



Magellan Healthcare of Virginia*

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

*In Virginia, Magellan contracts as Magellan Healthcare, Inc., f/k/a Magellan Behavioral Health, Inc., which is a subsidiary of Magellan Health, Inc.

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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 services for all members covered through any DMAS behavioral health fee-for-service program. Magellan also administers the non-traditional behavioral health services for members enrolled with a Medicaid/FAMIS Managed Care plan.

Covered Benefits
Community-Based Residential Level A
Community-Based Residential Level B
Crisis Intervention
Crisis Stabilization
Day Treatment/Partial Hospitalization Services for Adults
Inpatient Psychiatric Hospital Services - Freestanding Psychiatric Hospital
Inpatient Psychiatric Hospital Services - General Acute Care Hospital
Intensive Community Treatment
Intensive In-Home Services
Mental Health Case Management
Mental Health Skill-building Services
Multisystemic Therapies In-Home Behavioral Therapies (includes but not limited to ABA)
Opioid Treatment
Outpatient Psychiatric Services
Outpatient Substance Abuse Services
Psychosocial Rehabilitation
Residential Substance Abuse Treatment for Pregnant & Post-Partum Women
Residential Treatment Facility Level C
Substance Abuse Case Management
Substance Abuse Crisis Intervention
Substance Abuse Day Treatment
Substance Abuse Day Treatment for Pregnant & Post-Partum Women

Covered Benefits (continued)
Substance Abuse Intensive Outpatient Treatment
Therapeutic Day Treatment for Children & Adolescents
Treatment Foster Care Case Management

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.MagellanHealth.com/provider. You can look up authorizations and verify the status of a claim online at this provider site, in addition to completing other 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

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Network Provider Participation

Our Philosophy	Magellan is dedicated to selecting behavioral healthcare professionals, groups, agencies and facilities to provide member care and treatment across a range of covered services as defined by Virginia Department of Medical Assistance Services (DMAS).
Our Policy	To be a network provider of clinical services with Magellan under the BHSa program, you must be credentialed and enrolled according to Magellan and DMAS standards, and must be contracted with Magellan. Providers are subject to applicable licensing requirements.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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 and your provider participation agreement(s) as well as DMAS policies and regulations;◆ Provide services in accordance with applicable Commonwealth and federal laws and licensing and certification bodies. Contracted providers for the BHSa network are required to abide by DMAS regulations and manuals, and maintain active licensure for their contracted provider type and specialty at each service location;◆ Agree to cooperate and participate with all care management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures;◆ Make sure only providers currently credentialed with Magellan render services to Magellan members; and◆ Follow Magellan's credentialing and re-credentialing policies and procedures.
What Magellan Will Do	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none">◆ Provide assistance 24 hours a day, seven days a week;◆ Assist providers 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) and URAC; and◆ Maintain a credentialing and re-credentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability or any other status protected by applicable law.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Types of Providers

Our Philosophy

Magellan is dedicated to recruiting and retaining individual practitioners and institutional providers with the behavioral healthcare credentials to provide care and treatment across a range of products and services to members in the Virginia Medicaid/FAMIS programs. Magellan refers members to credentialed and contracted practitioners in private practice, practitioners in a group practice, and provider organizations including facilities and agencies.

Our Policy

Magellan refers members to credentialed and contracted providers in the following categories:

