Behavioral Health Provider Orientation

MedStar Family Choice
District of Columbia Medicaid

2021
Agenda

- Program information and covered services
  - Care coordination
  - Commitment to quality improvement
  - Magellan provider network
  - Reimbursement/claims process
  - Magellan provider website
  - Wrapping up
You play an important role in serving MedStar enrollees.

The District’s Department of Healthcare Finance (DHCF) selected MedStar Family Choice (MFC) Health Plan as one of the three managed care organizations (MCOs) to provide healthcare and pharmacy services under its Medicaid Managed Care Program (MMCP).

MedStar Family Choice selected Magellan Healthcare to be their behavioral health (BH) partner to manage BH services covered by the MCO and coordinate care/case management for services covered by Department of Behavioral Health (DBH).

The District’s MMCP consists of:

- DC Healthy Families Program (DCHFP)
- DC Healthcare Alliance Program (Alliance)
- Immigrant Children’s Program (ICP)
Covered services managed by Magellan

- Inpatient psychiatric hospitalization
- Psychiatric residential treatment facility (for enrollees under age 22)
- Mental health partial hospitalization program
- Mental health intensive outpatient program
- Mental health outpatient services
  - Diagnostic and assessment services
  - Individual, group and family counseling
  - Federally Qualified Health Center (FQHC) behavioral health services
  - Medication treatment
  - Pregnancy related services
  - Pediatric behavioral health services (in school setting with specified requirements)
- Substance use disorder outpatient services (clinic and other licensed professional services)
- Withdrawal management and residential substance use disorder (within the in-lieu-of limit)
Care coordination, complex case management and transportation for enrollees receiving services through DBH certified entity

- Community-based interventions
- Multi-systemic therapy (MST)
- Assertive community treatment (ACT)
- Community support
- Recovery support services
- Vocational supported employment
- Clubhouse services
- Crisis services

Will coordinate referrals to DBH for SUD outpatient rehabilitation services
### Waiver 1115: Responsible entities

**Psychiatric hospitalization, withdrawal management and residential SUD services**

Enrolled individuals, aged 21-64, in an IMD facility, who require short-term inpatient or residential treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>Beneficiary’s Medicaid Enrollment</th>
<th>If the Length of Stay is...</th>
<th>Provider Should Bill...</th>
<th>Responsible Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospitalization</td>
<td>MCO</td>
<td>Within the “in lieu of” limit</td>
<td>MCO</td>
<td>MCOs are responsible for member stays that do not exceed fifteen 15 days in a calendar month.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than the “in lieu of” limit</td>
<td>DHCF</td>
<td>DHCF is responsible if the member requires more than 15 cumulative “in lieu of” days per month or if a continuous length of stay crosses two calendar months, for up to 30 cumulative days total.</td>
</tr>
<tr>
<td></td>
<td>FFS</td>
<td>Up to 60 consecutive days</td>
<td>DHCF</td>
<td>DHCF is responsible.</td>
</tr>
<tr>
<td>Withdrawal Management and Residential SUD Services (excludes Room and Board)</td>
<td>MCO</td>
<td>Within the “in lieu of” limit</td>
<td>MCO</td>
<td>MCOs are responsible for member stays that do not exceed 15 days in a calendar month.</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>FFS</td>
<td>No limit</td>
<td>DHCF</td>
<td>DHCF is responsible.</td>
</tr>
</tbody>
</table>
Waiver 1115: Responsible entities, cont’d

Other waiver services

<table>
<thead>
<tr>
<th>Service</th>
<th>Beneficiary’s Medicaid Enrollment</th>
<th>Provider Should Bill...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Behavioral Health Practitioners</td>
<td>MCO</td>
<td>MCO</td>
</tr>
<tr>
<td>(Psychologists and Other Licensed Providers)</td>
<td>FFS</td>
<td>DHCF</td>
</tr>
<tr>
<td>Clubhouse</td>
<td>MCO</td>
<td>DHCF</td>
</tr>
<tr>
<td></td>
<td>FFS</td>
<td>DHCF</td>
</tr>
<tr>
<td>Recovery Support Services (RSS)</td>
<td>MCO</td>
<td>DHCF</td>
</tr>
<tr>
<td></td>
<td>FFS</td>
<td>DHCF</td>
</tr>
<tr>
<td>$0 Co-Pay for MAT</td>
<td>MCO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>FFS</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Newly eligible provider types for waiver 1115 services include:
- Psychologists
- Licensed professional counselors
- Licensed independent social workers
- Licensed marriage and family therapists
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Verify eligibility

Prior to rendering services, verify enrollees are assigned to MedStar Family Choice (MFC) and are eligible for benefits.

