*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services.

Table of Contents

SECTION 1: KNOX-KEENE REGULATIONS INTRODUCTION	4
Welcome.....	4
Contact Information.....	4
SECTION 2: MAGELLAN’S BEHAVIORAL HEALTH NETWORK	5
Recredentialing – Continuous Credentialing.....	5
SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN	6
Before Services Begin.....	6
Senate Bill 855	10
Appealing Care Management Decisions – Member Complaints and Appeals.....	11
Member Access to Care – Appointment Access Standards	14
Keeping Your Practice Data Current.....	16
SECTION 4: THE QUALITY PARTNERSHIP	19
A Commitment to Quality	19
Provider Input	20
Cultural Competency and Language Assistance Services	21
SECTION 5: PROVIDER REIMBURSEMENT	23
Claims Filing and Claims Disputes	23

See [Appendices to the California provider handbook supplement](#)

California Medical Necessity Criteria - The Magellan California subsidiaries, Human Affairs International of California and Magellan Health Services of California, Inc. – Employer Services have adopted certain guidelines by which requests for services will be evaluated for medical necessity. These guidelines include ASAM, LOCUS, CALOCUS, CASII, ESCII, MCG and [Magellan Care Guidelines](#) as outlined in the National Provider Handbook. Please refer to the California Review Criteria / Guidelines Grid for a designation of service and the corresponding criteria.

Clinical Practice Guidelines - The Magellan California subsidiaries, Human Affairs International of California and Magellan Health Services of California, Inc. – Employer Services have adopted Magellan’s [Clinical Practice Guidelines](#) as outlined in the National Provider Handbook.

California Member Grievance Forms (English and Spanish)

Independent Medical Review Policy

Claims Settlement Practices and Dispute Resolution

Language Assistance Services

Sample Patient Financial Responsibility Acknowledgement Form

Please refer to the Magellan [National Provider Handbook](#) and its [Appendices](#) section for all policies and procedures with the exception of the pages and appendices set forth above. This Handbook Supplement provides additional guidance in connection with HMO plans and

*Employee Assistance Programs regulated under the Knox-Keene Health Care Service Plan Act; this Supplement does **not** apply to services in connection with other group health plans. All references in this Supplement and in the National Provider Handbook, including Appendices, to “Magellan” should be read as referring to Human Affairs International of California and/or Magellan Health Services of California, Inc. – Employer Services.*

SECTION 1: KNOX-KEENE REGULATIONS INTRODUCTION

Welcome

Magellan Health Services, Inc. conducts its behavioral health business in California that is regulated under the Knox-Keene Health Care Service Plan Act (“Knox-Keene”) through two California-based subsidiaries: Magellan Health Services of California, Inc. – Employer Services and Human Affairs International of California. Magellan is committed to meeting the quality assurance and consumer protection and provider protection requirements of the Knox-Keene Act and regulations issued by the Department of Managed Health Care (“DMHC”). This section sets forth special obligations of Magellan and providers contracted with Magellan designed to ensure compliance with Knox-Keene requirements.

Contact Information

Magellan Healthcare: 1-800-288-0558

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Recredentialing – Continuous Credentialing

Our Philosophy

In support of Magellan's ongoing commitment to promoting quality care for our members, we regularly re-review provider licensure.

Our Policy

Recredentialing of providers with respect to licensure is conducted on a continuous basis.

What You Need to Do

In support of this policy, you are responsible to renew your professional license on a timely basis to avoid any lapse in licensure.

What Magellan Will Do

If you fail to renew your license on a timely basis, we will send you a reminder and suspend your network status. If you fail to renew within 60 days, we will terminate your network participation.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Before Services Begin

Our Philosophy

Magellan joins with our members, providers and customers to make sure members receive the most appropriate services and experience the most desirable treatment outcomes under their benefits.

Our Policy

Magellan refers members to providers 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 requests for clinical services upon request.