- ◆ *Individual Practitioner* – a clinician who is licensed by the Virginia Department of Health Professions and who provides behavioral healthcare services and bills under his or her own Taxpayer Identification Number. Individual practitioners must meet Magellan and/or other applicable credentialing criteria (See [appendix](#) of the Magellan National Handbook) and have a fully executed provider agreement with Magellan.
- ◆ *Group Practice* – a practice contracted with Magellan as a group entity and as such, bills as a group entity for the services performed by its Magellan-credentialed clinicians. Clinicians affiliated with the group must complete the individual credentialing process, and the group must have at least one active/credentialed group member in order to be eligible to receive referrals from Magellan.
- ◆ *Organization* – a facility or agency licensed and/or certified in Virginia to provide behavioral health services. Examples of organizations include, but are not limited to: general hospitals with psychiatric programs, freestanding behavioral health facilities, community service boards, outpatient mental health clinics, agencies which provide mental health rehabilitation services such as mental health skill building services, intensive in-home and treatment services and therapeutic day treatment. ***Please refer to the [Organization Provider Handbook Supplement](#) for additional information about facility/organization providers including organization provider credentialing criteria.***

What You Need to Do

Your responsibility is to:

- ◆ Provide Magellan with a complete Form W-9 for the contracting entity to facilitate referrals and claims processing;
- ◆ Notify Magellan and complete a new Form W-9 if your contracted entity changes;

- ◆ Notify Magellan of any changes to the list of practitioners in your group within 10 business days;
- ◆ Notify Magellan of changes in your service location, mailing and/or financial address information; and
- ◆ Adhere to the credentialing policies outlined in this handbook.

**What Magellan
Will Do**

Magellan's responsibility is to:

- ◆ Review providers and prospective providers for credentialing or re-credentialing without regard for race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability, or any other status protected by law;
- ◆ Develop and implement recruitment activities to solicit quality behavioral health providers to participate in the Virginia Medicaid/FAMIS programs; and
- ◆ Make website-based tools available to providers so they can update their practice information in a convenient online fashion.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Credentialing

Our Philosophy	Magellan is committed to the provision of quality care to our members. In support of this commitment, organizations must meet or exceed a set of credentialing criteria to be eligible to provide services to our members.
Our Policy	Magellan employs credentialing criteria and decision-making processes in the review and selection of behavioral healthcare practitioners and organizations for inclusion in our provider network. Our provider credentialing criteria satisfy the requirements of applicable regulatory bodies and our customers.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ Complete and submit all required application materials and related documents, including any documentation of current accreditation, and attest to their accuracy. We cannot process incomplete applications.◆ Be in good standing with state and federal regulatory entities, as applicable.◆ Hold current licensure or certification in accordance with applicable state and federal laws.◆ For organizations, providers must hold appropriate current accreditation, or for applicable services hold Department of Behavioral Health and Developmental Services (DBHDS) licensure for covered behavioral health services. This license shall be provided to Magellan during credentialing and re-credentialing as evidence of a current state license site visit that will be used in lieu of an accreditation and/or a Magellan site visit for those covered services.◆ Provide primary source verification (PSV) of professional licenses of your medical and clinical staff members. This means contacting state licensing boards to verify that professionals hold a current license, education and training to practice without restrictions or sanctions. Additional required queries include the National Practitioner Data Bank (NPDB), the Health Inquiry and Protection Data Bank (HIPDB), and the Office of Inspector General/General Services Administration (OIG/GSA) databases for Medicare/Medicaid sanctions. For physicians, PSV also includes verification of Board Certification, and current, Drug Enforcement Agency (DEA) registration, and, if applicable, state Controlled Dangerous Substance (CDS) registration.◆ Attest that there are no Medicare or Medicaid sanctions or exclusions from participation in federally funded healthcare programs by the

organization, its staff, subcontractors, agents, directors, officers, partners or owners with 5 percent or more controlling interest. Immediately report to Magellan should any sanction or exclusion information be discovered.

- ◆ Fulfill Magellan requirements for malpractice claims history review.
- ◆ Meet Magellan's minimum requirements for professional and general liability insurance coverage. For the Virginia BHSA program, providers are required to maintain minimum of \$1 million per occurrence and \$1 million aggregate coverage for both general and professional liability. Coverage may be obtained through a commercial insurance carrier, unless, for organizations, the provider can show evidence of a fully funded self-insurance policy which meets the minimum coverage requirements.
- ◆ Participate in a site visit upon request.
- ◆ Participate in re-credentialing every three years or in compliance with regulatory and/or customer requirements.