District of Columbia Government Medicaid IVR system:
- Phone: 1-202-906-8319 (inside DC metro area)
- Phone: 1-866-752-9233 (outside DC metro area)

District of Columbia website:
www.dc-medicaid.com

Note: Use the DC Medicaid IVR system or website to confirm the most up-to-date enrollee eligibility information, as there may be a lag between the DC system and when the information is loaded to Magellan’s system.
Enrollee access to care

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 the situation.

You can obtain higher level of care authorizations 24 hours a day, seven days a week; specialized outpatient service authorizations (such as psych testing) will be covered during business hours.

YOU MUST:

- Inform enrollees of how to proceed, should they need services after business hours.
- Provide coverage for your practice when you are not available, including but not limited to an answering service with emergency contact information.
- Respond to telephone messages in a timely manner.
- Provide immediate emergency services when necessary, to evaluate or stabilize a potentially life-threatening situation.
- Provide services within six hours of a referral in an emergent situation that is not life-threatening.
- Provide services within 24 hours of a referral in an urgent clinical situation.
- Provide services within 30 business days of referral for routine clinical services.
Magellan requires preauthorization notification for all higher levels of care, including:

- Inpatient hospitalization - no later than 24 hours after admission.
- Psychiatric and substance abuse residential treatment.
- Partial hospitalization programs.
- Intensive outpatient programs.
- Non-routine outpatient services.
  - Psychological/neuropsychological testing
  - Prolonged physician services
  - Developmental testing
  - Electroconvulsive therapy (ECT)
  - Office-based opioid treatment (OBOT)
  - Medication-assisted treatment (MAT)
Preauthorization process

How to request service authorization

• **Phone number:** 1-800-777-5327

• **Website:** [www.MagellanProvider.com](http://www.MagellanProvider.com)
  - After signing in, select *Request Member Care* from the left menu.

Medical necessity criteria

• Magellan uses *Magellan Healthcare Guidelines*.

• Find these online [www.MagellanProvider.com](http://www.MagellanProvider.com) (from the *Get Information* box, select *Medical Necessity Criteria*).
Utilization management (UM) review

• Higher levels of care require utilization management to ensure that enrollees are being treated at the appropriate levels of care.

• Preauthorization is required for higher levels of care. The exception is emergent inpatient care. That must be within 24 hours of admission.

• After initial authorization, facilities/providers will be provided with a last covered day of service for the enrollee. They are responsible for contacting Magellan for a concurrent review no later than the last covered day. The review will be completed with a care manager, and the enrollee will be authorized for more days/units, stepped down to a lower level of care or discharged.

• If there are questions or a need for more information, providers may be scheduled to discuss the case with the medical director.

• Providers may use the appeals process if there is a clinical disagreement.
Discharge planning for behavioral health

Magellan’s case management team will:

• Carry out welcome-home calls within 48 hours post-discharge.

• Assist in discharge planning with facilities and providers to ensure that step-down appointment(s) are in place within seven days post-discharge and met within 30 days post-discharge to ensure stabilization and community tenure.

• Provide ongoing care coordination 45-60 days post-discharge, if clinically appropriate.

• Complete a risk assessment to determine level severity and needed services, identify treatment barriers, direct and support follow-up with resources identified, if enrollee opts in to case management programming.

• Provide ongoing education and support.

• Assist with treatment referrals and linkage.

• Refer enrollee to higher level of support, if indicated.

• Collaborate with MedStar Family Choice’s case management team.
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- **Commitment to quality improvement**
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In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards and apply them in clinical work with enrollees.

**Key quality measures include:**

- Clinical record documentation
- Coordination of care
- Enrollee rights and responsibilities
- Notification of adverse incidents
- Monitoring of atypical antipsychotic medication

We obtain provider feedback through various channels including provider satisfaction surveys, our national Provider Services Line and the Magellan provider website.
Magellan appeals for MedStar Family Choice DC

Magellan is delegated for all enrollee and provider appeals.

An appeal is used when an enrollee or provider disagrees with an initial determination or a revised determination related to the stoppage, reduction or restriction on a previously authorized benefit.

