Provider Training and Orientation

FOR MAGELLAN BEHAVIORAL HEALTH OF PA, INC.
PROVIDERS

2023

Magellan HEALTHCARE®

Magellan's Mission Statement

Magellan Behavioral Health of Pennsylvania is committed to ensuring the delivery of high-quality behavioral health care to help individuals and families achieve their goals.

We partner with local counties, providers, Members, families and other stakeholders to ensure a system of care based on innovation, clinical excellence and a philosophy of wellness that focuses on discovering personal strengths, building hope and offering choices.

Together, we facilitate and accelerate transformation of the behavioral health system, supporting individuals and families on their journey toward recovery, building resilience in their lives and securing a healthier future.

Training Library

Welcome to Magellan Behavioral Health of Pennsylvania, Inc. (Magellan)! This 4-part training is designed to give Magellan network providers specific information on the delivery of behavioral health care services to members of the HealthChoices' Program in Bucks, Cambria, Lehigh, Montgomery and Northampton Counties in Pennsylvania. The comprehensive training is broken into the following modules:

- Part I: Introduction to HealthChoices and Magellan; Network Overview and Billing
- Part II: Clinical Department Overview
- Part III: Quality Improvement Department Overview
- Part IV: Compliance Department Overview; Member Services Support and Other Resources

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Attestation of Completion

- It is important that new providers review the full training library (four separate modules) in addition to both provider handbooks and follow all procedures and guidelines when providing services to members in the HealthChoices' Program.
- Please share the training modules, as appropriate, with all provider staff that have either direct or indirect contact with Magellan HealthChoices members.
- There is an attestation attached to the training(s): please be sure to complete the attestation form and submit it to Magellan upon completion. The Magellan staff who is working with you to take the training will provide the form.
- In addition to signifying completion of the training, the attestation form requests confirmation that:
  - Member Rights and Responsibilities are handed out to every HealthChoices member upon intake.
  - Providers are aware of various Outcomes Assessment Tools that are available on Magellan's website.

HealthChoices and Magellan

Pennsylvania HealthChoices

What is it?

- The HealthChoices Program is the name of one of Pennsylvania's mandatory managed care programs for Medical Assistance recipients. The HC program covers both physical health and behavioral health benefits.
- Through Behavioral Health Managed Care Organizations, recipients receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services. This component is overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS). For more information, please reference:

MCO Information (pa.gov)

Magellan is a BH-MCO

- Every HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based on his or her county of residence.
- HealthChoices requires PA Counties to ensure high quality care and timely access to appropriate mental health and drug and alcohol services, and to facilitate effective coordination with other needed services.
- Child and Adolescent Service System program [CASSP] and Community Support Program [CSP] principals and Department of Drug and Alcohol Programs [DDAP] Treatment philosophies are utilized to ensure high quality of care.

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Magellan Behavioral Health of PA, Inc.

- Magellan Behavioral Health of PA, Inc. has 25+ years' experience with HealthChoices.
- Magellan is subcontracted as the mandatory behavioral health managed care organization in the following HealthChoices counties: Bucks, Cambria, Lehigh, Montgomery and Northampton.
- 4 Regional Offices:
  - Newtown, Bucks County
  - Bethlehem, Lehigh County
  - Norristown, Montgomery County
  - Johnstown, Cambria County

Network Department Overview

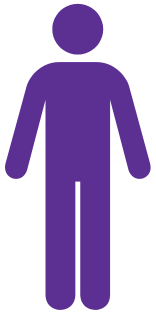
Network Department Scope

How can the Network Department provide assistance?

- Our responsibility is to provide information and guidance to ensure your contractual relationship with Magellan is appropriate to your provider category.
- We can assist with credentialing and re-credentialing.
- We can provide assistance with billing.
- We offer provider assistance with contractual and provider handbook questions.
- We provide support with Medicaid Promise Enrollment.

Provider Contract Types

- Facility Contract – A facility or agency licensed and/or authorized by the state in which it operates to provide behavioral health services.
- Group Contract – 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 with active Medicaid Enrollment.
- Individual Contract – A clinician who provides behavioral health services and bills under his or her own Tax ID/ SS#.

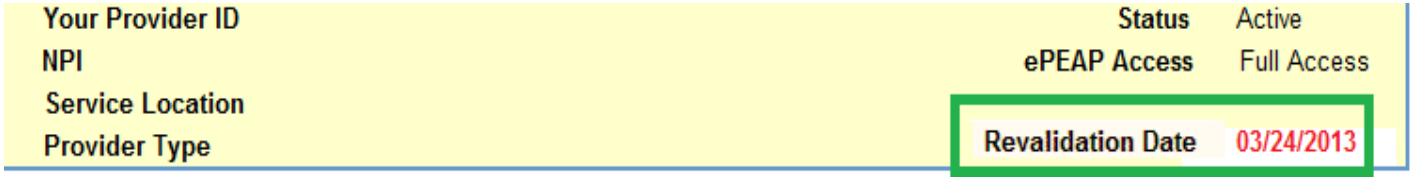


MA Enrollment

- **All contracted providers must have current and valid Promise enrollments for all active services and locations.**
  - ✓ Provider should review current contracted services and verify all enrollments are active and current.
  - ✓ Without current MA enrollment, providers are not able to be reimbursed for Medicaid services.
  - ✓ Base Application Link: PROMISe Enrollment (pa.gov)
  - ✓ Supplemental services must complete application through BH-MCO within the county the services are rendered.
    - ✓ Provider attestation completed by BH-MCO
- **MA Revalidation is required every 5 years.**
- **Claims processing may be stopped and retracted for services that are not enrolled.**

Medical Assistance Revalidation

- Supplemental services must complete application through BH-MCO within the county the services are rendered. You will not need to complete multiple applications for each BH-MCO. The Revalidation is good for all counties.
- Revalidation process will be every five years. Allow time for any issues that may come up with the application submission process.
- Magellan must provide Supplemental attestation forms to be uploaded by the provider to complete enrollment process for any supplemental service
- Providers will be required to give Magellan Promise tracking/ATN numbers to ensure compliance
- [PROMISe Enrollment (pa.gov)]



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Provider Handbooks

- Magellan's Provider Handbooks outline the policies and procedures with which providers are required to comply when serving members whose care is managed by Magellan and/or its affiliated companies.
- HealthChoices Providers must comply with the policies and procedures contained in the Pennsylvania HealthChoices Supplement, and any other applicable handbooks, including the National Provider Handbook and the Magellan Organizational Provider Handbook Supplement.

Satellite Sites & Licensing For IBHS/ABA Providers ONLY

- IBHS licenses are issued regionally. There are 4 regional field offices: Western Field Office, Northeast Field Office, Southeast Field Office, and Central Field Office. A provider is only required to get multiple licenses if it provides services in multiple regions.
- If a provider has multiple locations in one region, they do not need each site licensed, unless the site provides on-site services. However, your service description must include all locations under the regional license.
- A provider is required to submit 1 service description for each IBHS license.
- If a provider's service changes, an updated service description must be submitted to the licensing field office for approval. If a provider's address changes, a provider must notify OMHSAS's licensing field office and, if the provider is enrolled in MA, it must also notify MA enrollment.
- *Not all locations in the region require MA enrollment unless providing on-site services

Billing and Claims

Claims Requirements

- All claims for covered services provided to HealthChoices Members must be submitted to and received by Magellan as follows:
  - Within **sixty (60) calendar days from date of service** for most levels of care except as provided below
  - Within **sixty (60) calendar days from date of discharge for 24/hr** levels of care
  - Within sixty (60) calendar days of the last day of the month or the discharge date, whichever is earlier, when billing monthly for longer treatment episodes of care at a 24/hr level facility
  - Within sixty (60) calendar days of the claim settlement for third party claims. This date is based on the date of the other carriers decision.

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

Submission of Clean Claims

- Claims TIPs can be found at the following location: https://www.magellanprovider.com/getting-paid/preparing-claims/claims-tips.aspx

- Several tools are available including:
  - Elements of a clean claim
  - Claim DOS
  - Claim DON'TS
  - Coordination of benefits

- **Considerations for the Submission of Clean Claims**
  - ✓ Submitting claims correctly
  - ✓ Submitting claims timely
  - ✓ HealthChoices rate setting process with the OMHSAS
    - The Office of Mental Health and Substance Abuse Services (OMHSAS) reviews paid claims to determine the cost of care in Per Member/Per Month capitation fee that is paid monthly for consumers based on their recipient group.
  - ✓ Verifying member eligibility
  - ✓ Correct service location (rendering address and place of service)
  - ✓ Claims reconciliation

Claims Processing

- In accordance with applicable law, Magellan will pay clean claims within 45 days of the date of receipt. Clean claims are defined as claims that can be processed without obtaining any additional information from the provider or from a third party (Magellan pays 90% of all claims within 30 days of receipt).
- Upon receipt of a claim, Magellan reviews the documentation and makes a payment determination. As a result of this determination, a remittance advice, known as an Explanation of Payment (EOP) is sent to you. The EOP includes details of payment or the denial. It is important that you review all EOPs promptly.
- Check runs are weekly pending the county of eligibility:
  - **Northampton = Wednesday**
  - **Bucks = Thursday**
  - **Cambria, Lehigh & Montgomery = Friday**

Claims Submission

- Accepted Methods for Submission of Claims:
  1. Electronic Data Interface (EDI) via Direct Submit
  2. EDI via a Third Party Clearinghouse
  3. "*Claims Courier*"—Magellan's Web-based Claims submission tool (www.MagellanProvider.com)
  4. Paper Claims: CMS-1500 (Non-Facility-Based Providers) or UB-04 (Facility-Based Providers)

Electronic Data Interface (EDI) Direct Submission

- Provider sends HIPAA transaction files directly to and receives responses from Magellan without a clearinghouse.
- If you are able to create an 837 in a HIPAA compliant format, we *recommend* EDI Direct Submission.
- There is a simple testing process to determine if Direct Submit is right for you.
- Direct Submit supports HIPAA 837P and 837I claims submission files.
- It's free to providers.
- EDI Testing Center:
  - Self-enroll by creating a unique user ID and password
  - Download EDI guidelines
  - Upload and test files
  - Obtain immediate feedback regarding the results of the test
  - Independently validate EDI test files to ensure compliance with HIPAA rules and codes

EDI Testing Center Process (Direct Submission)

- Web-based testing is easy to follow
- Simple six-step process
- You will be assigned an IT analyst to guide you through the process and address any questions
- The process typically takes about 3 to 4 weeks to complete the process, so allow ample time to complete your independent testing.
- Go to www.edi.MagellanProvider.com to start the process.
- EDI Hotline 1-800-450-7281

Magellan Preferred Clearinghouses

- **Capario** (formerly MedAvant and ProxyMed)
  1901 E Alton Ave, Suite 100
  Santa Ana, CA 92705
  800-586-6938
  E-mail: PayerAdvocacy@Capario.com

- **Availity** (formerly THIN)
  PO Box 550857
  Jacksonville, FL 32255-0857
  800-282-4548
  Web site: www.availity.com

- **Change Healthcare** (formerly Emdeon and Relay Health)
  3055 Lebanon Pike
  Nashville, TN 37214
  615-932-3000
  Web site:
  http://www.changehealthcare.com/

- **Trizetto Provider Solutions, LLC.**
  One Financial Plaza
  501 North Broadway 3rd Floor
  St. Louis, MO. 63102
  800-969-3666
  Web site:
  www.trizetto.com/providersolutions

- **Payerpath** (formerly Mysis and Allscripts)
  9030 Stony Point Pkwy
  Suite 440
  Richmond, VA 23235
  877-623-5706
  Web site: www.payerpath.com

- **Office Ally**
  PO Box 872020
  Vancouver, WA 98687
  1-866-575-4120
  Web site: www.officeally.com

- **HEALTHEC** (formerly IGI Health, LLC)
  371 Hoes Lane
  Piscataway, NJ 08854
  Phone: 732-271-0600
  Web site: https://www.healthec.com

Electronic Claims Submissions: Claims Courier

- No-cost web-based data entry application
- Professional claims only (no institutional claims)
- For credentialed and participating providers
- Access www.MagellanProvider.com; Sign-in and go to “Submit a Claim Online”
- For low volume claim submitters who don’t want to use a clearinghouse
- Similar to the CMS 1500 claim form, with additional fields to make the application HIPAA-compliant
- A Claims Courier Demo can be accessed at: www.MagellanProvider.com

Claims Addresses

- Paper Claims must be submitted to the below addresses (claims are not accepted at the Care Management Centers):
  - MBH-Bucks, PO Box 1715, Maryland Heights, MO 63043
  - MBH-Cambria, PO Box 2157, Maryland Heights, MO 63043
  - MBH-Lehigh, PO Box 2127, Maryland Heights, MO 63043
  - MBH-Montgomery, PO Box 2277, Maryland Heights, MO 63043
  - MBH-Northampton, PO Box 2065, Maryland Heights, MO 63043

Reviewing of Claims

- Use Availity Essentials for Magellan eligibility, benefits and viewing claim transactions/EOBs

- Availity (magellanprovider.com)

- Availity Contact Information

  - Availity provider support is available via Availity Client Services (ACS):
  - E-ticketing–Available 24/7 on https://www.availity.com.
  - Chat –Available throughout the day via Community Support on https://www.availity.com.
  - Phone–1.800.AVAILITY(282.4548) Monday-Friday 8a.m.-8p.m.ET

Using Modifiers to distinguish unique services

- **Modifier 59** is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter. When these services occur on the same day, the provider will need to use modifier “59” in the last position of your contracted procedure codes.
- **Modifier FQ** is used to distinguish audio-only services. It was developed specific to Telehealth sessions that did not include a video component; however, Magellan has expanded its use to include any treatment service that is conducted by phone or an audio-only telehealth service. When an audio-only service is provided, the provider will need to use modifier “FQ” in the last position of your contracted procedure codes.

Resubmission of Claims

- Claims with *Provider* billing errors are called "Resubmissions".
- Resubmissions must be submitted within 60 calendar days from the date of the EOB.
- Resubmitted claims can be sent electronically via an 837 file. There is a specific indicator for an adjusted claim (please consult Magellan's companion guide or the EDI hotline for assistance).
- Resubmitted claims sent via paper should be stamped "Resubmission" and include:
  - Date of original submission
  - Claim number if applicable

Resubmission of Claims- Magellan Website

- Corrections can be made to claims submitted through Magellan's website using *View Claims Submitted Online* and "Resubmit" by the appropriate claim.
- The following fields can be amended: Place of Service, Billed Amount; or Number of Units. This functionality is **only** available for claims with a status of *Received/ Accepted*.
- Corrections to claims other than Place of Service, Billed Amount or Units must be submitted as hard copy via postal mail. Please note "Corrected Claim" on the form before sending.