**What Magellan
Will Do**

Magellan's responsibility to you is to:

- ◆ Provide you with initial application and re-credentialing materials with instructions for completion.
- ◆ Complete the credentialing and re-credentialing process in a timely manner that is, at a minimum, within industry, state- or customer-established timeframes.
- ◆ Have your credentialing or re-credentialing application reviewed by a Magellan Regional Network and Credentialing Committee (RNCC).
- ◆ Notify you in writing upon completion of the credentialing or re-credentialing process.
- ◆ Perform site visits as needed.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Re-Credentialing

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 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Reporting Changes in Practice Status

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 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Updating Practice Information

Our Philosophy

We are committed to maintaining current, accurate provider practice information in our database in order to offer qualified providers to our members, and to enable our providers to receive important communications from Magellan in a timely manner.

Our Policy

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

Providers are required to notify Magellan of changes in administrative practice information using our online Provider Data Change Form (PDCF) effective January 1, 2015. Phone requests and faxes were no longer accepted as of this date. By using the PDCF, providers can update information online in real time, a method more efficient and accurate than other forms of communication.

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

What You Need to Do

Your responsibility is to:

- ◆ Update changes in your administrative practice information listed below using our online Provider Data Change Form by signing in to www.MagellanHealth.com/provider and selecting Display/Edit Practice Information;

- ◆ Notify us within 10 business days of any changes in your practice information including, but not limited to, changes of:
 - Service, mailing or financial address,
 - Telephone number,
 - Business hours,
 - Email address, and
 - Taxpayer Identification Number;
- ◆ Promptly notify us if you are unable to accept referrals for any reason including, but not limited to:
 - Illness or maternity leave,
 - Practice full to new patients,
 - Professional travel, sabbatical, vacation, leave of absence, etc.;
- ◆ Promptly notify us of any changes in group practices, including, but not limited to:
 - Practitioners departing from your practice,
 - Practitioners joining your group practice,
 - Changes of service, mailing or financial address,
 - Changes in practice ownership, including a change in Taxpayer Identification Number (TIN), and/or National Provider Identifier (NPI),
 - Telephone number,
 - Business hours, and
 - Email address;
- ◆ Contact your field network coordinator or area contract manager if directed to do this by the online application; some changes may require a contract amendment before you can initiate or bill for services;
- ◆ Update and maintain your Provider Profile information (enables you to enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.);
- ◆ Promptly review and revise for accuracy any confirmation of Provider Data Change Forms you receive from Magellan.

What Magellan will do

Magellan's responsibility for provider data changes is to:

- ◆ Maintain our online Provider Data Change Form resulting in real-time information with no additional verification requirements; and
- ◆ Contact you for clarification, if needed.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Contracting with Magellan

Our Philosophy	<p>Magellan's provider agreements protect members, providers and Magellan by defining:</p> <ul style="list-style-type: none">◆ The rights and responsibilities of the parties;◆ The application of Magellan's policies and procedures to services rendered to members;◆ The programs/services available to members;◆ The provider network for member use; and◆ The reimbursement for covered services. <p>Depending on a provider's type of practice, Magellan will issue an individual, group or organization agreement.</p>
Our Policy	<p>All Magellan network providers are required to have an executed Magellan provider agreement in which the provider agrees to the following terms and conditions:</p> <ul style="list-style-type: none">◆ Adherence to Magellan's policies, procedures and guidelines;◆ Timely participation in re-credentialing and/or quality improvement activities;◆ Reimbursement provisions for covered services rendered to members; and◆ Not billing members for covered services other than for copayments or coinsurance, if applicable, as outlined in the benefit plan (i.e., no "balance billing"). <p>Additional documents required in order to serve members enrolled with a Medicaid/FAMIS Managed Care plan are:</p> <ul style="list-style-type: none">◆ A Behavioral Health Participation Agreement (required of all VA BHSa providers);◆ A Virginia Medicaid Addendum (required of all VA BHSa providers);◆ For Community Service Boards - a VICAP Amendment (required of providers performing the Virginia Independent Clinical Assessment);◆ A Sites of Service form (required of all Organization providers) – not applicable for individual or group practitioners.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ Sign a Magellan provider agreement, and all relevant addenda/amendments;◆ Understand the obligations and comply with the terms of the Magellan provider agreement; and◆ Be familiar with and follow the policies and procedures contained within this handbook and applicable supplements.