- **Timeframe within which Magellan will make a decision about an appeal:**
  - **Expedited:** 72 hours
  - **Standard:** 30 calendar days

- **Appeal submission options:**
  - Submit written request, outline the reason for the appeal, and include necessary documentation within 60 calendar days.
  - **U.S. Mail:** Attn: Appeals Department, Magellan Healthcare, P.O. Box 1718, Maryland Heights, MO 63043
  - **Fax:** 1-888-656-5712
  - **Upload on provider website:** [www.MagellanProvider.com](http://www.MagellanProvider.com)
  - **Phone:** 1-800-777-5327
Magellan claim appeals/disputes for MedStar Family Choice DC

- A claim appeal/dispute can be filed for a denied claim.
- Submit within 90 business days of the denial letter date or EOB.
- Written request; outline the reason for the appeal and necessary documentation; submit via:
  - **Mail:** Attn: Appeals Department, Magellan Healthcare, P.O. Box 1718, Maryland Heights, MO 63043
  - **Fax:** 1-888-656-5712
  - **Upload on provider website:** [www.MagellanProvider.com](http://www.MagellanProvider.com)
- Magellan will make a decision about the appeal within 30 calendar days of receipt of the request and provide notification verbally and in writing.
Magellan grievances and complaints for MedStar Family Choice DC

• Submit grievances and/or complaints for enrollees and providers to Magellan.

• Magellan will investigate the grievance and you will receive a proposed written resolution.

• Submit via:
  - U.S. Mail: Attention: Complaints and Grievances, 14100 Magellan Plaza, Maryland Heights, MO 63043
  - Fax: 1-888-656-5034 – Attention: Complaints and Grievances
  - Phone: 1-800-777-5327
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Credentialing / recredentialing

OUR POLICY

- Magellan providers are required to successfully complete the credentialing review process prior to being accepted as a network provider and the recredentialing process every three years unless otherwise required by applicable state and federal law, a customer, and/or an accrediting entity.

- Only credentialed providers may render services to Magellan members as in-network providers.

- Clinicians affiliated with a group practice must complete the individual credentialing process in order to render covered services to Magellan members.

- Each service site within an organization requires separate credentialing. New locations added to the contract anytime thereafter, must also be credentialed before being considered an in-network location for Magellan.
Recredentialing procedures

**Important note: Recredentialing is required every three years**

Ensure you keep your CAQH application current and respond to any request from our recredentialing department; not meeting recredentialing timeframes is the most common reason for involuntary termination from the network.

Upon receipt of your completed application, we re-verify your credentials, and our Regional Network and Credentialing Committee (RNCC) reviews for continued network participation.

We review quality indicators – such as complaints, adverse incidents, and treatment records reviews – during the recredentialing process.
Recredentialing for organizations

Recredentialing procedures (continued)

1. To monitor network quality, Magellan reviews organization/facility credentials every three years as required by contract and/or applicable state law.

2. Six months prior to the credentialing anniversary, we mail a recredentialing notification to the mailing address on record for the organization/facility.

3. Magellan will make three outreach attempts to acquire any missing data, e.g., updated malpractice information. If the provider does not respond, the recredentialing application will be closed, and the provider will be placed in suspended status with a future termination date. Final notification will be issued to the mailing address on file for the organization.
Recredentialing for *individual practitioners*

Recredentialing procedures (continued)

1. To monitor network quality, Magellan reviews **provider** credentials every three years as required by contract and/or applicable state law.

2. Approximately six months prior to the recredentialing due date, Magellan will attempt to access your CAQH application. If we cannot, we will let you know. To avoid delays in recredentialing, please do the following:
   - Log on to CAQH at [http://proview.caqh.org](http://proview.caqh.org) and complete your application, sending all required documents to CAQH. Ensure that you have re-attested to your information and have authorized Magellan to access your application. **Best practice: Attest to your data every 120 days.**
   - If you do not have access to the CAQH universal application, you may request a paper recredentialing application.

3. Magellan will make three outreach attempts to acquire any missing data e.g., updated malpractice information. If the provider does not respond, the recredentialing application is closed and the provider is placed in suspended status with a future termination date. Final notification will be issued to the mailing address on file for the practitioner.
**ROSTER CHANGES**

When group/organization membership changes (e.g., a practitioner joins or leaves your group):

- **For organizations/facilities: you must update your staff roster** via the Magellan provider website. This includes adding or removing any/all practitioners as applicable.