Claims Resolution

- Claims that providers feel were denied *incorrectly* are considered “Claims Inquiries”.
- If supporting documentation is not required for Magellan to review your claim, providers should contact the Magellan provider line, at 877-769-9779 or 800-686-1356, and speak to a customer service associate. If necessary, the customer service associate will submit a service request application (SRA) to Magellan’s claims resolution team for further investigation.
- If you receive a claim denial that cannot be corrected with the help of customer service and the SRA process, you have **one year (365 days)** from the date of service to file a written inquiry. Your inquiry must include supporting documentation that refutes the reason for the denial, including the Medicaid member ID number(s), claim number(s), date(s) of service, and outstanding amount owed per county.
- If you have supporting documentation to reconsider payment for your claim, you may submit a written claim inquiry, with your supporting documentation, to Magellan at:

Magellan Behavioral Health of Pennsylvania, Inc.
Attn: Claims Resolution
105 Terry Drive, Suite 103
Newtown, PA 18940

or by email

ClaimAppealsPAHC@magellanhealth.com

Common Billing Errors

- The following are common claims errors that may result in a denial. Double check all claims prior to submission to avoid delays due to these errors:
  - Authorized units do not match billed units
  - More than one month of service is billed on one claim form
  - Recipient's ID is missing (Please use Medicaid ID numbers)
  - Recipient's date of birth is missing
  - Itemized charges are not provided when a date span is used for billing
  - EOB is not attached to third-party claim form
  - Revenue code, procedure code and/or modifier(s) are incorrect
  - Duplicate claim submissions are not identified as "resubmissions" or "corrected claims"
  - Diagnosis code is not an accepted code (current ICD-10 codes are required)
  - Service and/or diagnosis billed is not permitted under the provider's license
  - NPI Number-National Provider Identification
  - Billing authorization codes not billing codes
  - Incorrect service location
  - Incorrect Place of Service

Third Party Liability (TPL)

- Medicaid is always the last payer; Therefore, providers must exhaust all other insurance benefits first, before pursuing payment through Magellan HealthChoices.
- Claims for services provided to HealthChoices Members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an EOB. HealthChoices **will not** make payments if the full obligations of the primary insurer are not met.
- As a Magellan provider, you are required to hold HealthChoices members harmless and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.
  - In fact, providers are prohibited from collecting out-of-pocket expenses from Members for any covered services (including no-shows and missed appointments).

Coordination of Benefits

- If a member has Medicare as a primary benefit, and the service is covered by Medicare, the individual can get care from any Medicare provider they choose. The provider does not have to be in Magellan's network. You also do not have to get prior authorization from Magellan. Magellan will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.
- If the member needs a service that is not covered by Medicare but is covered by Magellan, the individual must get the service from a Magellan network provider. All Magellan rules, such as prior authorization and specialist referrals, apply to these services.
- If the member does not have Medicare but has another commercial/ private health insurance and they need a service or other care that is covered by their other insurance, the individual **must get the service from a provider that is in both the network of your other insurance and Magellan's network**. You need to follow the rules of the other insurance and Magellan, such as prior authorization and specialist referrals. Magellan will work with the other insurance to decide if it needs to pay for the services after the other insurance pays first.

Updating Provider Information

Reporting Updates to Service Locations and Other Changes

- Providers should notify Magellan in writing or through the provider website (www.magellanprovider.com) within ten (10) days of any changes, additions or deletions related to their site including:
    - Service, Mailing or Financial address; Telephone number; Business hours; E-mail address; Taxpayer identification or NPI number
    - Inability to accept referrals for any reason
    - Additions or deletions of practitioners to a Group Practice
- Providers also have a responsibility to notify Magellan if any of the following credentialing information changes:
    - Licensure status (i.e. provisional license)
    - Tax ID changes
    - Certification(s)
    - Hospital privileges
    - Insurance coverage
    - Past or pending malpractice actions

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Maintenance of Provider Information

Schedule routine intervals to provide updates: Magellan recommends providers set time aside to keep current service capabilities and contact information up-to-date, at a minimum quarterly

Focus on addressing cultural preferences: All providers should consider updating the racial, ethnic, and language options for their organizations to help us and our members understand availability across the network

Benefit to members: When providers keep their information about staff availability and language abilities current, it allows Magellan to support members in accessing the care they need

Provider Data Changes in Real Time

- Make changes to your practice data, such as e-mail address, office locations, telephone numbers, business hours and staff rosters.
- Update specialties offered within your contracted services.
- It's completed online via our secure and efficient website.
- Immediately upload your practice information to Magellan's systems.
- Ensure that accurate information is loaded in Magellan's systems and available to Magellan members.
- **This should be reviewed and updated on a quarterly basis, at a minimum**
- As earlier noted, Magellan encourages providers to provide detailed updates with a focus on race, ethnicity, and language fields
- Updating provider contact information for appropriate provider communications
- **REMINDER**: *Current practice data is vital to facilitating effective member referrals, claims processing and correspondence.*

Updating Provider Information

How to Update Your Provider Specialty Information

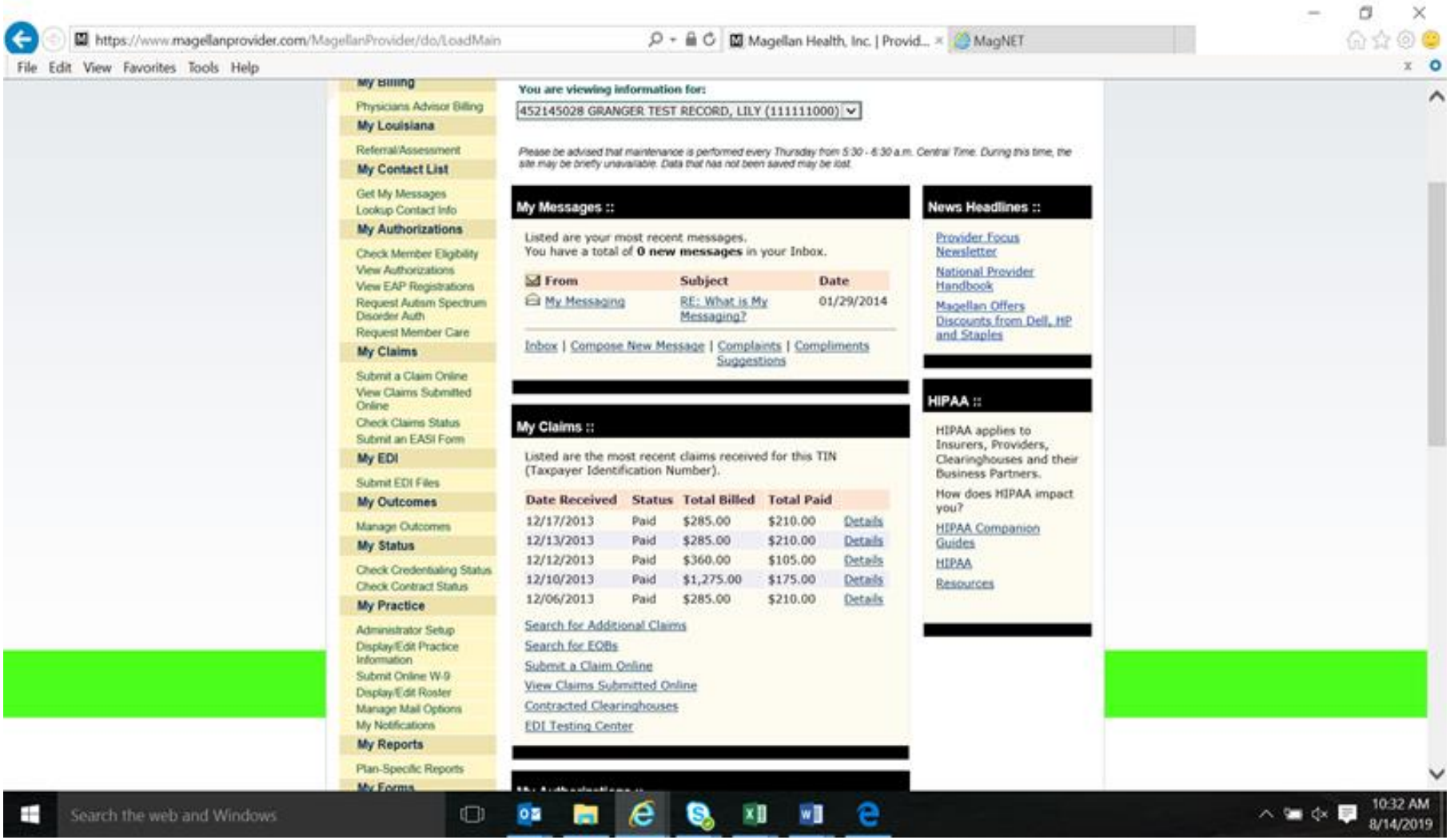
Go to Magellan's Provider Website - https://www.magellanprovider.com

Enter your Username and Password on the right-hand side of the screen

Updating Provider Information (continued)

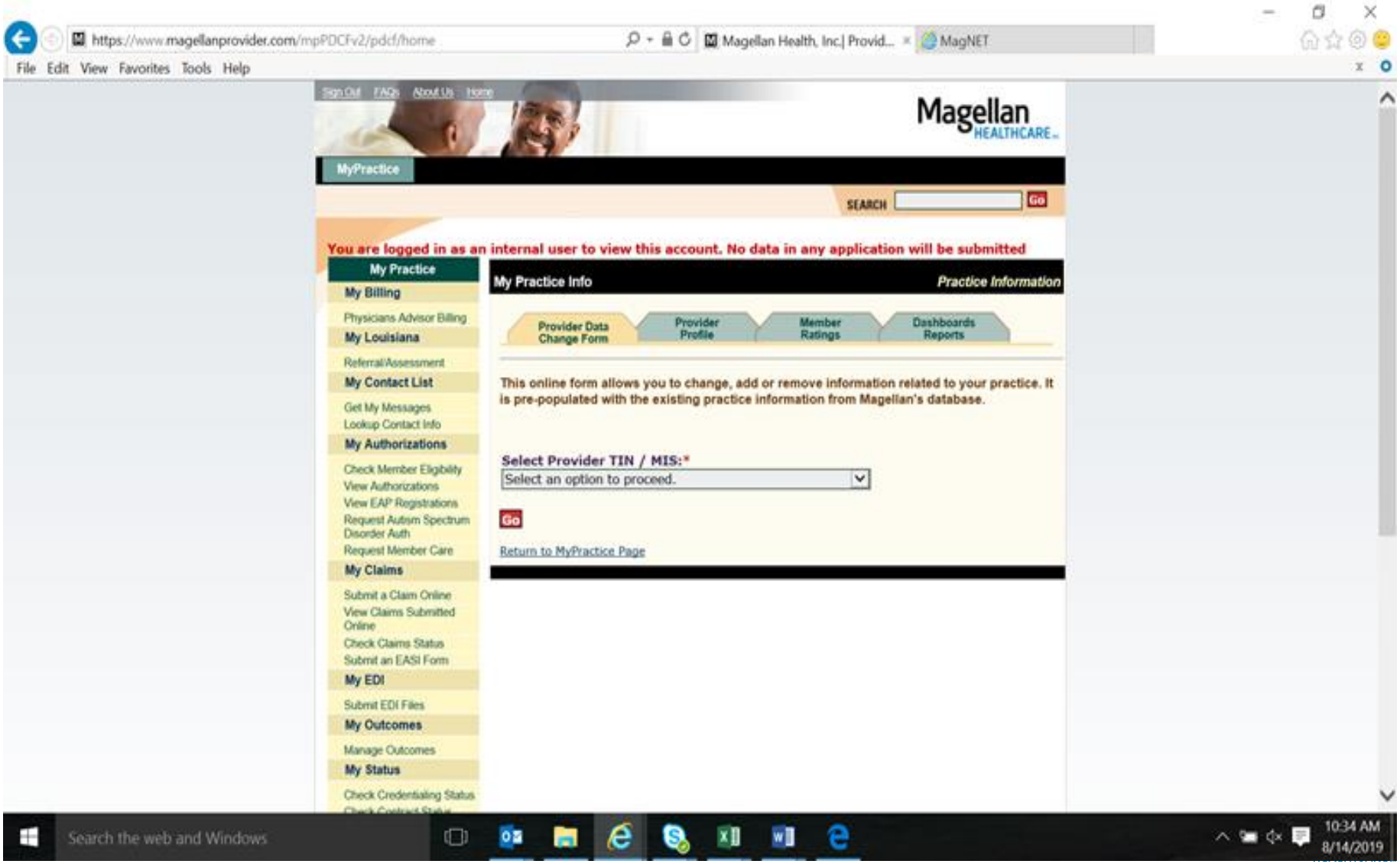
Go to: My Practice

The Provider Data Change form is located on the left side of the page. Select Edit/Change Practice Information.



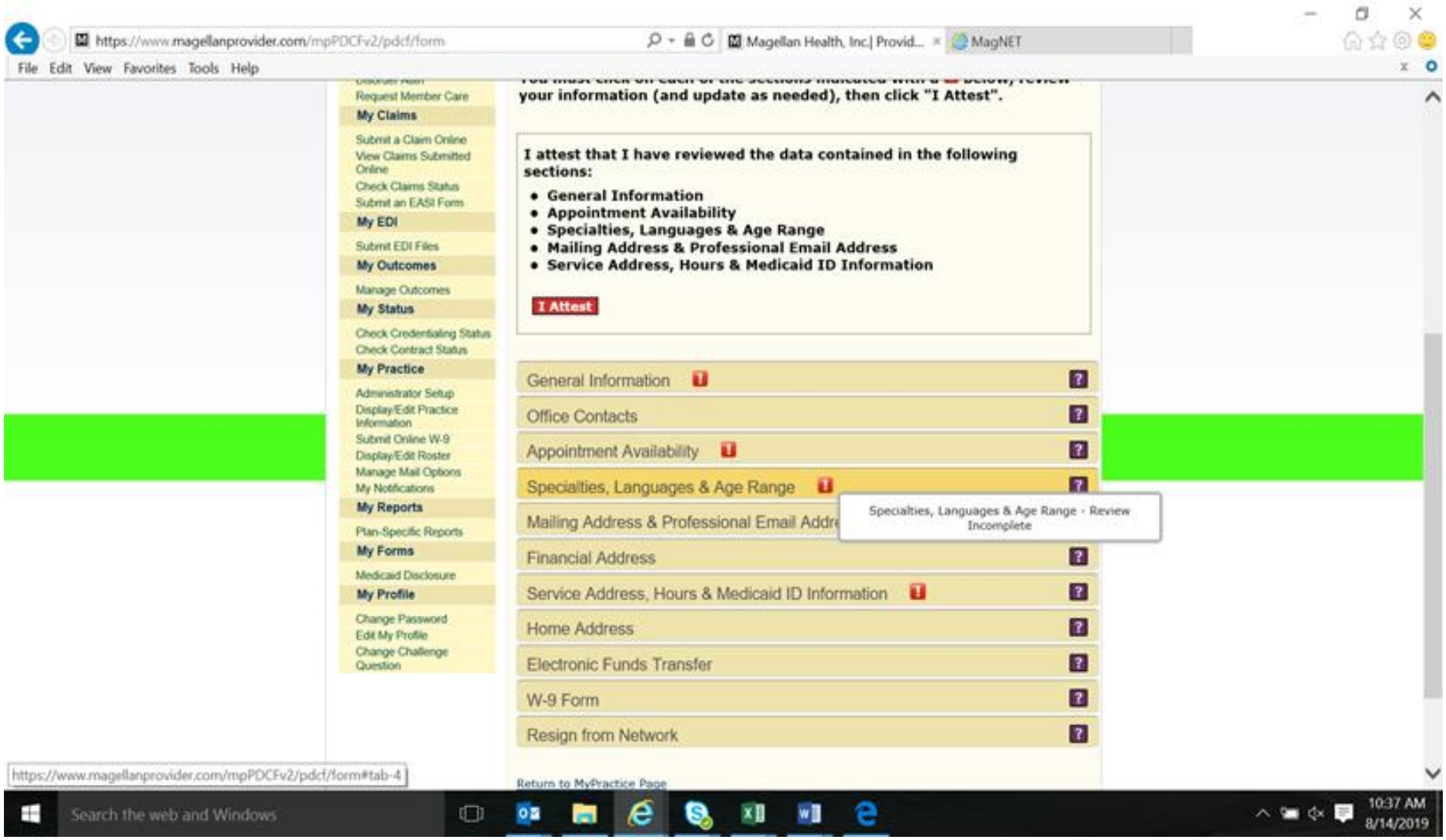
Updating Provider Information (continued)

Enter the TIN and MIS combination for the specific location(s) you need to update.