**What Magellan
Will Do**

Magellan's responsibility is to:

- ◆ Offer a Magellan provider agreement and all relevant addenda/ amendments to providers identified for participation in the Magellan VA BHSA provider network;
- ◆ Indicate the members, services , or Medicaid plans covered by the agreement based on the reimbursement schedules provided; and
- ◆ Execute the agreement after it has been returned and signed by the provider and the provider has successfully completed the credentialing process. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Appealing Decisions That Affect Network Participation Status

Our Philosophy	Providers have a right to appeal Magellan quality review actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network.
Our Policy	Client requirements and applicable federal and state laws may impact the appeals process; therefore, the process for appealing is outlined in the letter notifying a provider of changes in the conditions of their participation due to issues of quality of care or services.
What You Need to Do	Your responsibility is to: <ul style="list-style-type: none">◆ Follow the instructions outlined in the notification letter if you wish to appeal a change in the conditions of your participation based on a quality review determination.
What Magellan Will Do	Magellan's responsibility is to: <ul style="list-style-type: none">◆ Notify you in a timely manner of the determination that the condition of your participation is changed due to issues of quality of care or service; and◆ Consider any appeals submitted in accordance with the instructions outlined in the notification letter, subject to applicable accreditation and/or federal or state law.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Contract Termination

Our Philosophy Magellan's philosophy is to maintain a diverse, quality network of providers to meet the needs of Virginia Medicaid/FAMIS members. In addition, we believe that providers should advocate on behalf of members in obtaining care and treatment for behavioral health and substance abuse disorders.

Our Policy Network providers **will not** be terminated from the networks of Magellan and/or its affiliated companies for any of the following reasons:

- ◆ Advocating on behalf of a member regarding their behavioral health treatment needs;
- ◆ Filing a complaint against Magellan;
- ◆ Appealing a decision of Magellan; or
- ◆ Requesting a review of or challenging a termination decision of Magellan.

Network providers may be terminated from the networks of Magellan and/or its affiliated companies for the following reasons, including, but not limited to:

- ◆ Failure to submit materials for re-credentialing within required timeframes;
- ◆ Suspension, loss or other state board actions on licensure;
- ◆ Provider exclusion from participation in federally or state-funded healthcare programs;
- ◆ Quality of care or quality of service concerns as determined by Magellan;
- ◆ Failure to meet or maintain Magellan's credentialing criteria;
- ◆ Provider-initiated termination; or
- ◆ Violation of contract terms.

What You Need to Do Your responsibility is to:

- ◆ Advocate on behalf of members;
- ◆ Maintain your professional licensure in a full, active status;
- ◆ Respond in a timely manner to re-credentialing requests; and
- ◆ Follow contract requirements, policies, and guidelines including appropriate transition of members in care at the time of contract termination.

If you choose to terminate your contract with Magellan, you should:

- ◆ Submit your notice of termination in writing, in accordance with the terms of your provider agreement, to:
Magellan Healthcare
Attn: Network Operations
14100 Magellan Plaza
Maryland Heights, MO 63043
Fax 1-888-656-0429
- ◆ If you are a group member, notify members in your care and transition them to a group member credentialed with Magellan.