What You Need to Do

Your responsibility is to:

Obtain Precertification and Ongoing Certification

Providers are required to obtain precertification for admission and ongoing certification for continued care for non-routine services, non-emergency hospitalizations and other facility-based mental health and substance use disorder services, subject to the member's benefit plan. Some of the non-routine services include: intensive outpatient program (IOP), outpatient electroconvulsive therapy (ECT), applied behavior analysis (ABA), transcranial magnetic stimulation (TMS), psychological testing, neuropsychological testing, and biofeedback, provided these services are a covered benefit.

As of April 12, 2021, for all requests for services (precertification, concurrent and retro-certification) providers must provide medical records supporting the requested services. Requests for services without accompanying medical records will be administratively denied for lack of information necessary to render a determination.

If a provider does not obtain precertification for services, Magellan will allow the provider a one-day grace period to obtain retroactive certification and supply documentation to support medical necessity criteria. For retrospective reviews, Magellan will take into consideration extenuating circumstances that prevented the provider from timely notification, e.g., gravely disabled or psychotic member unable to provide insurance information.

Based on the member's benefit plan, services provided without precertification or ongoing certification may be subject to retrospective medical necessity review. If medical necessity cannot be demonstrated, services may not be covered. Where applicable, if retrospective requests are denied for medical necessity, Magellan will issue an administrative denial for failure to certify services, effective

the date of admission or last covered day of ongoing services. Magellan will review services for medical necessity prospectively from the date of notification forward. If retro-certification is denied, the facility is held liable for all services that took place prior to Magellan being notified, from date of admission. In-network providers must hold members harmless under these circumstances.

Please also note that Magellan is available to take calls for all services 24 hours a day, seven days a week. Magellan continues to expect providers to contact Magellan for notification after hours for all services requiring certification. Magellan after-hours staff will perform a clinical review for certification for inpatient hospitalization; for residential, partial hospitalization, or intensive outpatient services, the facility must call the next business day for certification.

Your responsibility is to:

Outpatient Care

- Confirm member eligibility, member benefits, applicable member copayments/coinsurance/deductibles, and timely filing timelines prior to the member's visit, via provider portal or contact center.
- Obtain pre-authorization for outpatient ABA services, biofeedback and psychological/neuropsychological testing (all provider types), TMS, ECT and OBOT.
- Obtain additional outpatient authorizations for additional services as needed when applicable.
- Provide medical records and any other documentation necessary to substantiate medical necessity for the services requested.
- Acquire the copayment/coinsurance/deductible from the member at the time of the visit.
- Follow Magellan medical necessity criteria and clinical practice guidelines.
- Submit all claims to Magellan on behalf of the member.
- Coordinate care with outpatient behavioral health providers and PCPs in writing or by telephone.

Your responsibility is to:

Facility-Based Care

- Understand federal and state standards applicable to providers.
- Comply with federal and state standards.
- Contact Magellan for prior authorization of all facility-based care services.
- Provide medical records and any other documentation necessary to substantiate medical necessity for all services requested.
- Not require a primary care physician (PCP) referral from members.
- Not require prior authorization of emergency services or urgent care services.
- Requests for substance use residential treatment services must include reference to the level of treatment as outlined in ASAM criteria (3.1, 3.3, 3.5 or 3.7).

- Arrange for appropriate outpatient care/discharge planning including securing of 7-day follow-up after hospitalization (FUH) appointment, appropriate stepdown coordination, and linkage to appropriate resources including coordination with Magellan case management programs prior to discharge.
- Provide an individualized care and treatment program.
- Alert outpatient providers of admission and coordinate care with outpatient behavioral health providers and PCPs in writing or by telephone.