Updating Provider Information- Specialties, Languages, and Age Ranges

This function will allow you to make any changes to your identified specialties as well as add additional ones.



Updating Provider Information- Specialties, Languages, and Age Ranges

Click the Edit button to make your changes. Be sure to save the changes to add them to your Profile.

POMS Requirement

Performance/Outcome Management System (POMS)

- POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources. The database, which is maintained and managed by the Department of Human Services (DHS), contains an extensive array of raw data concerning enrollees in Behavioral Health Managed Care Organizations (BH-MCO). The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. DHS utilizes the performance measures/indicators to continuously evaluate the effectiveness of the HealthChoices' program.
- POMS allows DHS to identify members with a serious illness or risk of illness; establishes a data baseline for member functioning at registration or entry into the HealthChoices' system; updates member data as the course of treatment evolves; and finalizes member data at closure of treatment.

POMS: Provider Requirement

- The reporting of POMS data by providers is mandated by DHS to collect priority population data on every HealthChoices' member receiving **mental health services** at certain points during treatment (drug & alcohol providers are not required to submit POMS). The requirement to submit POMS data is outlined in the Magellan HealthChoices Provider Handbook Supplement as well as your Provider Agreement (Magellan Medicaid Addendum).

- POMS data must be submitted at the following intervals:
  - When you are seeing the member for the first time (initial registration);
  - When you are seeing the member for the first time under HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to HealthChoices);
  - When you are seeing the member for the last time (either termination from your care, if the member is moving to another provider; or closure, if the member is ending all mental health treatment); and
  - Whenever there is a change in any POMS element.

POMS: Provider Requirement

- POMS data that must be submitted includes the following elements:
  - Member Name
  - Member ID (Medicaid ID)
  - Member DOB
  - Registration Date (member's initial appointment date with the provider)
  - Close Date, if applicable (member's discharge date from the provider)
  - Close Reason, if applicable
  - Member's Priority Population designation
  - Member's Race
  - Member's Ethnicity
  - Member's Vocational or Educational status
  - Member's Living Status
  - Child/Adolescent School Information, if applicable (including attendance, behavior and performance)

POMS: Provider Submission

- Magellan has an online web tool for collecting the data required for the HealthChoices mandated reporting of POMS. Online entry includes user friendly access and search functions allowing for a time efficient data entry process by providers. Individuals submitting POMS data on behalf of a provider must have a log-in for the Magellan Provider Portal (magellanprovider.com). After successful log-in, users should look for "PA Outcomes Measurement" under "My Practice".
- If a user needs access to "PA Outcomes Measurement", but it does not appear in your menu, please use the 'Get My Messages' application to send a message through the site or email ProviderServices@magellanhealth.com directly to request access to the application.
- Effective July 1, 2022, Magellan no longer accepts paper or hard copy submission of POMS data. All POMS data must be submitted online through the Magellan Provider Portal.
- Providers that are submitting Treatment Authorization Requests (TARS), must attest on the cover sheet for every authorization request that they are submitting POMS data on the Magellan Provider Portal.

Ordering, Referring & Prescribing (ORP)

Ordering, Referring & Prescribing (ORP)

- Reporting ORP is necessary to comply with program integrity provisions of the Affordable Care Act (ACA), which states that the State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan to enroll as participating providers effective January 1, 2018.
- 42 CFR 455.410 - Enrollment and screening of providers requires providers, including those who order, refer and prescribe services to Medicaid recipients, to enroll in the Medicaid program. This requirement is also found in the definition of “Provider” in 42 CFR §438.2 Definitions as amended in the Medicaid Managed Care Final Rule published May 6, 2016 (Federal Register Vol. 81, No. 88).

ORP (continued)

What Practitioner Levels/Levels of Care does this impact?

- All psychiatrists, psychologists, Certified Registered Nurse Practitioners (CRNP), and physician assistants practicing independently or within a licensed facility, who order, refer, or prescribe services for HealthChoices' eligible recipients in the PA Medical Assistance programs. This also includes psychiatrists who may be rendering services via telehealth.
- In addition to the above referenced practitioner levels, HealthChoices' levels of care that currently require a "prescription" from a psychologist and or a psychiatrist, such as IBHS/BHRS, RTF, and CRR Host home, also fall under this requirement.

ORP (continued)

What you need to do:

- To ensure that the services that you render are eligible for reimbursement, you need to actively work with all applicable practitioner levels to secure enrollment for their appropriate Provider Type/Specialty.
- Information regarding the DHS enrollment process and electronic applications can be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994
- DHS has committed to a “rapid enrollment” process to accommodate these requirements.
- All claims technical assistance for ORP is located on: www.MagellanofPA.com

ORP (continued)

Next Steps:

- For providers' staff who are not currently enrolled, they need to start the process of completing the applications **IMMEDIATELY**, by accessing the DHS link: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994
- Begin submitting claims using a valid NPI number for ORP staff.
- Magellan will continue to evaluate overall compliance to determine when claims edits will be turned on.
- Providers will be formally notified of any non-compliance and request for action.
- For questions related to this information, please e-mail us at: PAHCPQuestions@magellanhealth.com

PA HealthChoices Network Contact List

Toll-Free Provider Lines:

- 877-769-9779 (Bucks & Montgomery Counties)
- 866-780-3368 (Lehigh & Northampton Counties)
- 800-424-3711 (Cambria County)

Fax numbers:

- 866-667-7744 (Bucks, Cambria and Montgomery Counties)
- 866-382-1258 (Lehigh & Northampton Counties)

Contacts:

- Mitch Fash – Senior Manager, Network Management
- Jessica Pearce – Senior Network Management Specialist
- Michael Ditty – Network Management Specialist
- Jessica Torano – Network Management Specialist
- Jeffrey Stumm – Network Management Specialist
- Crystal Devine – Network Management Specialist
- Alyssa Gorzelsky – Claims Resolution Specialist

Clinical Department Overview

Clinical Department Scope

How can the Clinical Department provide assistance?

- Provide clinical oversight of all services/ levels of care
- Participate in treatment planning meetings as needed
- Provide pre-authorization review and authorization of services utilizing medical necessity
- Provide assistance with clinical discussion regarding case needs
- Provide assistance on coordination of care
- Assess need for specialty care programs
- Provide coordination with county partners
- Evaluate presenting clinical information for care concerns

Child and Adolescent Service System Program [CASSP]

CASSP (Child and Adolescent Service System Program) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements.

- Child-centered
- Family-focused
- Community-based
- Multi-system
- Culturally competent
- Least restrictive/least intrusive

- Child-centered: Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

- Family-focused: The family is the primary support system for the child and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

- Community-based: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious, cultural organizations and other natural community support networks.

- Multi-system: Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

- Culturally competent: Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

- Least restrictive/least intrusive: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

Consumer Support Program [CSP] Principles

Consumer-Centered/Consumer-Empowered
Services are based upon the needs of the individual and incorporate self-help and other approaches that allow consumers to retain the greatest possible control over their own lives.

- Culturally competent
- Designed to meet special needs
- Community-based/Natural supports
- Flexible
- Coordinated
- Accountable
- Strengths-based

Demonstrating respect for the consumer supports the individual’s hopefulness and nurtures the person's self-esteem. When people convey trust in the consumer, it strengthens the consumer's confidence and motivation to assume increased responsibility for taking control of one's own life.

- **Culturally competent**
  Services are sensitive and responsive to racial, ethnic, religious and gender differences of consumers and families.

- **Designed to meet special needs**
  Services are designed to meet the needs of persons with mental illness who are also affected by such factors as old age, substance abuse, physical illness or disability, mental retardation, homelessness or involvement with the criminal justice system.

- **Community-based/Natural supports**
  Services are provided in the least coercive manner and in the most natural settings possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning and leisure activities of the community.

- **Flexible**
  Services are designed to allow people to move in and out of the system and within the system as needed.

- **Coordinated**
  Treatment services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Coordination includes linkages with consumers, families, advocates and professionals at every level of the system of care.

- **Accountable**
  Service providers are accountable to the users of services and include consumers and families in planning, development, implementation, and monitoring and evaluating services.

- **Strengths-based**
  Services build upon the assets and strengths of consumers and help people maintain a sense of identity, self-esteem and dignity.

Office of Mental Health and Substance Abuse Services [OMHSAS]

- OMHSAS is one of seven program offices under the Pennsylvania Department of Human Services (DHS). All DHS program offices administer services that provide care and support to Pennsylvania's most vulnerable individuals and families.
- OMHSAS Goals:
  - Transform the children's behavioral health system to a system that is family driven and youth guided.
  - Implement services and policies to support recovery and resiliency in the adult behavioral health system.
  - Assure that behavioral health services and supports recognize and accommodate the unique needs of older adults.
- For more information:
  - https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/default.aspx
  - Deputy Secretary Office: 717-787-6443

Department of Drug and Alcohol Programs [DDAP]

The Department of Drug and Alcohol Programs mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce drug, alcohol and gambling addiction and abuse; and to promote recovery, thereby reducing the human and economic impact of the disease.

Responsible for the licensure of any partnership, corporation, proprietorship, or other legal entity intending to provide drug and alcohol treatment services. The department has regulatory responsibility through its licensure authority over both public and private drug and alcohol treatment facilities.

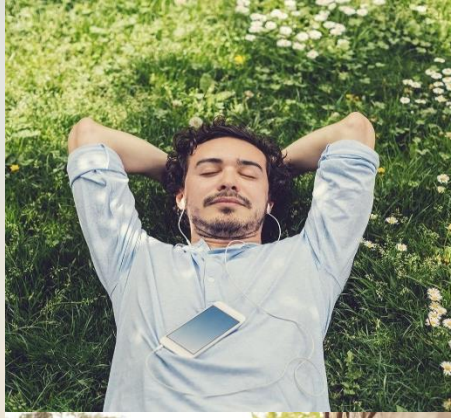
- Use E-Toolkit, Marketing campaigns, and Get Help Now connections
- Get Help Now/Recovery starts with a call – 1-800-662-HELP
- For more information: www.ddap.pa.gov

Special Needs and Priority Populations

Magellan works with a broad range of local and state agencies, community stakeholders, health plans, members, families, and caregivers on issues across the PH-BH care continuum to support the needs of Special Needs and Priority Populations.

Magellan works closely to coordinate care and services across all systems to optimize whole-person care and outcomes for our members and their families.

Magellan utilizes the **eMbraceCare Care Model** to support our most vulnerable populations, included but not limited to adults with serious and persistent mental illness; youth who have, or who are at risk for, serious emotional disturbance; individuals who are transitioning from the State Hospital back to the community; Transition Age Youth; individuals with Mental Health – Intellectual Disability [MH-ID]; and individuals with Substance Use Disorders.



eMbraceCare - to support our most vulnerable populations

eMbraceCare uses a person-centered approach that is designed to support an individual's achievement of improved personal health outcomes and wellness by encouraging positive living and the provision of services that meet the person's needs in a whole health manner.

Positive Living includes a focus on all 8 Dimensions of Wellness including: emotional, environmental, financial, intellectual, occupational, physical, social and spiritual – helping individuals achieve positive living goals in each of these domains.

Magellan empowers individuals to living meaningful lives in the community of their choice and achieve their personal goals and their full potential. At Magellan, we know recovery is real. Our Care Management process fully supports and enables a tailored recovery experience, with the ultimate goal of helping each individual achieve aspects of positive living and **embrace positive living.**

Integrated Care & Value Based Reimbursement Models

As a national leader in Behavioral Health and fully integrated Physical Health [PH] – Behavioral Health [BH] services, Magellan understands and is fully committed to bring best practices from throughout the nation to our Pennsylvania programs. We work with our county partners to craft collaboration strategies and responses to local needs.

- Innovative integrated health initiatives for both PH-BH and Community HealthChoices [CHC] populations – have increased access to care, expanded evidenced –based models and improved cost.
- Treatment coordination for individuals with complex PH-BH needs to more readily access services and optimize health outcomes. Magellan's approach helps bridge gaps in service and results in a comprehensive approach to deliver optimum results for whole-person health for Members.

Magellan Behavioral Health of Pennsylvania (Magellan) has been at the forefront in using value-based reimbursement models as a tool to partner with our providers in delivering the highest-quality care. In 2016, in partnership with our county partners, we launched our initial value-based strategy.

- Through our models, we collaborate with our county partners and providers to align providers' incentives and reimbursement with high-quality services. Provider engagement in our value-based purchasing models helps ensure each practice's structure and processes are set up to maximize quality care.
- Magellan Facility Incentive Program (MFIP), Assertive Community Treatment (ACT), Family Based Services (FBS), Outpatient, Blended Case Management (BCM), Transition to Independence Process (TIP) and Montgomery County Community Behavioral Health Center (CBHC).

Best Practices

New programs and services have been created that help to increase members' access to care, improve service use rates, expand the continuum of services in alignment with evidence-based models, and we have maximized clinical appropriateness and quality of care. These new programs have helped to meet the unmet needs of "underserved" and/or special populations. For example:

- Wellness Recovery Teams for individuals with co-occurring serious mental illness and complex physical health needs
- Mobile Crisis and Warm Lines that provide intensive community support for individuals and families to prevent the need for hospitalization
- Dual Diagnosis Treatment Teams (DDTT) for individuals with co-occurring mental health challenges and intellectual disabilities
- Certified Recovery Specialists for members with substance use disorders
- The Transition to Independence Process (TIP) for transition age youth
- Pivotal Response Treatment (PRT) and Applied Behavior Analysis (ABA) for children and adolescents with autism
- Supported housing/apartment living, Critical Time Intervention (CTI) and specialized case management teams for individuals with housing challenges
- Medication-Assisted Treatment (MAT) models for individuals with substance use disorders
- Forensic residential treatment and community support teams for individuals with criminal justice involvement

Best Practices - Continued

We have also introduced and implemented a variety of innovations to improve health outcomes for individuals and their families. For example:

- Incorporated recovery and resiliency principles into our system of care, creating a hope-filled environment that nurtures and invites member empowerment, growth, recovery, and resiliency
- Implemented a quality management program that is outcomes and data-driven through Value Based Purchasing initiatives, continuous evaluation of the quality of services, and routine monitoring of core performance indicators
- Prioritized network and innovative program development, including the expanded use of evidence-based and promising practices such as Dialectical Behavior Therapy, Assertive Community Treatment, and Trauma Focused Cognitive Behavioral Therapy, to meet the evolving needs of the members we serve, resulting in stronger providers and the delivery of high-quality, accessible care
- Advanced work in health care integration, member-centered recovery, and family-driven and youth-guided initiatives, through such activities as the creation of a network of peer-support providers, the implementation of Wellness Recovery Teams, and the launch of MY LIFE

Clinical Practice Guidelines

Clinical Practice Guidelines

Magellan develops or adopts clinical practice guidelines to assist providers in screening, assessing and treating common disorders. Prior to adopting each guideline, a multi-disciplinary panel including board-certified psychiatrists and clinical staff examines relevant scientific literature and seeks input from network providers as well as consumers and community agencies. Once implemented, Magellan reviews each guideline at least every two years for continued applicability and updates guidelines as necessary. Magellan's adopted guidelines are intended to augment, not replace, sound clinical judgment.