**What Magellan
Will Do**

Magellan's responsibility is to:

- ◆ Respect your right to advocate on behalf of members based on their behavioral health needs;
- ◆ Not terminate your contract for advocating on behalf of members, filing a complaint, appealing a decision, or requesting a review of or challenging a termination decision of Magellan;
- ◆ Notify you when re-credentialing materials must be submitted and monitor your compliance;
- ◆ Communicate quality concerns and complaints received from members;
- ◆ Notify you of the reason for contract termination and your appeal rights, as applicable, if your contract is terminated; and
- ◆ Notify members in your care and facilitate care transition plans if your contract is terminated.

For specific information concerning contract termination obligations of both parties, consult your Magellan agreement.

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: <ul style="list-style-type: none">◆ Participate in the care management processes, often necessary before beginning care, and at intervals during treatment, as required by the member's benefit plan; and◆ 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.
What Magellan Will Do	Magellan's responsibility is to: <ul style="list-style-type: none">◆ 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 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.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

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 requests for clinical services upon request.
What You Need to Do	<p>Your responsibility is to do the following when a member presents for care:</p> <ul style="list-style-type: none">◆ 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 registration is required, the preferred method is to log into www.MagellanofVirginia.com and follow the protocol for registering the requested service. Please note that registration is necessary for claims to be paid. If registration is not completed, then an administrative non-authorization will be issued.◆ When a service authorization is required, follow Magellan’s service authorization process by completing the applicable authorization request methodology [i.e., Request Higher Level of Care, Service Request Application (SRA), or Treatment Request Form]. Specifics regarding service authorization requests are found in full at www.MagellanofVirginia.com.◆ To receive authorization and reimbursement of Level A, B, or C Residential, 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 Level A, B, or C Residential.◆ For authorization of Intensive In-Home (IIH) Services, Therapeutic Day Treatment (TDT) or Mental Health Skill-building Services (MHSS) for children and adolescents, the Independent Clinical Assessment (ICA), also referred to as VICAP, must be conducted by the ICA

evaluator prior to the provider submitting a service authorization request. The one exception to this VICAP ICA requirement is for members being discharged from inpatient or Level A, B, or C Residential. In these situations, the initial authorization for IIH, TDT, or MHSS may be submitted without an ICA. However, an ICA must be done prior to a request for the first reauthorization or concurrent review. Full details of this procedure including timeframes and process are described on the SRA form used when submitting a request for IIH, TDT, or MHSS.

- ◆ When an Independent Clinical Assessment (ICA) is administered, the preferred method for authorization for the VICAP evaluator is to log into www.MagellanofVirginia.com and submit the VICAP summary form. This must be within one business day of the ICA. Specifics regarding ICA requests are found in full at www.MagellanofVirginia.com.
- ◆ For certain service authorization requests, the CANS, CON, and/or Plan of Care are 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 and contact information 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.

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 authorized when it meets the medical necessity criteria for this service.
Our Policy	Our policy is to authorize 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	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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;◆ Psychological testing must be authorized if more than seven hours are billed in a six-month period.◆ Request authorization for psychological testing if request is beyond the limit noted in previous bullet by completing the <i>Request for Psychological Testing Authorization</i> form available in the For Providers / Forms area of the Magellan of Virginia website; and◆ Fax, submit online or mail the completed and signed testing request form to the Magellan Virginia Care Management Center.◆ If the testing occurs over a period of more than one day, bill the total number of hours on the last day that testing occurred.
What Magellan Will Do	<p>Magellan’s responsibility is to:</p> <ul style="list-style-type: none">◆ Promptly review your completed request form in accordance with applicable federal and state regulations;◆ Respond within three business days to your request;◆ Contact you directly if further information is needed; and◆ Offer you the opportunity to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested testing based on clinical criteria.