What Magellan Will Do

Magellan’s responsibility to you is to:

Outpatient Care

- Operate toll-free telephone numbers to respond to provider questions, comments and inquiries (see [contact information](#) above).
- Establish a multi-disciplinary Utilization Management Committee to oversee all utilization functions and activities.
- Make decisions about non-urgent prior authorizations within five business days of receipt of the request. The determination will be communicated via telephone or fax to the requesting provider within 24 hours of making the determination.
- Conduct an expedited coverage review when the member’s condition is such that he/she faces an imminent and serious threat to his or her health, including, but not limited to the potential loss of life, limb, or other major bodily function, or the standard time frame for the decision-making process would be detrimental to the member’s life or health or could jeopardize the member’s ability to regain maximum function. Upon receipt of a request that is complete, a medical necessity review of requested services is initiated, and verbal notification of the determination is given to the provider in a timely fashion appropriate for the member’s condition not to exceed 72 hours after receipt of the request, if applicable for OP services.

Magellan’s responsibility to you is to:

Facility-Based Care

- Operate a toll-free telephone number to respond to provider questions, comments and inquiries (see [contact information](#) above).
- Establish a multi-disciplinary Utilization Management Oversight Committee to oversee all utilization functions and activities.
- Make decisions about expedited prior authorizations within 72 hours of the receipt of the request and give verbal notification within 24 hours of the decision. Written notification will be sent within the shorter of two business days from when the determination is made or 72 hours of receipt of the request.
- Understand federal and state standards applicable to providers.

- Comply with federal and state standards.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Senate Bill 855

Effective Jan. 1, 2021, this law applies to all California regulated health plans, including California regulated Employee Assistance Programs.

1. Plans must provide coverage for medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. All healthcare services plans (e.g., Magellan) must apply specific clinical criteria and guidelines when conducting utilization review.
3. Magellan will utilize guidelines set forth in the most recent version of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. (See the “California Review Criteria / Guidelines Grid” in the State/Client-Specific Criteria section of the [Medical Necessity Criteria](#) page.)
4. Requests for services will be evaluated for medical necessity based on the prescribed guidelines.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Appealing Care Management Decisions – Member Complaints and Appeals

Our Philosophy

Magellan supports the right of members to appeal adverse decisions and to comment on service or care concerns.

Our Policy

We provide a formal mechanism for members to appeal adverse decisions, to express comments related to care or service, to have appeals or complaints appropriately investigated, and to receive a timely and professional response.

An *appeal* is a formal request for reconsideration of a non-authorization decision or adverse claim determination) with the goal of finding a mutually acceptable solution. For an appeal prior to the provision of the services, the member may submit the appeal or the provider, acting on the member's behalf, may submit an appeal. Examples of actions that can be appealed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service.

An *expedited appeal* is a request that is made when the routine decision-making process might seriously jeopardize the life or health of a member, or when the member is experiencing severe pain. An expedited decision may involve an admission, continued stay, or other health care services.

Our mechanism for clinical appeals includes access to independent medical review when required by Knox-Keene, the Patient Protection and Affordable Care Act (Health Care Reform law), other applicable law, and/or our customer contracts.

What You Need to Do

To support this policy, your responsibility is to:

- For Western Health Advantage (WHA) and Employee Assistance Program (EAP), furnish a copy of our complaint form (See the [California Member Grievance Form appendix](#) or [Spanish version](#)) to each member with a complaint.
- For Blue Shield of California, Positive Healthcare, and Health Plan of San Mateo (HPSM), refer member to their health plan to file a complaint.

- Cooperate with us in investigating and resolving member complaints and/or appeals without speaking negatively or derogatory about Magellan to the members.
- Members may not be charged for services beyond the applicable copayment, deductible or coinsurance applied by their benefit. However, a member may be charged for services that have been denied authorization by Magellan if the member agrees, in writing, to be financially responsible for such services on a form that meets the requirements set forth below. The member's written agreement must be obtained *after the services have been denied but before they have been provided* and following notification that the services are not covered by the plan. General financial responsibility acknowledgments signed upon admission are not sufficient. The written agreement should contain the following elements (see Sample Patient Financial Responsibility Acknowledgement Form in [appendices](#)):
 - A description of the services to be rendered
 - The dates of service
 - The cost of the service
 - Alternative treatment and cost
 - Information regarding the right to appeal and/or contact the appropriate regulatory body
 - Signature of the patient or patient's legal representative
 - Signature of a witness

Please note that this waiver is required even if you elect to appeal the non-authorization. Updates to the status of the non-authorization require an updated waiver. Please be further advised that failure to obtain a valid waiver may result in the determination that you engaged in prohibited balance-billing, which would require you to reimburse the member for any amounts paid beyond the deductible and/or copay.