Consumer Guidelines

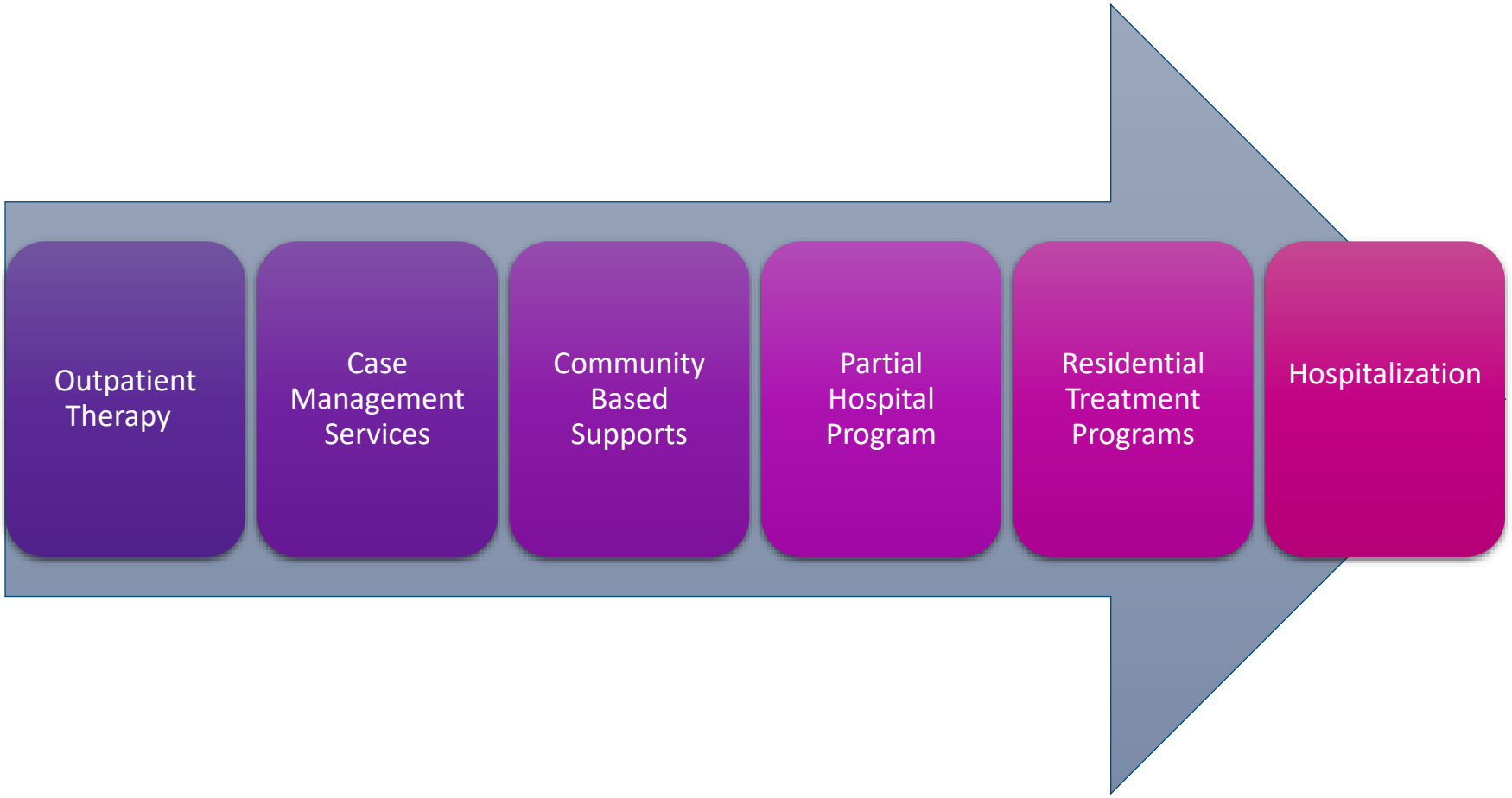
Consumer guidelines are summaries of Magellan's adopted clinical practice guidelines (CPGs). Clinical practice guidelines (CPGs) define evidence-based best practices for our network providers to use when treating our members and their families. These CPGs help our providers care for patients who have a mental health or substance use disorder.
Before a guideline is adopted, Magellan's Clinical Practice Guidelines Task Force conducts a thorough review of clinical literature, analyzing research findings for their scientific merit and the degree to which they contribute new knowledge to the assessment and treatment of mental health or substance use disorders. The results of the literature review either form the basis for Magellan's guidelines or are synthesized into introductions to the guidelines we adopt but that were written by other organizations, such as with the American Psychiatric Association.

Behavioral Health

Levels of Care

Levels of Care: From Least to Most Restrictive

Mental Health



Outpatient Services

Mental health treatment services that target behavioral symptoms and work to maintain stability while managing symptoms to promote self-sufficiency.

Anyone can access outpatient therapy services, at any time.

- Can include Individual, Group and Family Therapy.
- Psychiatry care to manage prescribed psychotropic medication.
- Diagnostic evaluation, assessment and clinical treatment.
- Focus on managing symptoms and maintaining stability.

Case Management Services

Connection and Navigation

Works to support Magellan Members to gain access to resources including:

- education
- health
- vocational
- transportation
- advocacy
- respite care
- recreational services
- specialized mental health services

Anyone can make a referral for Case Management Services.

Examples include Intensive Case Management, Resource Coordination, Blended Case Management, Recovery Coaching, Transition to Independence (TIP)

Community Based Supports

- Wrap Around You
- Services provided where the person is living, going to school or work
- Services aimed at meeting the person where they are, in life and in treatment
- Interventions to help the person make progress on their recovery goals
- Examples include: IBHS, ABA, FFT, MST, FBS, CTT CPS, and My Life

Community Based Programming – Support Services – Doorways to Wellness and Recovery

- Recovery means getting better. Every person's recovery is individualized and may not be like someone else's.
- Resiliency is the ability to bounce back and adapt. Building resiliency includes learning new skills. It gives you a sense of hope and means you will be able to grow and learn to face challenges.
- There are many roads to recovery and each person has their own path.

Community Based Programming – Support Services Doorways to Wellness and Recovery

- What does it mean to be well? Wellness includes: Having your own money to do things you like, Being able to do creative things like paint, play music and work in a garden.
- Communities offer many programs that support Recovery, Resiliency and Wellness. These can be in-person groups, online groups and phone support programs.
  - Some examples include: dance programs, yoga programs, fitness programs, mentoring, creative arts programs, hiking groups, cooking programs, Alcohol Anonymous, Narcotics Anonymous, Autism Speaks, State-Wide Adoptions Network, grief and loss groups, and SMART. Please check your local area for programs that fit your needs.

My Life - Youth Involvement:
Magellan Youth Leaders Inspiring Future Empowerment

- MY LIFE is helping to improve the lives of youth between the ages of 13 and 23 who are dealing with issues related to mental health, substance use, foster care and juvenile justice. It gives youth the chance to become leaders in the community. Magellan Behavioral Health of Pennsylvania has partnered with Bucks, Cambria, Lehigh, Montgomery and Northampton counties to host MY LIFE groups in these counties.
- Through regular meetings, special events, performances, social media, and local and national presentations, youth share their stories and support each other in their recovery goals.

Become a fan of MY LIFE on Facebook!
My Life has a Facebook fan page (www.Facebook.com/MagellanRecoveryResiliencyMyLife).
The page helps to educate, inform, engage and build support for MY LIFE programs.

Magellan HEALTHCARE

Partial Hospital Program

- A short term daily treatment program
  - Approximately 3-6 hours day – 5 days a week [10 days]
- This program is focused on managing symptoms and maintaining stability and decreasing a person's risky behaviors.
- Individual, Group, and Family Therapy and Medication Management
- Members go home at the end of the day.

Residential Treatment

- Residing in a residence at a treatment facility other than a hospital.
- 24/7 setting
- When services cannot be safely provided in a community-based setting.
- Addresses safety and risk for self and others outside of the home setting.
- Works on increasing self-control, the capacity for constructive expression and adaptive skills to continue in a natural or less restrictive setting
- Individual, Group and Family Therapy, Case management supports and Medication Management

Hospitalization

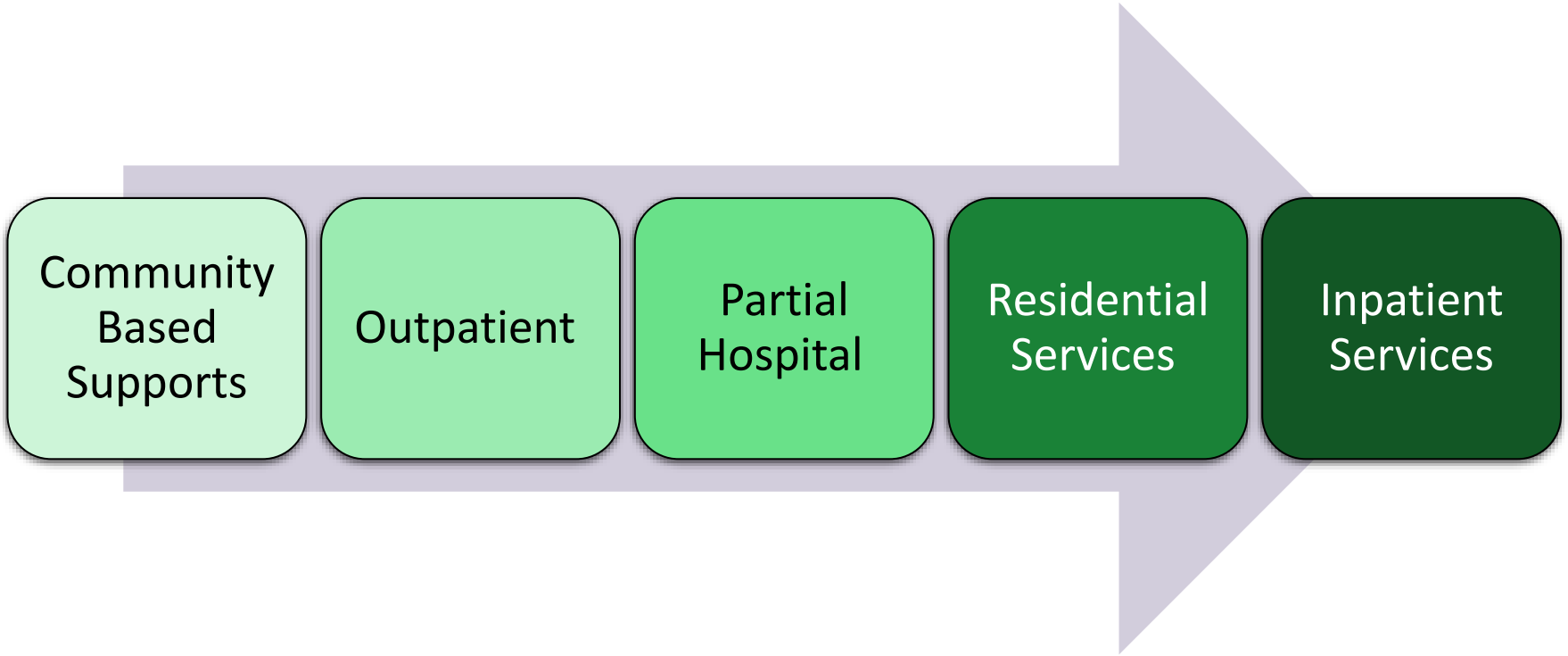
- An intensive, 24-hour service that focuses on decreasing dangerousness to self or others, grave disability, or complicating medical conditions that leave the member at risk.
- Inpatient hospitalization is short-term acute stabilization of a psychiatric emergency.
- Doctors, social workers and nurses work as a team with the individual to address the reason for the hospitalization.
- Can include Individual, Group, and Family Therapy as well as Medication Management.
- Individuals can be admitted to an Inpatient Psychiatric Hospital voluntarily or involuntarily (for limited time period).

Substance Use Disorder

Levels of Care

Levels of Care: From Least to Most Restrictive

Substance Use



Community Based Supports Substance Use Disorders (SUD)

Communities offer many programs that support Recovery, Resiliency and Wellness specific to Substance Use Disorders. These can be in-person groups, online groups and phone support programs. Some examples include:

- Alcoholics Anonymous AA
- Cocaine Anonymous CA
- Crystal Meth Anonymous
- Dual recovery Anonymous
- Narcotics Anonymous NA
- SMART Recovery
- Al-Anon Anonymous
- Nar-Anon
- Bily – Because I Love You
- Grass roots meet ups online groups on social medias platforms such as Facebook
- Loving someone with an addiction group
- Women for Sobriety

Each region has different programs, and there are some nationwide programs as well.

Substance Use Disorder Treatment

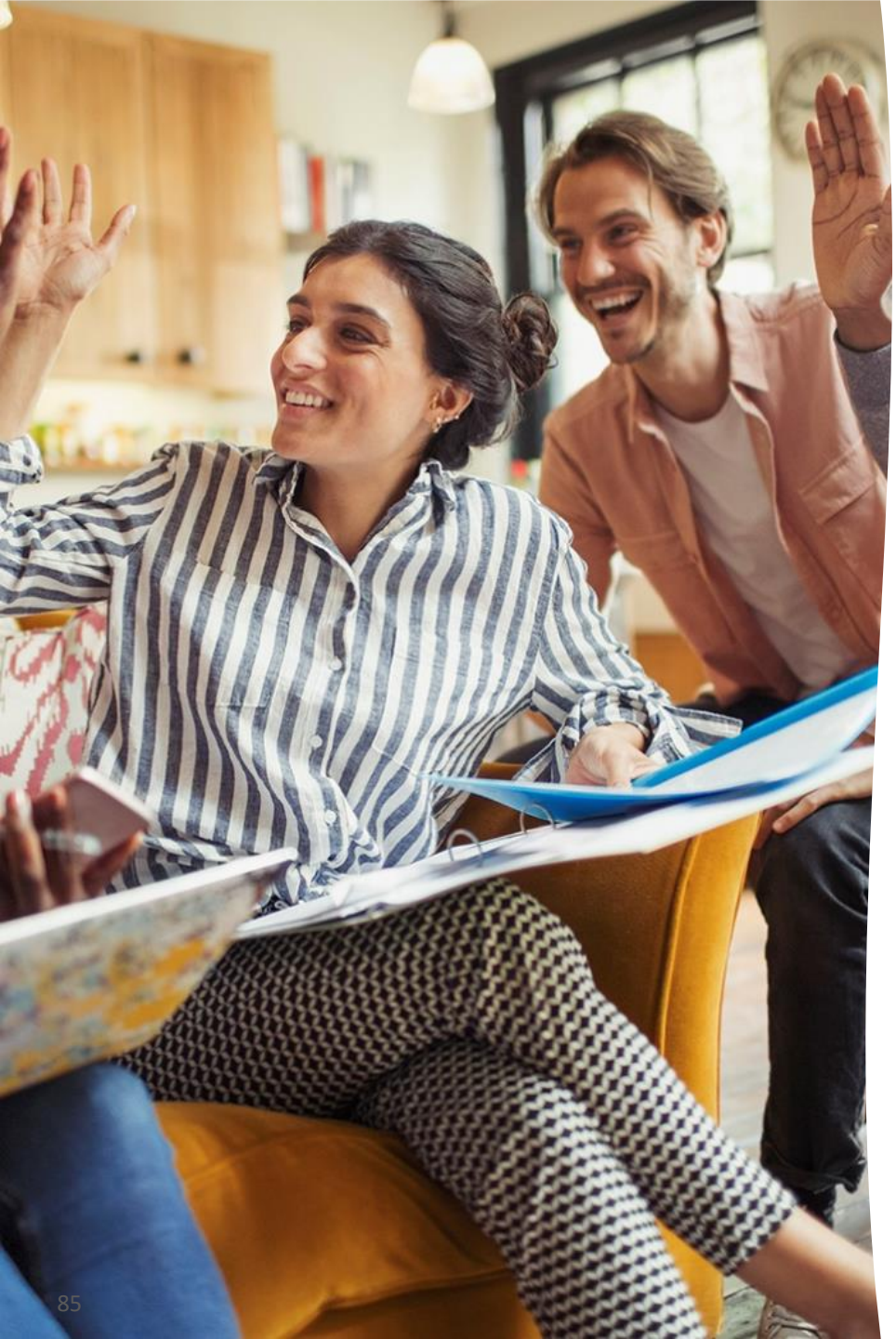
- Helping a person achieve changes to alcohol, tobacco or other drug use or addictive behaviors including lifestyle, attitude, and undermining behavior issues that impact treatment success with clinical services supports.
- They promote personal responsibility and reintegration of the individual into the network systems of work, education and family life
- A comprehensive Drug and Alcohol assessment is **the first step** to accessing treatment.