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	<p>Continued stay utilization management review is required for various covered services, including but not limited to:</p> <ul style="list-style-type: none">◆ Inpatient◆ Community Mental Health Rehabilitative Services (CMHRS)◆ Outpatient <p>A complete list of services requiring continued stay review is found in Appendix A.</p>
What You Need to Do	<p>If after evaluating and treating the member, you determine that additional services are necessary:</p> <ul style="list-style-type: none">◆ Magellan recommends that providers submit the appropriate service request form or call the designated Magellan care management team member <i>at least</i> 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 the Virginia Department of Medical Assistance Services (VA 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. 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	<p>Magellan's responsibility to you is to:</p> <ul style="list-style-type: none">◆ 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; and
 - Three business days for all other continued stay authorization decisions.

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	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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 the Virginia Department of Medical Assistance Services (DMAS). Members may appeal clinical denials or partial approvals to DMAS without requesting a reconsideration with Magellan. Request for reconsiderations must be made within 30 days of receiving the written notice of adverse determination.
What Magellan Will Do	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none">◆ Involving inpatient stays, notify you verbally of any adverse determination and the reconsideration and appeal process for you according to the member's benefit plan, to be followed up by a written adverse determination;◆ 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 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 abuse 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	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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:<ul style="list-style-type: none">● 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: <i>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.</i>◆ 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:

Emergency	Immediately assist with access to emergency care (such as 9-1-1 call or Emergency Room).
Non-life-threatening emergency	Appointment within 6 hours of the call
Urgent care	Appointment within 48 hours of the call
Routine care	Appointment within 10 business days of the call

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.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Continuity, Coordination and Collaboration

Our Philosophy

We appreciate 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 CSB to which the member is returning. We have noted an increase in episodes of "false discharges." This involves when someone other than the member or present provider notifies Magellan of the member discharge. *Please note that episodes of false discharge information will result in provider referral to the Magellan QI department.*
- ◆ **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:

- ◆ Collaborate with our 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 us and/or MCO to establish discharge plans that include a post-discharge scheduled appointment within seven days of discharge;
- ◆ Notify us 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 we 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, 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 a MCO Liaison to coordinate care between physical health and behavioral health services.

** 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.*

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

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 website. This includes information about the National Center on Psychiatric Advance Directives at <http://www.nrc-pad.org/>, Virginia-specific information at www.virginiaadvancedirectives.org, as well as the Virginia Department of Health Advance Health Care Directive Registry at <https://www.virginiaregistry.org/>, 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 and InterQual medical necessity criteria for making service authorization decisions. DMAS criteria are mainly based on Virginia Administrative Code, the DMAS CMHRS Manual, the DMAS Psychiatric Services Manual and the DMAS EPSDT Behavioral Therapy Program Manual. McKesson's InterQual criteria, which is proprietary (and is only available to providers who purchase them), are used for determining medical necessity for Inpatient Psychiatric requests, and in conjunction with DMAS criteria for Level A, B and C Residential, and Outpatient Psychiatric and Substance Use Disorder treatment. Medical necessity criteria approved by DMAS is used for Psychological Testing requests that are for more than seven hours per six months.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ Review and be familiar with DMAS 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 comment form located at www.MagellanHealth.com/provider, or by submitting your feedback in writing to the applicable Magellan Care Management Center's medical director.
What Magellan Will Do	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none">◆ 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

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[REFER TO NATIONAL HANDBOOK FOR THIS SECTION](#)

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Clinical Monographs

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SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

New Technologies

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SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

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.MagellanHealth.com/provider, are our 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. We encourage you to use these websites often as a self-service tool for supporting your 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;
- ◆ Sign in to Magellan's secure website to access applications (e.g., eligibility, authorizations and claims) by using your username and password; or if you don't have a username and password, click the "New User" link;*
- ◆ 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:
 - Member eligibility inquiry,
 - Request for initial and subsequent authorization,

- Authorization inquiry and report download,
- View 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),
- Check credentialing and contract status for all providers,
- Display/edit practice data (to enable you to monitor and request changes to your practice information),
- 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.