As a reminder, per your agreement with Magellan, Section 2.4.6 Member Hold Harmless Commitment:

In the event a Member requires services which are beyond the scope or duration of Medically Necessary Covered Services under this Agreement, Facility shall verify with Payer that the Payer has no independent obligation to provide those non-Covered Services and if that verification is obtained from Payer, Facility may bill the Member for those non-Covered Services; provided, however, that prior to delivering such services, Facility informs the Member that such services are non-Covered Services and Member elects in writing to receive those non-Covered Services prior to having such services delivered. Any rates charged by Facility to a Member for non-Covered Services in accordance with the provisions of this section, shall be the rates negotiated by Facility and Plan for such services set forth in the Exhibits to this Agreement.

- Support a member’s application for independent medical review. When our denial is based on our conclusion that the treatment is experimental or investigational, we expect you, as appropriate, to furnish written certification that (i) standard treatments have not been effective in improving the member's condition, (ii) standard treatments would not be medically appropriate for the member, or (iii) there is no more beneficial standard therapy covered by the plan than the requested treatment, and that the treatment is likely to be more beneficial than any standard therapy.

Please see the Independent Medical Review Policy in [appendices](#).

What Magellan Will Do

We will send a letter acknowledging a grievance within five calendar days of receipt and a resolution letter or a pended resolution letter within 30 calendar days of receipt.

We will furnish determinations on expedited appeals within the shorter of one business day or three calendar days, regarding standard pre-service appeals within 15 calendar days, and regarding post-service appeals within 30 calendar days.

We will provide a copy of all relevant documents to the independent review organization within three business days of receipt of an independent review request from the DMHC and provide the member an annotated list of the documents sent to the review organization. We will implement an independent medical review decision within three business days of receiving the decision from the DMHC.

Member Access to Care – Appointment Access Standards

Our Philosophy

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

Our Policy

Our access-to-care standards allow members to obtain behavioral health services by an in-network provider within a time frame that reflects the clinical urgency of the situation.

What You Need to Do

In support of that commitment, we have established appointment and telephone access standards. We strongly encourage you to follow these standards.

Appointment Access Standards

- **Life-Threatening Emergency Access:** If you are unable to see a member with a life-threatening emergency immediately, we ask that you immediately refer the member to the nearest emergency room, advise the member to call 911, or advise the member to call the nearest Psychiatry Emergency Team (PET).
- **Non-Life-Threatening Emergency Access:** We expect you to see members with non-life-threatening emergencies within six hours of contact.
- **Urgent Access:** We expect you to see health plan and other managed care members with urgent situations within 48 hours of contact and Employee Assistance Program (EAP) members with urgent situations within 24 hours of contact.
- **Routine Access:** We expect you to see health plan and other managed care members for routine care within 10 business days of contact (15 business days for psychiatrists) and EAP members for routine care within three business days of contact.
 - **Physician/Prescriber Threshold for Routine Outpatient Follow-up Care After Initial Visits/Assessment/Evaluation:** Physician/prescribers offer health plan and other managed care members routine **follow-up care** appointments within 90 days following the initial visit, assessment or evaluation.
 - **Non-Prescriber Threshold for Routine Outpatient Follow-up Care After Initial Visits/Assessment/Evaluation:** Non-prescribers offer health plan and other managed care

members **routine follow-up care** appointments within 30 days following the initial visit, assessment or evaluation.