Substance Use Disorder Services

- The American Society of Addiction Medicine (ASAM) provides the most widely used set of guidelines for placement. ASAM replaces the PCPC (Pennsylvania Client Placement Criteria). As of January 2019, PCPCs are not accepted.
- Under ASAM, Substance Use Disorder programs are offered based on services provided, not necessarily the building they are housed in. This can include levels of services related to dedicated medical care staff to licensed and credentialed support staff.
- Detox treatment is now known as Withdrawal Management.
- Services can be within a free-standing provider clinic that is appropriately licensed in a community setting, and/or a specialty unit in a general or psychiatric hospital or other licensed health care facility.

Medication-Assisted Treatment (MAT)

- Evidenced-based
- Used to enhance the success of recovery from chemical dependence
- Examples: Methadone, Suboxone, Naltrexone, Vivitrol, and Nicotine Replacement Therapies
- Can be provided in conjunction with Outpatient or Inpatient Substance Use Disorder Services



Outpatient Substance Use Disorder

ASAM 1.0 & ASAM 2.1

- Provider-based location
- Programs offered during evening hours to allow people to work or attend school.
- Intensive Outpatient – IOP SUD includes extended Individual, Family and Group Therapy.
- IOP is usually 3 days per week (9 hours on average).

Partial Hospital Program Substance Use Disorder

Adolescent ASAM 2.5 & Adult ASAM 2.5

- Designed to help achieve changes to alcohol, tobacco, or other drug or addictive behaviors including lifestyle, attitude, and undermining behaviors that impact treatment success.
- The focus is on managing symptoms and maintaining stability and decreasing a person's risk behaviors.
- This program allows the member to go home at the end of the treatment day.
- Treatment includes Individual, Group and Family Therapy
- Includes Medication Management
- Occupational, and recreational therapies, and educational component as appropriate

Residential Services – Substance Use Disorder

Includes living for a period of time in a treatment facility with 24-hour staff and medical care directed support for evaluation, observation, medical monitoring and addiction treatment.

Is appropriate for members that require inpatient treatment, but not the full resources of an acute hospital setting. Individuals have **subacute** biomedical and emotional, behavioral, or cognitive problems.

This program supports to help the member achieve changes to alcohol, tobacco or other drug use or addictive behaviors including lifestyle, attitude, and undermining behavior issues that impact treatment success with clinical services supports.

Residential Services Substance Use Disorder (cont.)

The goals of treatment in residential programs are to promote abstinence from substance use, arrest or other addictive and anti-social behaviors and effect change in participants' lifestyles, attitudes and values. Examples include:

- Clinically Managed Low –Intensity Residential Services (ASAM 3.1)
- Clinically Managed Medium -Intensity Residential Services (ASAM 3.5-Adolescent)
- Clinically Managed Highest-Intensity Residential Services (ASAM 3.5)
- Clinically Managed Highest-Intensity Residential Services-Enhanced (ASAM 3.5E)
- Medically Monitored Intensive Inpatient Services (ASAM 3.7)
- Medically Monitored Inpatient Withdrawal Management (ASAM 3.7WM [Withdrawal Management [WM])

Hospitalization for Substance Use Disorder

Services are delivered in an **Acute Care** inpatient setting. For Members who have biomedical, emotional, behavioral, cognitive problems that are so severe that they require primary medical and nursing care supports.

This program supports the Member achieve changes to alcohol, tobacco or other drug use or addictive behaviors including lifestyle, attitude, and undermining behavior issues that impact treatment success with clinical services supports.

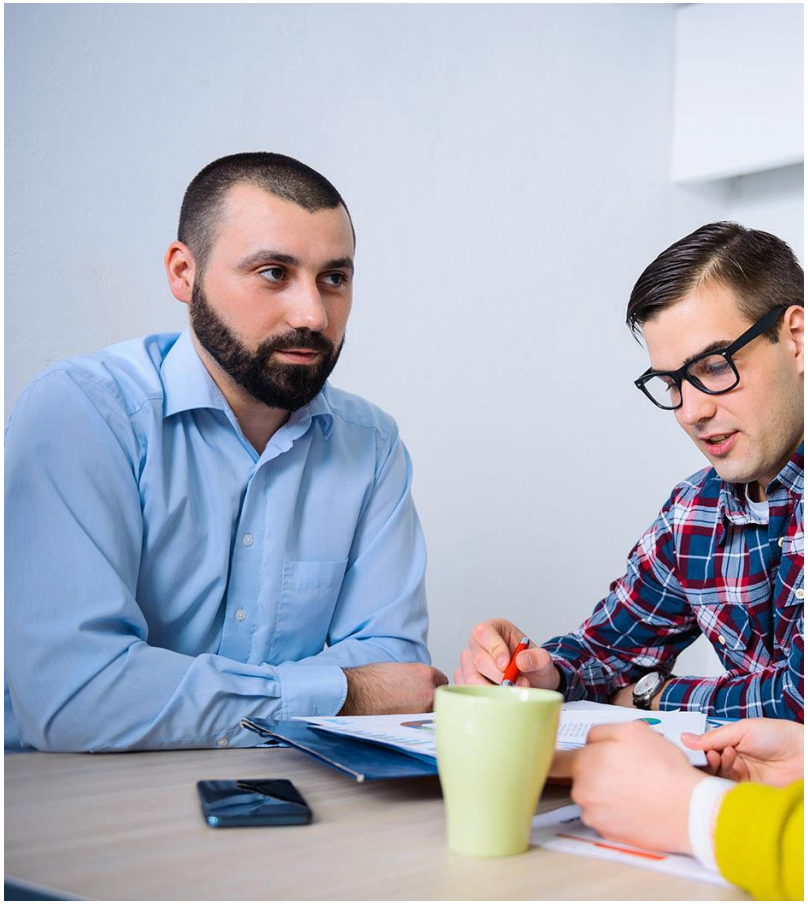
Hospitalization for Substance Use Disorder (cont.)

The goals of treatment in these programs are to promote abstinence from substance use, arrest or other addictive and anti-social behaviors and effect change in participants' lifestyles, attitudes and values.

Includes concurrent biomedical treatment for both physical health concerns and SUD.

Includes health education, individual, group and family therapy, and medication management. Examples include:

- Medically Monitored Intensive Inpatient Services (ASAM 3.7)
- Medically Monitored Inpatient Withdrawal Management (ASAM 3.7WM [Withdrawal Management [WM])
- Medically Managed Intensive Inpatient Services (ASAM 4.0)
- Medically Managed Intensive Inpatient Withdrawal Management (ASAM 4.0WM-Withdrawal Management)



Utilization Management Reviews

Requesting Authorization for Services

Service provision <u>may or may not</u> require authorization prior to the services starting.

- Magellan and our providers use state-approved guidelines to determine the best services and levels of care for individuals that we serve.
- Each service/level of care has different guidelines for authorization.
- Please verify need for prior authorization via Magellan's provider website or contact Magellan by phone.
- **<u>Clinical Pre-Authorization requests</u>** can be obtained via:
  - Telephonic review
  - Paper submission
  - Online submission
- For services that do not require a pre-authorization, the provider directly bills Magellan after each episode of care.

Telephonic Review - What you need to know…

- **Telephonic review** – a live phone call with a Magellan Care Manager to review the member's clinical treatment needs and medical necessity. If approved, an authorization will be verbally provided during the call. Authorization will also be visible via the Magellan Provider Website.
- Please have the following ready to be discussed for the member's care:

  - ✓ Diagnosis with ICD-10 codes
  - ✓ Medication update
  - ✓ Changes in Psychosocial status including updates on living arrangements, cultural issues, legal/ court related concerns, school status if applicable
  - ✓ Physical health concerns
  - ✓ Substance use concerns – including use pattern
  - ✓ System involvement – legal, child services, other
  - ✓ Behavioral concerns/referral behaviors leading to this episode of care
  - ✓ Treatment plan with interventions to target referral behaviors
  - ✓ Crisis plan/ relapse prevention plan
  - ✓ Summary of progress related to referral behaviors
    - What is working
  - ✓ Barriers to Recovery
    - What is not working
  - ✓ Coordination of care with other programs and referrals made
    - Agency name[s], contact person[s] and phone contact information
  - ✓ Discharge/ aftercare plan with related appointments confirmed
    - Date/Time/Contact person for this appointment to be provided
  - ✓ Any other areas that have not been covered

Paper submissions - What you need to know …

- **<u>Paper submission</u>** – Treatment request faxed or submitted online to Magellan for clinical review of treatment needs and medical necessity. Authorization is visible via the Magellan Provider Website.
- Please be sure to:
  - Include all pertinent clinical information – remember, you know these members better than Magellan staff. When in doubt include it!
  - Print or type- the information must be legible for review
  - Be aware of your computer or fax machine's quality of transmission
  - Know your Magellan provider website login or who at your agency has permission to login
    - Refer to the MagellanProvider.com online training for online submission assistance

Online submissions - What you need to know …

- **Online submission** – Treatment request submitted online to Magellan though the Availity Essential system for clinical review of treatment needs and medical necessity. Authorization is visible via the Magellan Provider Website.
- Additional training on the Availity Magellan Authorization system can be found here: System (magellanprovider.com)
- Please be sure to:
  - Include all pertinent clinical information – remember, you know these members better than Magellan staff. When in doubt include it!
  - Type the information
  - Know your Magellan provider website login or who at your agency has permission to login
    - Refer to the MagellanProvider.com online training for online submission assistance

Services Not Covered

- Medical Services
  - Examples – Nursing Home Care, Dental Care, Vision Care, Hearing Care, Chiropractic Care, X-rays, Transportation Services, Family planning- birth control, pregnancy testing
  - These services are available through your Physical Health Managed Care Organization [PH-MCO]
- Prescription Coverage
  - Most medication is covered by your Physical Health Managed Care Organization [PH-MCO]
  - Some medications require prior approval
- Each Physical Health Managed Care Organization [PH-MCO] has a Special Needs Unit [SNU] – these units help with physical health issues that may affect behavioral health and can be a great resource.

Questions? Outreach for support

Provider Services Contact Information

Bucks/Montgomery: (877) 769-9779

Cambria: (800) 424-3711

Lehigh/Northampton:(866) 780-3368

Member Services Contact Information

Bucks: (877) 769-9784

Cambria: (800) 424-0485

Lehigh: (866) 238-2311

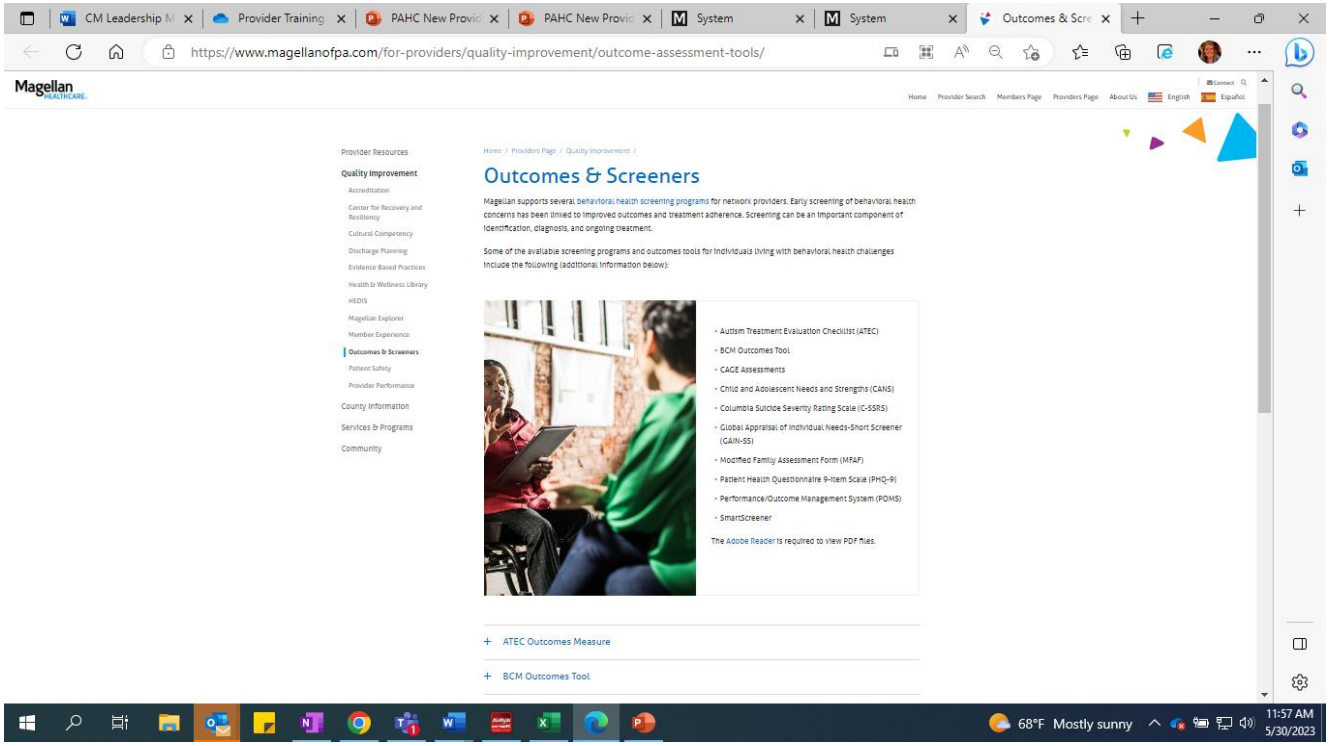
Montgomery: (877) 769-9782

Northampton: (866) 238-2312

Screening Tools Available to Providers

Screening Programs Available Through Magellan

- Magellan offers to providers the SmartScreener, CAGE, CSSRS and the CANS assessment tools.
- Materials are available at the www.MagellanofPA.com :
- Please connect with your Care Manager to discuss strategies and to learn more about opportunities relating to the Screening Programs supported by Magellan.



Magellan HEALTHCARE

SmartScreener

- The SmartScreener was developed by Magellan using validated, reliable, and well-researched brief screens identified by SAMHSA.
- The screens were chosen to maximize identification of behavioral health and co-morbid substance use, with screened conditions making up more than 90% of behavioral health complaints.
- Each tool is available in English and Spanish.
- The SmartScreener includes screening for insomnia (ISI-3), depression (PHQ-2), anxiety (GAD-2), alcohol (AUDIT-1), drugs (DAST-1), and pain (PEG- 3).
- The SmartScreeners is “smart” because each tool expands to the longer versions of the tool when the minimum threshold for each one to three item brief screen is met. Specifically, the tools expand to the ISI- 7, PHQ-9, GAD-7, AUDIT-10, and DAST-10. The PEG is only a three-item screener.
- Upon completion of the screener, the member and provider are given a report with the screening results by screener, both the raw number and the color-coded risk level for the screener of low, mild, medium, high, or severe.
- Consumer friendly messaging encourages a member to act on screens, based on the severity threshold. When the individual signs into their secure account, screens with moderate and higher severity are matched with recommendations to use the symptom based DCBT modules for insomnia, pain, depression, anxiety, OCD, and alcohol and drug use.
- Lastly, the providers have the Screen and Engage Results Review technical assistance for understanding the results of the screening and steering care in the Screen and Engage Results Review.