SECTION 4: THE QUALITY PARTNERSHIP

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	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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 and orientation 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 network, or you receive a referral of a member whose provider has left the 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 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;
- ◆ Provide timely information and decisions on credentialing and re-credentialing processes; and
- ◆ Resolve grievances and reconsiderations within applicable timeframes.

SECTION 4: THE QUALITY PARTNERSHIP

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. Magellan continually assesses network composition by actively recruiting, developing, retaining and monitoring a diverse provider network compatible with the member population.
- What You Need to Do** Your responsibility is to:
- ◆ Provide Magellan with information on languages you speak.
 - ◆ Provide Magellan with any practice specialty information you hold on your credentialing application.
 - ◆ Provide oral and American Sign 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, including bilingual staff and 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. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness.

SECTION 4: THE QUALITY PARTNERSHIP

Member Safety

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[REFER TO NATIONAL HANDBOOK FOR THIS SECTION](#)

SECTION 4: THE QUALITY PARTNERSHIP

Accreditation

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SECTION 4: THE QUALITY PARTNERSHIP

Prevention 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	We obtain provider input on our programs and services through provider satisfaction surveys, participation in Magellan quality committees as appropriate, our provider website, and through special requests for feedback, such as for our clinical practice guidelines and prevention program development.
What You Need to Do	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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 (under FAQs/Feedback or under My Messages after secure sign-in) or by contacting your local Care Management Center staff for investigation and resolution of the issue.
What Magellan Will Do	<p>Magellan's responsibility is to:</p> <ul style="list-style-type: none">◆ 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.

SECTION 4: THE QUALITY PARTNERSHIP

Member Rights and Responsibilities

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SECTION 4: THE QUALITY PARTNERSHIP

Confidentiality

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SECTION 4: THE QUALITY PARTNERSHIP

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	<p>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.</p> <p>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 as a part of credentialing for participation in Magellan's network and on other occasions as determined by quality or clinical reviews.</p> <p>Site visits may include, but not be limited to, a review of the following:</p> <ul style="list-style-type: none">◆ 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, CSB 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	<p>Your responsibility is to:</p> <ul style="list-style-type: none">◆ 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 you 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, we request that our providers maintain organized, well-documented member medical records that reflect continuity of care for members. We expect 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 generally reviews a random sample of treatment records from providers who received referrals from Magellan.

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 our 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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SECTION 4: THE QUALITY PARTNERSHIP

Provider Satisfaction Surveys

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[REFER TO NATIONAL HANDBOOK FOR THIS SECTION](#)

SECTION 4: THE QUALITY PARTNERSHIP

Adverse Outcome Reporting

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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: <ul style="list-style-type: none">◆ Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Magellan provider network.
What Magellan Will Do	Magellan's responsibility is to: <ul style="list-style-type: none">◆ 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 of a change in the conditions of your network participation, if determined to be required;◆ Advise you, in writing, if any action is taken as a result of the inquiry and review process; and◆ Advise you of your rights to appeal a Regional Network and Credentialing Committee (RNCC) determination if the decision is to terminate your participation in the provider network due to quality of care or service issues. The procedure for appeals is included in written notification of such a determination and includes submission of any appeal request and any additional information not previously presented, in writing, with 33 calendar days of the mailing of the RNCC determination. Appeals are heard by the members of the National Network and Credentialing Committee (NNCC) Appeals Subcommittee. Written notification of the subcommittee's determination of the appeal includes the specific reasons for the decision.

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>

**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

Provider Exclusion from Federally or State-Funded Programs

Our Philosophy

Magellan promotes provider compliance with all federal and Commonwealth of Virginia laws on provider exclusion. The U.S. Department of Health and Human Services (HHS) through the Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federally funded healthcare programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online. According to the HHS-OIG, “basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.” In addition, the U.S. General Services Administration’s (GSA) web-based System for Award Management (SAM) Exclusion Database is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits. The SAM Exclusion Database replaced the U.S. General Services Administration’s (GSA) web-based Excluded Parties List System (EPLS), which is no longer in use.