- **Follow-Up Visit Post Hospital Discharge (HEDIS):** We expect you to see a member within seven calendar days of their discharge from an inpatient facility upon request from either the facility, the member, or the Magellan care manager via in-office or a telehealth appointment (if you are contracted to offer that service option).
- **Unavailability:** Notify us immediately when you become unavailable for new referrals by updating your appointment availability and/or requesting a hold of referrals for any date span via the provider website. Any hold request beyond 90 days must be submitted in writing and reviewed by the Network and CNCC committee for approval to be granted.

Telephone Access Standards

- **Return Calls:** We expect you to return member's call within one business day, any time a member requests a call back. Of course, if a member message indicates urgency, please respond immediately or in accordance with good professional practice guidelines.
- **Outgoing Phone Message or Answering Service:** Include your telephone response time to members via your outgoing phone message and/or answering service. We also ask that your phone message or answering service informs members that if they believe their situation requires immediate intervention, they should:
 - Go to the nearest emergency room
 - Call 911
 - Page you (if an available option)
 - Contact the nearest Psychiatry Emergency Team (PET)

In-Office Wait Times

Members should not have to wait more than 15 minutes after the scheduled appointment time except when an emergency interrupts your schedule.

Referral Supplement – California Provider Specialty Information

Providers can update frequently and maintain their specialties and appointment availability via the www.MagellanProvider.com site using the online Provider Data Change Form as explained in the National Provider Handbook. This information is requested to meet regulatory requirements of the California Department of Managed Health Care.

What Magellan Will Do

In support of our commitment to these standards and to meet our regulatory obligations, we may contact you through random audits to gauge your ability to meet these standards. Failure to meet these standards may result in sanctions, up to and including termination of your provider participation agreement. If you have any concerns or comments, please contact us toll-free at 1-800-288-0558.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Keeping Your Practice Data Current

Department of Managed Health Care (Senate Bill No. 137), NCQA and CMS Data Validation regulatory requirements

Our Philosophy

Maintaining accurate practice information for in network providers, groups and facilities to ensure members whose plans are managed by Magellan receive timely access to in network mental health, substance abuse and/or EAP treatment.

Our Policy

Magellan maintains a formal data validation program to ensure compliance with regulatory requirements. We require all providers active in Magellan's California network to review update and/or attest to the accuracy of their practice information annually during the annual assessment audit and at a minimum every quarter or 90 calendar days.

What You Need to Do

Keeping your practice information up to date through Magellan's online Provider Data Change Form is essential to ensuring appropriate referrals, appointment availability and accurate and timely claims processing, in addition to complying with contractual stipulations outlined in your provider/group/facility participation agreement(s) with Magellan. *If you do not have computer access or unable access Magellan's website, contact the Provider Services Line at 1-800-788-4005 to complete your telephonic update and/or attestation.*

Providers are required to update and/or attest to the accuracy of the following practice information through Magellan's online Provider Data Change Form:

- Name
- Practice location or locations (mailing, financial and practice locations)
- Contact (telephone and fax number) information
- Professional level/level of licensure
- National Provider Identifier (NPI)
- California license number and type of license
- Office hours and appointment availability
- Area(s) of specialty and subspecialty, including board certification as applicable
- The providers office email address as applicable

- Provider language capabilities as applicable
- Hospital admitting privileges as applicable
- If the provider is active under Group Participation Agreement with Magellan, confirm the affiliated group practice through which the provider sees Magellan members.

To update practice information:

1. Go to www.MagellanProvider.com and sign in securely with your username and password.
2. Under **My Practice** in the left-hand menu, click **Display/Edit Practice Information**. The first tab that displays is the *Provider Data Change Form*.
3. Select your TIN/MIS combination and click **Go**.
4. **Verify all information and update as needed.** This includes your street address, phone number, office hours, ability to accept new patients, language and specialty information. *Group practice administrators: Be sure to validate information for all practitioners on the roster from the Roster Maintenance section.*
5. **Attest to the accuracy of your practice information on a quarterly basis.** To fully complete this step, review each of the required categories indicated by the **red exclamation marks**. Updated categories will reflect a green check mark.
6. Once information is verified, click on the red **“I attest”** box.