CAGE Screening Tool

- The CAGE Alcohol Abuse Screening Tool and the CAGE Substance Abuse Screening Tool are four-question tools used to screen for drug and alcohol use. The CAGE is a quick questionnaire to help determine if an alcohol and/or drug assessment is needed. If a person answers yes to one or more questions, a complete substance use assessment is advised.

Columbia-Suicide Severity Rating Scale (C-SSRS)

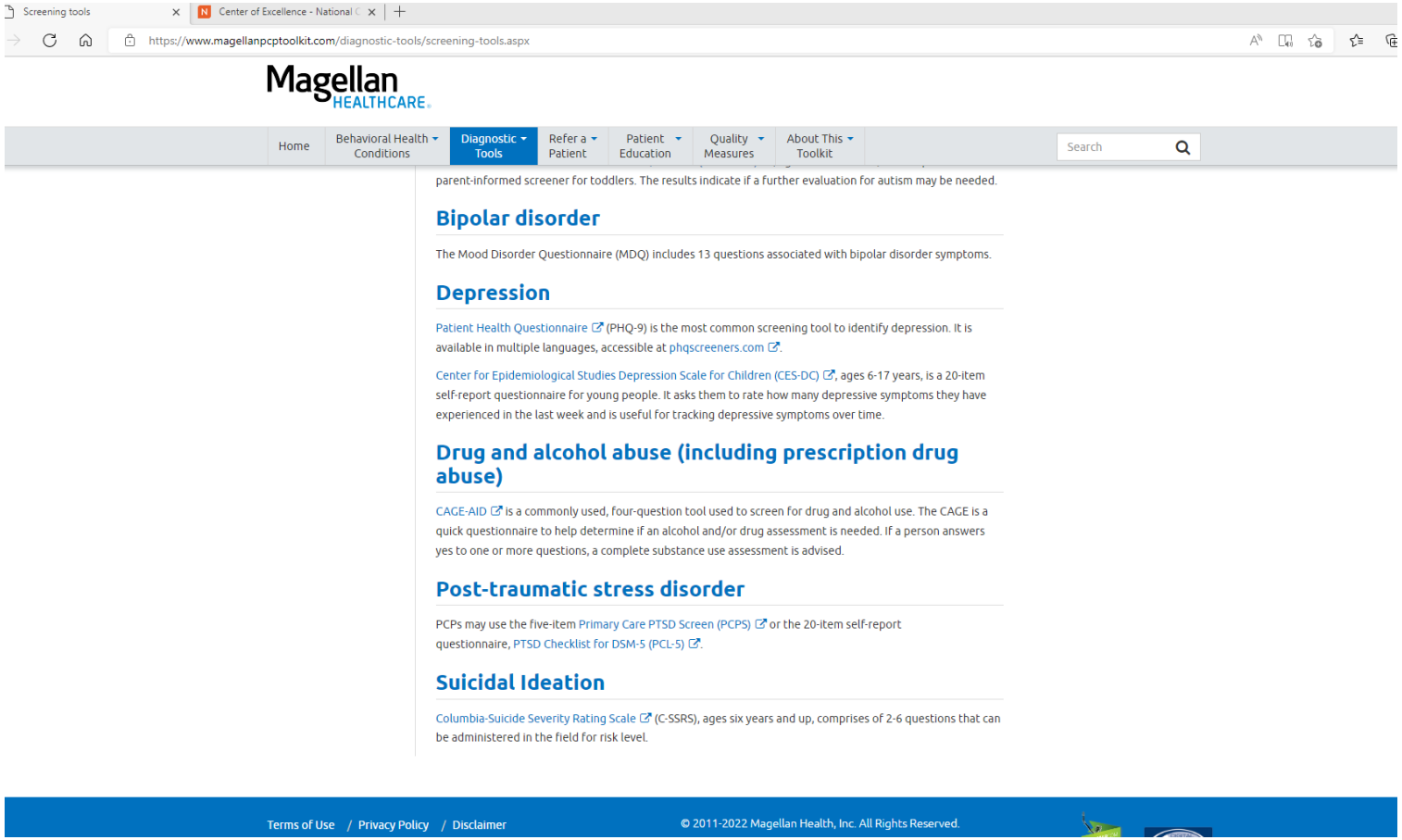
- The Columbia-Suicide Severity Rating Scale (C-SSRS), can be administered to individuals ages six years and up. It comprises of 2-6 questions to assess risk for suicide, determine the severity of risk, and identify appropriate interventions based on the level of severity. The tool was initially developed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

Child and Adolescent Needs and Strengths (CANS)

- The Child and Adolescent Needs and Strengths (CANS) Assessment is a screening tool required for youth recommended for BHRS/ABA/IBHS and IRTF.
- The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.
- The CANS consist of domains that focus on various areas in a child's/youth's life, and each domain is made up of a group of specific items.
- There are domains that address how the child/youth functions in everyday life:
  - Emotional or behavioral concerns
  - Risk behaviors
  - Strengths and on skills needed to grow and develop
  - Family's beliefs and preferences
  - General family concerns/needs

Screening Programs Available Through Magellan

- For organizations not utilizing the full complement of tools in the SmartScreener, Magellan has individual tools available for providers. These include the Patient Health Questionnaire (PHQ-9) and the Columbia-Suicide Severity Rating Scale, among others.



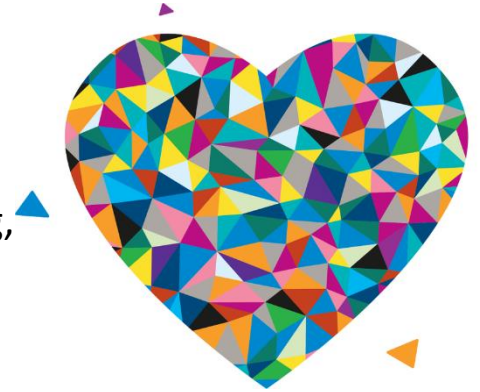
Magellan HEALTHCARE

Access Standards

Member Access to Care

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

Provider responsibility is to:



- 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 from Magellan and/or members 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 referral from Magellan in an emergent situation that is not life-threatening;

Member Access to Care

Provider responsibility (continued):

- Provide services within 24 hours of referral from Magellan in an urgent clinical situation
- Provide services within 7 business days of referral for routine clinical situations;
- Provide follow-up services to routine care (does not include medication management or group therapy):
  - Prescribers within 90 days after an initial behavioral health visit;
  - Non-prescribers within 30 days after an initial behavioral health visit
- Provide services within seven days of a member's discharge after an inpatient stay;
- For continuing care, continually assess the urgency of member situations and provide services within the timeframe that meets the clinical urgency
- Complete Magellan's appointment availability surveys to assist us in evaluating whether our networks meet access expectations and standards for all required levels of care; and
- Notify Magellan if you are not able to meet these standards or are unable to accept new referrals for any extended time period.

Member Access to Care

Magellan's responsibility is to:

- Communicate the clinical urgency of the member's situation when making referrals;
- Assist with follow-up service coordination for members transitioning to another level of care from an inpatient stay; and
- Request your participation in appointment availability surveys

Quality Improvement

Key Quality Improvement Initiatives

Key Quality Improvement Initiatives

- Patient Safety
- Complaints and Grievances Processes
- Assess-Shape-Collaborate Referrals
- Performance Improvement Projects (PIPs)
- Ensuring a robust offering of evidence-based practices across the service delivery system
- Cultural competency throughout the network
- Maintaining accreditation

Key Quality Improvement Initiatives

- Maintaining accreditation
- Cultural competency throughout the network
  - Language assistance services and training resources
- Ensuring a robust offering of evidence-based practices across the service delivery system
- Performance Improvement Projects (PIPs)
  - Encouraged Integrated Health efforts
  - OMHSAS Initiatives
- Assess-Shape-Collaborate Referrals
- Patient Safety
  - Treatment Record Reviews (TRR)
  - Corrective Action Plans (CAPs)
  - Adverse Incident Reporting (AIs)
  - Licensure status updates (Provisional license reviews)
  - Provider Performance Concerns (PPCs)
- Complaints and Grievances Processes
  - Complaint resolution activities
  - Complaint Resolution Plans (CRPs)
  - Adverse determinations
  - Grievance proceedings
  - Retrospective review process

NCQA Accreditations

Full MBHO Status

- Magellan is an accredited Managed Behavioral Healthcare Organization (MBHO) through National Committee for Quality Assurance (NCQA).

Magellan is committed to providing high-quality care and upholding NCQA Standards.

- Approximately 60 Standards for the MBHO Accreditation

NCQA Standards for MBHO

- Utilization Management, Credentialing and Re-Credentialing, Members' Rights and Responsibilities, and Preventive Behavioral Healthcare Services

Distinction for Multicultural Healthcare

- Magellan achieved the MHC Distinction in August of 2021. This award verifies that Magellan provides culturally and linguistically sensitive services and is working to reduce health care disparities.

Thank you!

- Magellan appreciates provider and organizational efforts to partner and support our joint work. It is through support of our network and aligned county contractors that we're able to maintain these accreditations.

Magellan HEALTHCARE

Cultural Competency

Weaves Throughout Our Quality Improvement Efforts:

- Magellan commits to a strong cultural competency program.
- Magellan believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination.

CLAS Standards:

- Magellan recognizes the diversity and specific cultural needs of its members and employees and maintains a comprehensive program that addresses these needs in an effective and respectful manner.
- The Program is rooted in maintaining the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards).
- Magellan encourages all providers to familiarize and incorporate these principles into daily efforts.

Cultural Competency

Resources for Providers:

Cultural Competency and the LGBTQIA+ Tools are available on magellanofpa.com to help with development of provider cultural competency programs

Cultural Competency Resource Kit

Cultural competency trainings for staff available for (direct staff, clinical, and medical) on Magellan website
CME credits available

Additional Resources Available:

Magellanofpa.com>For Providers tab>Quality Improvement>Cultural Competency

Accessing Interpretation Services and Trainings

- How does Magellan make this available to providers when needed?
  - Interpreter services are not billed as a separate behavioral health service in the HealthChoices' Program.
  - While it is the responsibility of network providers to accommodate the specialized needs of HealthChoices' members, including securing interpreter services, Magellan can offer assistance securing these services as needed.
- Network providers may not decline a member's access to treatment based on their need for language assistance.
- Magellan offers language assistance services educational resources for network providers. These are located on Magellan's website at the following location.

Evidence Based and Best Practices

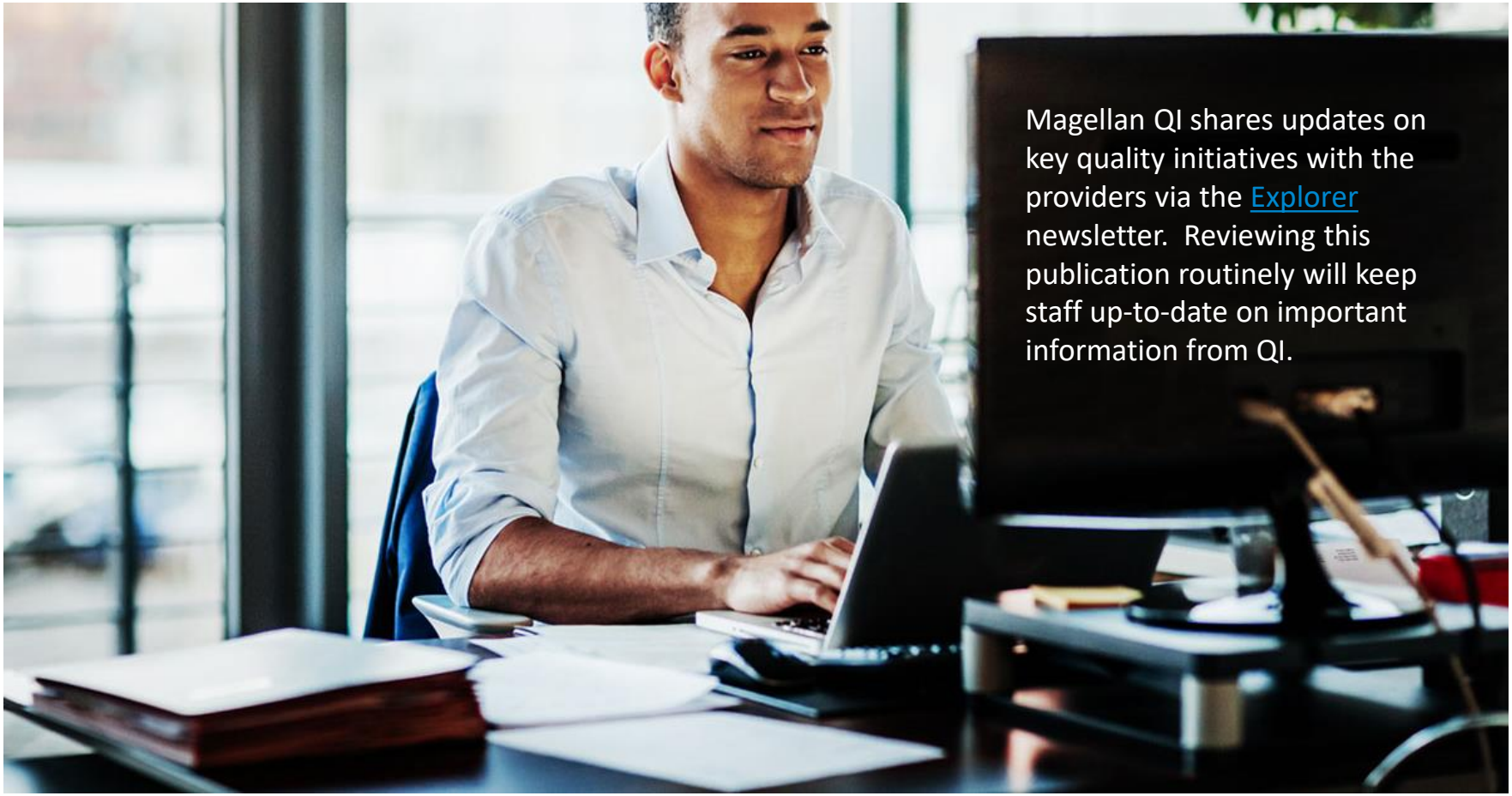
Currently, Magellan supports a wide range of EBPs across Magellan's contracted network. **Magellan requests that contracted providers and practitioners keep inventory and fidelity of** evidence-based or best practices that they offer and incorporate into treatment. Magellan will request that providers give report upon these practices at minimum annually.

This information is vital to Magellan, as it supports our efforts to help members connect to the most clinically appropriate services for their needs. Please note, you will need the applicable MIS number(s) for the programs reported upon to provide response.

If your organization provides multiple levels of care, it will be required that report is provided **for each level of care.** If the practice or organization is using a practice or model of treatment, it is unclear if it qualifies as an EBP, please include it**.**

If you're interested in additional resources pertaining to evidence-based or best practices, please **visit our website.**

Communications



Provider Performance

- **Monitoring Activities**

Assess-Shape-Collaborate (ASC) Referral Process

This is a quality improvement activity structured for identifying, reporting, tracking, and responding to non-emergent, non-safety-related concerns about provider performance.