- **For groups: you must update your group roster** via the Magellan provider website. **Note:** Adding a provider to the group roster does not automatically affiliate them to the group contract.

  - If the new group member is not already Magellan-credentialed, **have him/her begin the credentialing process**; this must be completed before the provider is eligible to receive referrals.

  - To become credentialed, the new group member should log on to CAQH at [http://proview.caqh.org](http://proview.caqh.org) and complete their application, sending all required documents to CAQH. The practitioner must also attest to their information and authorize Magellan to access their application.

  - Remember: Clinicians affiliated with a group practice must complete the individual credentialing process in order to render covered services to Magellan members.
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Magellan-paid claims requirements

Timely filing of claims:
- 365 days from date of service

Accepted methods for submission of claims:
- Electronic Data Interface (EDI) via direct submit www.edi.magellanprovider.com
- EDI via a clearinghouse, “Claims Courier” — Magellan’s web-based claims submission tool
- Paper claims on CMS-1500 or UB-04

Address for paper claims:
Magellan Healthcare
P.O. Box 2271
Maryland Heights, MO 63043

Magellan’s EDI Payer ID#: 01260
Checking claims status


2. Select **Check Claims Status** from the menu.

3. Search for claim by member or subscriber name, date of service, etc.
   - View claim details such as check number, date and payment method.
   - If claim is denied, reason code and description is provided.
   - View EOB online.
   - Contact Magellan at 1-800-777-5327 with claims-related questions.
Electronic funds transfer (EFT)

It is mandatory that providers sign up for EFT for Magellan-paid claims

What are the benefits of EFT?

- Claims payments get to your bank account more quickly than the standard process of mailing and cashing or depositing a check
- No risk of lost or misplaced checks
- More time to devote to your practice

Explanation of Benefits (EOB) are available on www.MagellanProvider.com

- Sign into the secure network
- Click on Check Claims Status from the left-hand menu
- Click on the EOB Search on the top tab
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A secure location for your transactions – sign in and get started!

You should receive a username and temporary password during the contracting process, OR you can select “New User” to obtain a username and temporary password.
Magellan website features

- Magellan provider handbook
- Medical necessity criteria
- Clinical guidelines
- Credentialing criteria
- Authorizations
- Claims submission and status
- Appeal/dispute submission form
- Provider profile application (to enhance the information members see about you in directories)
- Sample PCP communication forms
- Provider data change form
- Group and facility roster maintenance
- Award-winning Magellan provider newsletter, *Provider Focus*

Plus, search for member-friendly resources through Healthwise at [https://www.healthwise.net/magellanhealth](https://www.healthwise.net/magellanhealth)
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Things to remember

• Find the Magellan provider portal online at [www.MagellanProvider.com](http://www.MagellanProvider.com).
  − Providers and organizations must attest to the accuracy of practice information every 120 days at [www.MagellanProvider.com](http://www.MagellanProvider.com) (requires sign in).
  − Organizations and facilities must manage their roster staff to keep practitioner data accurate at [www.MagellanProvider.com](http://www.MagellanProvider.com) (requires sign in).

• Individual practitioners must update their CAQH profile and re-attest every 120 days at [http://proview.caqh.org](http://proview.caqh.org).

• Organizations and facilities must bill with [license level modifiers](http://www.MagellanProvider.com).

• Request authorizations for inpatient and higher levels of care at 1-800-777-5327.

• Verify eligibility on DHCF IVR system (202) 906-8315 or 1-866-752-0233, or online at [www.DC-Medicaid.com](http://www.DC-Medicaid.com).

• Submit claims within the timely filing limit of 365 days from the date of service.

• Review Magellan’s [online Provider Focus newsletter](http://www.MagellanProvider.com) each quarter for timely news and information about serving DC Medicaid enrollees.


• Contact Magellan’s national Provider Services Line at 1-800-788-4005 with questions about your relationship with Magellan and using the provider portal.
Thank You!

Questions?

For clinical questions, including those about authorization, assessment and treatment planning, contact Magellan at 1-800-777-5327.

For questions about the Magellan website functions, contracting/credentialing and claims, email ProviderServices@MagellanHealth.com or call the Magellan Provider Services Line at 1-800-788-4005.
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