In accordance with CA Senate Bill No. 137/Chapter 649/Section 2(j), in network providers are required to notify Magellan within five business days when either of the following occurs:

- If the provider is not accepting new patient appointments.
- If the provider had previously not accepted new patient appointments, but the provider is currently accepting new patients.

If you not accepting new patient appointments and are contacted by a Magellan member or potential member requesting an appointment, please redirect the member to Magellan to assist with alternative referral options (see [contact information](#) above).

What Magellan Will Do

Magellan will send data validation reminder communications to all noncompliant California providers every quarter. In network providers that are not compliant with Magellan’s data validation program over the course of two consecutive quarters will be reviewed at Magellan’s California Network and Credentialing Committee to address noncompliance of contractual obligations and the provider’s contract affiliations with Magellan may be impacted in accordance with CA Senate Bill No. 137/Chapter 649/ Section 2(l)(n).

In accordance with CA Senate Bill No. 137/Chapter 649/Section 2(p) Magellan reserves the right to delay payment or reimbursement owed to a provider if the provider continues to not be responsive to Magellan’s attempts to verify practice information over the course of two consecutive quarters and

subsequent corrective action measures implemented by the California Network and Credentialing Committee in accordance with CA Senate Bill No. 137/Chapter 649/Section 2(p).

If you have any concerns or comments, contact the Provider Services Line at 1-800-788-4005.

SECTION 4: THE QUALITY PARTNERSHIP

A Commitment to Quality

Our Philosophy

Magellan is committed to continuous quality improvement through a program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.

Our Policy

We conduct annual reviews of a random sample of provider treatment record documentation against standards for documentation and adherence to important elements of clinical practice guidelines. We conduct our reviews in accordance with regulatory mandates and in a manner consistent with respecting federal and state health information privacy regulations.

What You Need to Do

To support this policy, your responsibility is to respond to our written request for treatment records within the time frame requested.

What Magellan Will Do

We will review your records, provide you with feedback on your individual results and review aggregate data to identify areas where we may improve our assistance to you in meeting our documentation standards and clinical practice guidelines.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

Our Philosophy

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

Our Policy

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

What You Need to Do

To comply with this policy, your responsibility is to:

- Understand and comply with regulatory requirements and standards applicable to providers.
- Provide input and feedback to Magellan to actively improve the quality of care provided to members.
- Participate in quality improvement and utilization oversight activities if requested by Magellan.

What Magellan Will Do

Magellan's responsibility to you is to:

- Actively request input and feedback regarding member care.
- Operate a toll-free telephone number to respond to provider questions, comments and inquiries.
- Establish a multi-disciplinary Quality Improvement Committee to oversee all quality functions and activities.
- Maintain a health information system sufficient to support the collection, integration, tracking, analysis and reporting of data.
- Provide designated staff with expertise in quality assessment, utilization management and continuous quality improvement.
- Develop and evaluate reports, indicate recommendations to be implemented, and facilitate feedback to providers and members.
- Participate in annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas, and provide annual reports on performance improvement project results using a valid process for evaluation of the impact and assessment of the quality improvement activities.

SECTION 4: THE QUALITY PARTNERSHIP

Cultural Competency and Language Assistance Services

Our Philosophy

Magellan supports the right of members with limited English Proficiency (LEP) to assistance that enhances their ability to understand and obtain needed services.

Our Policy

We maintain a formal language assistance program (LAP) to identify and assist members with LEP.