What to Expect

- The Magellan Staff noting the opportunity in the ASC database will notify the Provider Staff of ASC filing
- ASC Committee routinely reviews concerns filed
- Magellan may connect with the provider organization for action towards the improvement opportunity

Categories of ASCs

- Inadequate discharge/aftercare planning
- Failure to obtain authorization
- Did not check Member eligibility
- Timeliness/Lateness
- Failure to address co-morbid issues
- Access Barriers

Categories of ASCs

- Missing or Conflicting Essential Clinical/Assessment Info
- Member Rights and Respect
- Did not adhere to MBH expectations around CM/UM/QI/Network
- Other concerns about service delivery

Treatment Record Reviews (TRRs)

There is purpose and value to this quality improvement activity. Some of these benefits include:

Ensure a consistent approach to treatment between providers, Magellan, and its contractors

Supports use of Clinical Practice Guidelines (CPG), as applicable

Proactive oversight for patient safety-related activities

To measure adherence to standards set by CMS, Pennsylvania DHS, Magellan's national and local teams

Types of Treatment Record Reviews

Integrated, both Routine and Targeted: Involve multiple teams to include variations of QI, Clinical, Network and/or Compliance

Follow-Up: Re-audits to assess changes or maintenance from initial audit results

Implementation Oversight Analysis of a new program following an approximately 90-day implementation period, or whenever adequate claims activity is measured, to assess the provider's performance towards key operational and clinical functions

Audit Preparation

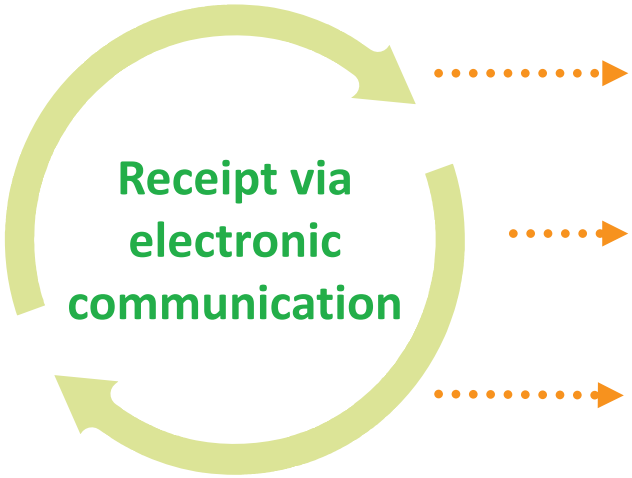
What to expect:

- Magellan may review records at your location; or we may request for records be submitted for remote review.
- Notification will come from Magellan
  - Magellan will contact you to determine a mutually agreeable date
  - Please be aware that certain extenuating circumstances may require Magellan to outreach with urgency and with little notice

Communication Requirements

1. Confirmation letter and tools will be sent electronically.
2. In most cases, member names will be sent one week prior to audit date via secured e-mail.
3. The entire Member record should be available for the TRR.

Audit Preparation and Review



- Clinical Tool
- Network Tool
- Claims Screening Tool
- Compliance Tool
- Electronic Health Record Questionnaire
- Cultural Competency Provider Self-Assessment Tool
- Clinical Practice Guideline (CPG) Tools, as applicable

Audit Expectations

What to expect after the review?

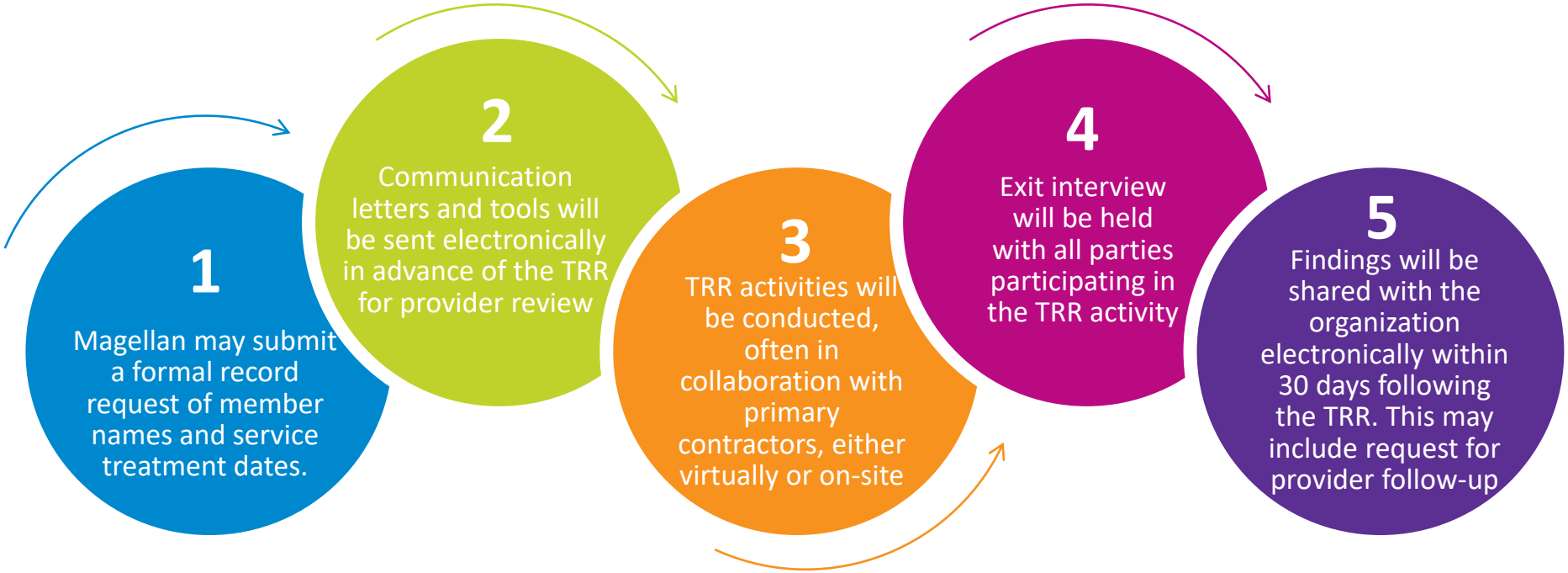
Participants of the TRR will connect for an exit interview, this is a verbal debriefing

Formalized findings will be received by the provider electronically within 30 days following the audit

Feedback will be organized in the following manner:

- Strengths
- Recommendations
- Items that require follow-up, as applicable

Stepping Through the Audit Process



Magellan HEALTHCARE

Ensuring Strong Outcomes for Improved Quality Care

The Corrective Action Process (CAP)

- The provider is asked to develop the CAP utilizing Magellan's root cause-driven CAP template
- The CAP template is an easy-to-use tool for providers to informally assess for the root cause/s of the performance issue and target corrective actions toward those root causes
- QI tracks receipt of the CAP until it is received from the provider
- Upon receipt of the CAP, QI engages the Magellan Subject Matter Expert (SME) in the review process
- QI reviews the SME feedback. QI also coordinates with the provider to obtain any requests for additional information requested by the SME and solicits feedback from the provider

This collaboration on the CAP continues until jointly Magellan and the provider are satisfied that the CAP will effectively address the performance issue

Root Cause-Driven CAP Template

Issue#:	1	Description:		Provider's Supporting Documents
Underlying / Root Cause:				
Action:				
Responsible Party:		Target Date:		Date Comp:
CQI Monitor to ensure plan is effective:				

SME Review				Provider Response	
AP Accepted? (Yes/No)		(If No, explain why below)	If Yes, Date AP Accepted		
Magellan Feedback					
Date	SME Init	AP Field	SME Comments	Date	Description
		Action			

Immediate Patient Safety Concerns

- Immediate, patient safety related concerns are directed to the QI Team for review by a Quality Improvement Reviewer
- These may come to Magellan from several venues:
  - Review of Incidents Reports (IRs) received
  - Through the utilization management process
  - Whistleblower notifications
  - Complaint investigations
  - Other sources, such as notification from key stakeholders

- All contracted providers are required to submit Incident Reports within 24 hours of occurrence for any reportable incident
- The investigating Quality Improvement Reviewer will conduct follow-up activities with the provider as appropriate
- The circumstances noted above are referred to as Sentinel Events or Provider Performance Inquiry Record concerns until any provider performance opportunities are formalized. Thereafter, these events are referred to as PPCs, validated Provider Performance Concerns.

Incidents Reported to Magellan

- Magellan anticipates that all providers, but especially larger programs, would have some volume of reportable incidents each year, regardless of quality performance of the provider.

- The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other
  - ➢ Link to Printable Form and Instructions
- Magellan encourages every network provider and practitioner to review the adverse incident definitions to ensure that your practices are congruent with expectations for reporting.
- Reporting requirements for Magellan have not changed. These remain consistent and in line with the **PA DHS Bulletin, OMHSAS-15-01.**
- Magellan provides an electronic format for incident reporting to ease provider burden.

Revised Process for Incident Report Submission

1

2

3

Open the Magellan of PA website

It may be advisable to create a bookmark for staff to the following location:

- For Providers tab>>
- Provider Resources>>
- Forms>>
- Adverse Incident Reports

Complete prompted data entry requests

Important considerations for items staff will need to complete the report:

- Provider MIS
- Provider Address
- Member Medicaid ID (county of eligibility and 10 digits)

Confirmation Process

Providers can expect to receive a thank you confirmation on the screen immediately upon submitting a report on the website.

- Magellan will review the report.
- Magellan's Quality Specialists may outreach with questions about reports, consistent with the current process.

Purpose of Incident Reporting

Where is Adverse Incident Reporting shared or reviewed?

- Formal reports such as within the Provider Profiles
- In the Magellan Behavioral Health of Pennsylvania, Inc. Clinical-Quality Annual Program Evaluation
- Routine sharing with primary contractors, no less frequent than monthly
- As needed for credentialing activities or other quality improvement oversight monitoring

Magellan and primary contractors do anticipate that every contracted provider will have some volume of Adverse Incident reporting

What does Magellan do with incidents reported?

- Every report is individually reviewed to ensure proper protocol was followed to manage the incident
- Track and trend to monitor for best practices or outlier scenarios throughout the Network.
- Inform needs of region-specific concerns or trends, including identification of needs for and informing the development of county-specific initiatives (e.g., development of Suicide Prevention Task Force)

If a provider is found to not be submitting Adverse Incident reports, a member of the Quality Improvement Team will contact leadership of that organization to discuss remediation and/or corrective actions

Reporting Requirements and Resources

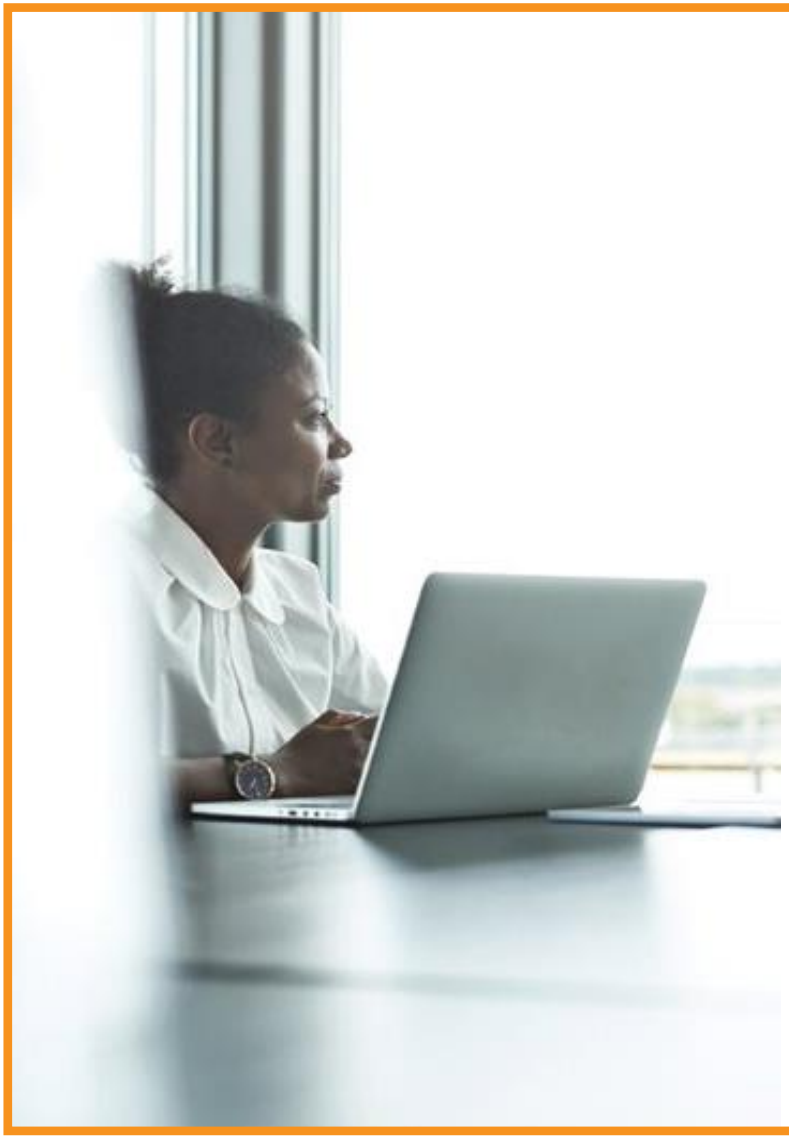
If the Incident being reported is a Sentinel Event, please also contact Magellan's QI Department.

A sentinel event includes any of the following:

- Death
- Permanent Harm
- Severe Temporary Harm
- Suicide (while in care)
- Suicide (within 72 hours of discharge)
- Abduction
- Elopement from Treatment Setting
- Rape of Member or Staff at Provider Facility
- Assault of Member or Staff at Provider Facility
- Homicide of Member or Staff at Provider Facility
- Flames or Smoke Exposure during Treatment
- Any Incident that involves contact with the Media

- ☑ Click here for Incident Types Definitions
- ☑ For the complete Magellan training for Adverse Incident Reporting, click here
- ☑ If your organization has questions about the Adverse Incident Reporting process after completion of this training, Magellan's Quality Improvement Team will be glad to offer additional technical assistance
- ☑ Please contact Dawn Haurin, Magellan Quality Specialist at 215-917-9818 to make this request

Reportable Adverse Incidents



- Report of any death for a member in treatment, natural cause or otherwise
- Significant suicide attempt
- Abuse/Neglect, including episodes of PA Childline reporting
- Restraint/seclusion
- Injury/illness requiring treatment beyond first aid
- Need for emergency services occurring while in care
- Missing person

Includes elopement from 24-hour treatment setting where member leaves grounds and staff lose eyesight for children and adults

- Significant medication error
- Provider Preventable Conditions

Magellan Response to Emergent Reportable Adverse Incidents

When safety-related matters are identified

QI takes lead for Magellan response within one business day:

- May outreach to provider that submitted the report for additional information
- Provide notification to Magellan leadership of the concerns
- Provide notification to other key stakeholders, e.g,. county contractors

QI will coordinate with the larger team:

- Develop a plan
- Evaluate next steps based on the feedback from Magellan leadership and County partners

QI coordinates next steps with the provider:

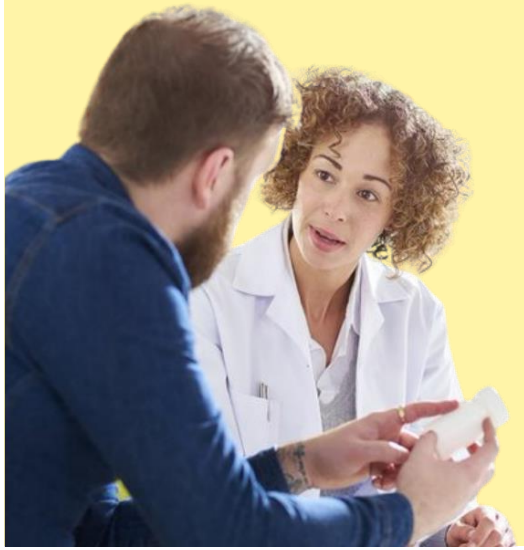
- May include an onsite review
- Potentially a CAP request
- Potentially chart review or other activities as deemed appropriate