Our Policy

Consistent with federal and Commonwealth of Virginia requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan’s policy is to ensure that excluded individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan’s product offerings. This policy is applicable to all Magellan lines of business.

What You Need to Do

Your responsibilities as required by the Centers for Medicare and Medicaid Services (CMS), further protects against payments for items and services furnished or ordered by excluded parties. As a participant in federally-funded healthcare programs, you must take the following steps to determine whether your employees and contractors/subcontractors are excluded individuals or entities:

- ◆ Screen all employees, agents and contractors/subcontractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- ◆ Search the HHS-OIG LEIE website at <https://exclusions.oig.hhs.gov> to capture exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.

- ◆ Immediately report to VA DMAS any exclusion information discovered.

In addition, to comply with Magellan’s fraud, waste and abuse programs, your responsibility is to:

- ◆ Check each month to ensure that you, your employees, agents, directors, officers, partners or owners with a 5 percent or more controlling interest and subcontractors are not debarred, suspended or otherwise excluded under the HHS-OIG LEIE at <https://exclusions.oig.hhs.gov>, the SAM Exclusion Database at <https://www.sam.gov> or any applicable state exclusion list where the services are rendered or delivered; and
- ◆ Immediately notify Magellan in writing of the debarment, suspension or exclusion of you, your employees, agents, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.
- ◆ Disclosure Requirements: Medicaid providers are required to disclose information regarding:
 1. The identity of all individuals and entities with an ownership or control interest of 5 percent or greater in the provider including information about the provider’s agents and managing employees in compliance with 42 CFR 455.104;
 2. Certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105; and
 3. Including you, the provider, the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or entity that has ever been convicted of any crime related to that person’s involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children’s Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.

What Magellan Will Do

Magellan’s responsibility is to conduct fraud, waste and abuse prevention activities that include:

- ◆ Check the SAM Exclusion Database, HHS-OIG LEIE, and applicable state exclusion lists during credentialing, prior to the employment of any prospective Magellan employee and prior to contracting with any vendor, and monthly thereafter. Exclusion lists for the Commonwealth of Virginia include:

- MCSIS - The Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS), is a web-based application that is a single source for collecting and sharing Medicare and Medicaid and CHIP provider termination data. Data is available via batch.
 - NPPES - National Plan and Provider Enumeration System (NPPES). This is the national database used to assign unique National Provider Identifiers (NPIs) for all healthcare providers. Data is available via batch.
 - SSA-MDF - Social Security Administration (SSA) - Master Death File (MDF). Produced by the Social Security Administration and distributed by the National Technical Information Service (NTIS), and contains over 85 million records of deaths, reported to the SSA, from 1936 to present.
- ◆ Ensure that excluded individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan's product offerings. This policy is applicable to all Magellan lines of business; and
 - ◆ Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases, and reporting fraud-related data to federal and state agencies in compliance with applicable federal and state regulations and contractual obligations.

SECTION 4: THE QUALITY PARTNERSHIP

HIPAA Transaction Standards

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SECTION 5: PROVIDER REIMBURSEMENT

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 abuse 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;
 - ◆ 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 tips under the “Getting Paid” section of www.MagellanHealth.com/provider.
- ◆ Submit BHSa claims electronically (the preferred method) or to:
Magellan Healthcare
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 VA 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 resubmitted claims upon receipt of requested information from the provider. To be timely, resubmitted claims must be sent within 12 months of 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* *to the following mailing address:

Magellan Healthcare of Virginia
11013 West Broad Street, Suite 100
Glen Allen, VA 23060

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 resubmitted claims upon receipt of requested information from the provider. To be timely, resubmitted claims must be sent within 12 months of 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).