What You Need to Do

- *Cultural sensitivity:* Be sensitive to language needs and cultural backgrounds of our members; treat all members in a manner compatible with their cultural health beliefs and practices and preferred language. See the “Cultural Sensitivity Tips” section in the [Language Assistance Services appendix](#).
- *Notice to members:* Inform LEP members of the availability of our free language assistance services in connection with their behavioral health benefits or EAP services.
- *Selection of interpreters and translators:* Use only qualified interpreters or translators when needed for an LEP member. Minimum qualifications include (i) being a native speaker and/or having at least 2 years’ experience of using English and each non-English language in health care settings and (ii) understanding of behavioral health terms and concepts in the non-English language(s). (You cannot be considered a bi-lingual provider unless you meet these standards.) If you are not a bi-lingual provider and do not have access to a qualified interpreter, we will arrange for a qualified interpreter at no cost to you or the member.
- *Language assistance costs:* Do not charge any member or his/her family or personal representative for interpretation or alternative-language translation services or represent to any member or his/her family or personal representative that there is a cost for such services.
- *Access to language assistance services:* Call us 24/7/365 for assistance in providing timely interpretation and translation assistance.
- See the “What We Expect from You, Our Provider” section of the [Language Assistance Services appendix](#) for more information.

What Magellan Will Do

We will make appropriate interpreter services available at our cost for LEP members who request interpreter services for all telephonic contacts and for your face-to-face communications with those members. We use a professional, credentialed interpretation company with interpreters in various

languages. If a member's language is not one of the languages provided by the interpretation company, there may be a slight delay in identifying an appropriate interpreter, but we will make efforts to locate an appropriate interpreter. See the [Language Assistance Services appendix](#) for more information.

SECTION 5: PROVIDER REIMBURSEMENT

Claims Filing and Claims Disputes

Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our provider contracts. We believe that informing providers of claims processing requirements helps avoid administrative denials that delay payment and require resubmission of claims. We recognize that we may make mistakes from time-to-time and are committed to addressing appropriately submitted provider concerns.

Our Policy

Magellan reimburses behavioral health treatment providers using Current Procedural Terminology (CPT®) fee schedules for professional services. Magellan's professional reimbursement schedules include the most frequently utilized CPT codes for professional services. *Our provider contracts require claims to be submitted within 90 days of the provision of covered services. We will deny claims not received within 90 days except when delay is caused by extraordinary circumstance.* 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.

Magellan complies with section 1371.8 of the Knox-Keene Act by reimbursing providers for services rendered in good faith pursuant to a written authorization for a specific type of treatment even if after the authorization Magellan determines that the service was not covered under the plan.

To help resolve provider disputes, we maintain a formal provider dispute mechanism.

What You Need to Do

To support this policy, your responsibility is to follow the detailed claim submission guidelines and, as necessary, provider dispute guidelines in the [Claims Settlement Practices and Dispute Resolution appendix](#).

To be eligible for payment for services notwithstanding that the services are not covered, the following must be present:

- Written authorization for services that was not revoked prior to delivery of the services
- Services rendered in good faith reliance on the written authorization
- A complete clean claim filed within the timely filing standards.

You will not be considered to have relied in good faith on the authorization unless you re-check eligibility with Magellan or, if available, a plan's online eligibility site whenever the authorization was issued more than five days prior to service delivery. Keep evidence of this eligibility check to verify the member was eligible (e.g., print screen of website showing eligibility, documentation of a call, etc.), as well as evidence of submission to the payer specifically, Magellan.

If an established patient/member missed an appointment, the provider must have a signed specific policy signed by the member PRIOR to the missed appointment that outlines that an "administrative/missed appointment" fee will be charged to the member that is not to exceed the contracted amount for that particular scheduled/missed appointment; in order to obtain payment from the member.

What Magellan Will Do

Within 15 working days of receipt of a clean claim, we will either (i) pay or deny your claim and send you a written explanation or (ii) send you an acknowledgement of receipt of your claim.

When you submit a provider dispute in accordance with the guidelines in the [Claims Settlement Practices and Dispute Resolution appendix](#), we will acknowledge receipt within 15 business days of receipt and issue a written determination within 45 business days of our receipt of the dispute, or, if insufficient information is furnished, an amended dispute.