Complaint & Grievance Process

Member Complaints

Member Complaint Definition:

A dispute or objection filed with Magellan by a Member, the Member's representative, or health care provider regarding a participating health care provider, or the coverage, operations, or management policies of Magellan, including, but not limited to:

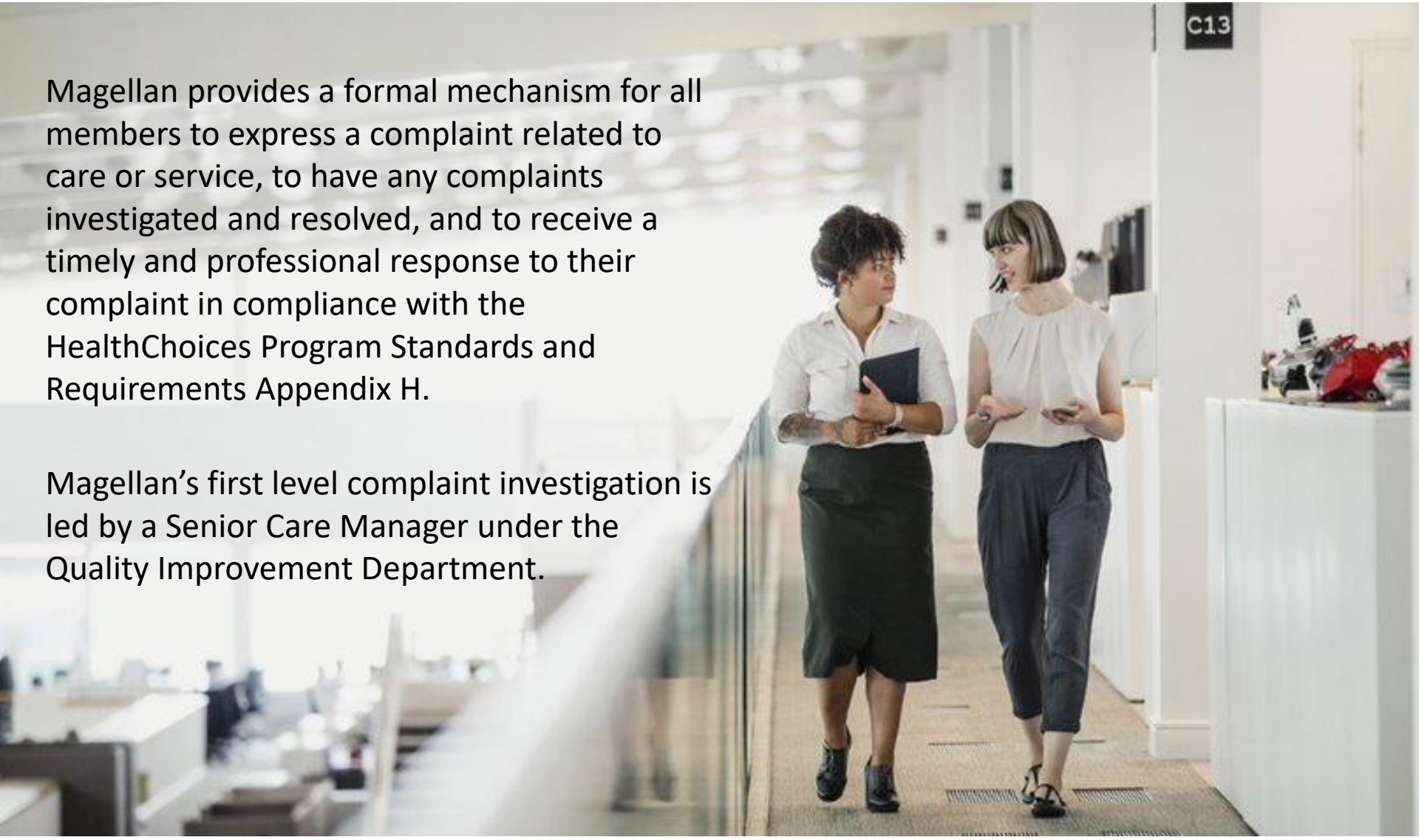


- A denial of authorization because the requested service is not a covered service
- The failure of a provider or Magellan to meet the required time frames for providing a service
- The failure of Magellan to decide a complaint or grievance within the specified time frames
- A denial of payment by Magellan after a service(s) has been delivered, because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- A denial of payment by Magellan after a service(s) has been delivered, because the service(s) is not a covered service(s) for the Member
- A denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities
- A Member's dissatisfaction with Magellan or a provider

Examples of Complaints

- A Member is unhappy with the care they are getting from a provider (i.e., rude treatment, no return calls, disagreement with treatment recommendations or medications prescribed, poor facility conditions, lack of appointment availability)
- A Member is unhappy that they have not received authorized services (service delays)
- A Member is unhappy that they cannot get a service from Magellan, because it is not a covered service through Medical Assistance
- A Member is unhappy that their provider or Magellan shared their private health information without the Member's consent

The Complaint Process



Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H.

Magellan's first level complaint investigation is led by a Senior Care Manager under the Quality Improvement Department.

The Complaint Process

When Magellan is notified of a new complaint:

- Magellan is required to send an acknowledgment letter to the member within five business days to confirm receipt of the Complaint. This letter summarizes the concerns reported and informs the member of their rights and the process.
- The committee considers the information available and determines if the complaint is supported or unable to be supported:
  - Supported – the complaint is determined to be founded **and requires follow up on the part of Magellan or the involved provider**.
  - Not Supported – the complaint is not founded or able to be corroborated based on the information available.
- Magellan is required to make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.
- If a member is not satisfied with the first level response, they can request a second level Complaint within 45 days of receiving the decision notice
- Complaints regarding the following issues are not subject to second level Complaint review, but members may request an External Review and/or Fair Hearing:

The Complaint Process (Continued)

- A denial of authorization because the requested service is not a covered service
- The failure of Magellan to meet the required time frames for providing a service
- A denial of payment by Magellan after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- A denial of payment by Magellan after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member
- A denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities
- The failure of Magellan to decide a complaint or grievance within the specified time frames

The Complaint Process (Continued)

If a member is not satisfied with the first level response, they can request a second level Complaint within 45 days of receiving the decision notice

Complaints regarding the following issues are not subject to second level Complaint review, but members may request an External Review and/or Fair Hearing:

- A denial of authorization because the requested service is not a covered service
- The failure of Magellan to meet the required time frames for providing a service
- A denial of payment by Magellan after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program
- A denial of payment by Magellan after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member
- A denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities
- The failure of Magellan to decide a complaint or grievance within the specified time frames

The Complaint Process: External Complaint

If a member is not satisfied with the second level Complaint response, they can request that the Pennsylvania Insurance Department conduct an "External Review" of the Complaint.

The member may request External Review from the Insurance Department within 15 days of receiving the second level Complaint decision notice.

Magellan submits the entire Complaint record to the Insurance Department for the review.

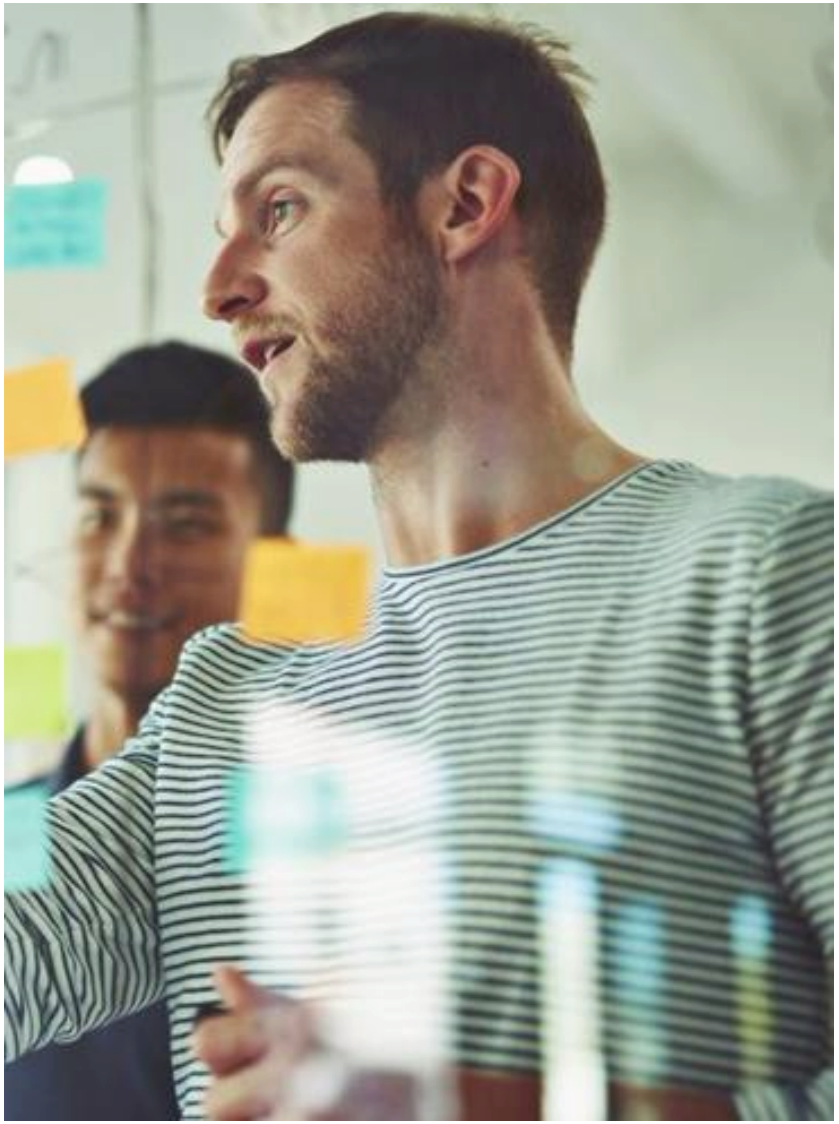
The Insurance Department completes the review. Their decision is binding on Magellan.

Provider Support for Member Complaints

- Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures (Section 2.2.1).
- A member's decision to file a complaint with Magellan should not compromise their services.
- Magellan sends written notice to the provider upon receipt of a complaint. The letter summarizes the concerns reported by the member and requests information and documentation that should be submitted for the review.
- The response and documentation should be faxed to 888-656-2380.
- The information collected through the investigation is presented to a first level complaint review committee, which makes the first level complaint decision.
- In making the decision Magellan considers the information collected, HealthChoices standards and regulations, contractual standards, and generally accepted standards of care and applies those standards to the issue at hand.
- Magellan partners with providers to address Member complaints. Please contact Magellan with any questions or any concerns regarding the complaint.
- Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints.

Complaint Resolution Plan (CRP)

- Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist.
- Magellan reviews data for trends involving individual providers or agencies, as well as trends regarding issues reported in complaints.
- If Magellan identifies a supported (substantiated) complaint involving your agency, Magellan staff will collaborate with you to develop a Complaint Resolution Plan to address the concern.
- The goal is to improve the care and the quality of services for HealthChoices members.
- Please review the Provider Communication shared with network providers here about this important and collaborative process.



Complaint Resolution Plan (CRP) Template

Issue#:	1	Description:		Provider's Supporting Documents
Underlying / Root Cause:				
Resolution:				
Responsible Party:		Target Date:		Date Comp:
CQI Monitor to ensure resolution				

SME Review:				Provider Response	
CRP Accepted?		(If No, explain why	If Yes, Date CRP Accepted		
Magellan Feedback					
Date	SME	CRP Field	SME Comments	Date	Description

Grievances

Magellan and the Pennsylvania Health Choices Program Standards and Requirements defines a grievance as:
A request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

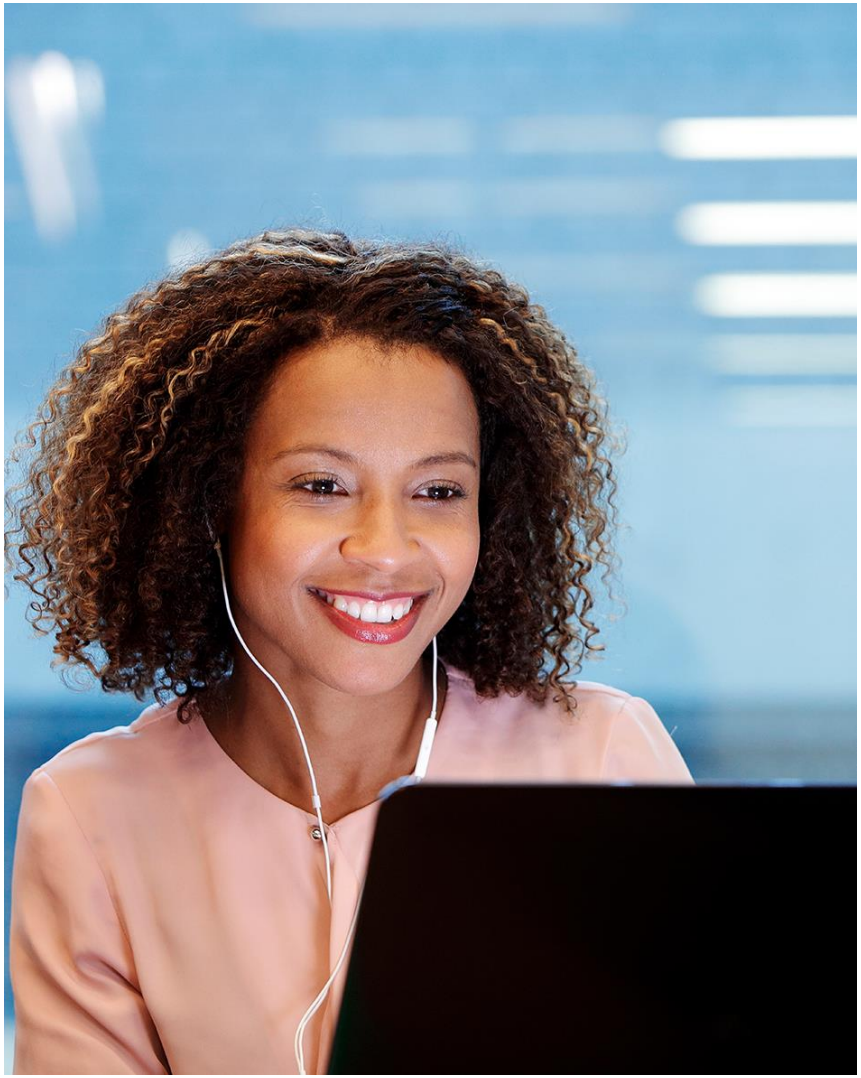
A Grievance may be filed regarding a Magellan medical necessity decision to:

- Deny, in whole or in part, payment for a service
- Deny, or issue a limited authorization of a requested service, including a determination based on the type or level of a service
- Reduce, suspend, or terminate a previously authorized service
- Deny the requested service but approve an alternative service

Provider Support for Grievances

- Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.
- If a level-of-care request is not authorized at the level, frequency or duration as requested, Magellan members are entitled to grieve a medical necessity denial.
- At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

Provider Support for Grievances (Continued)



- If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options.

- This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Consumer Complaint/Grievance Participation

- At certain levels of Magellan's Complaint and Grievance procedures, the review committee making the decision includes a Member (or for reviews involving children, a guardian of a Member).
- This perspective is extremely valuable in understanding each Member's concerns and helps shape positive outcomes.
- If you or someone you know is interested in learning more about this opportunity to serve on this committee, please click here for more information.

Questions may be directed to:

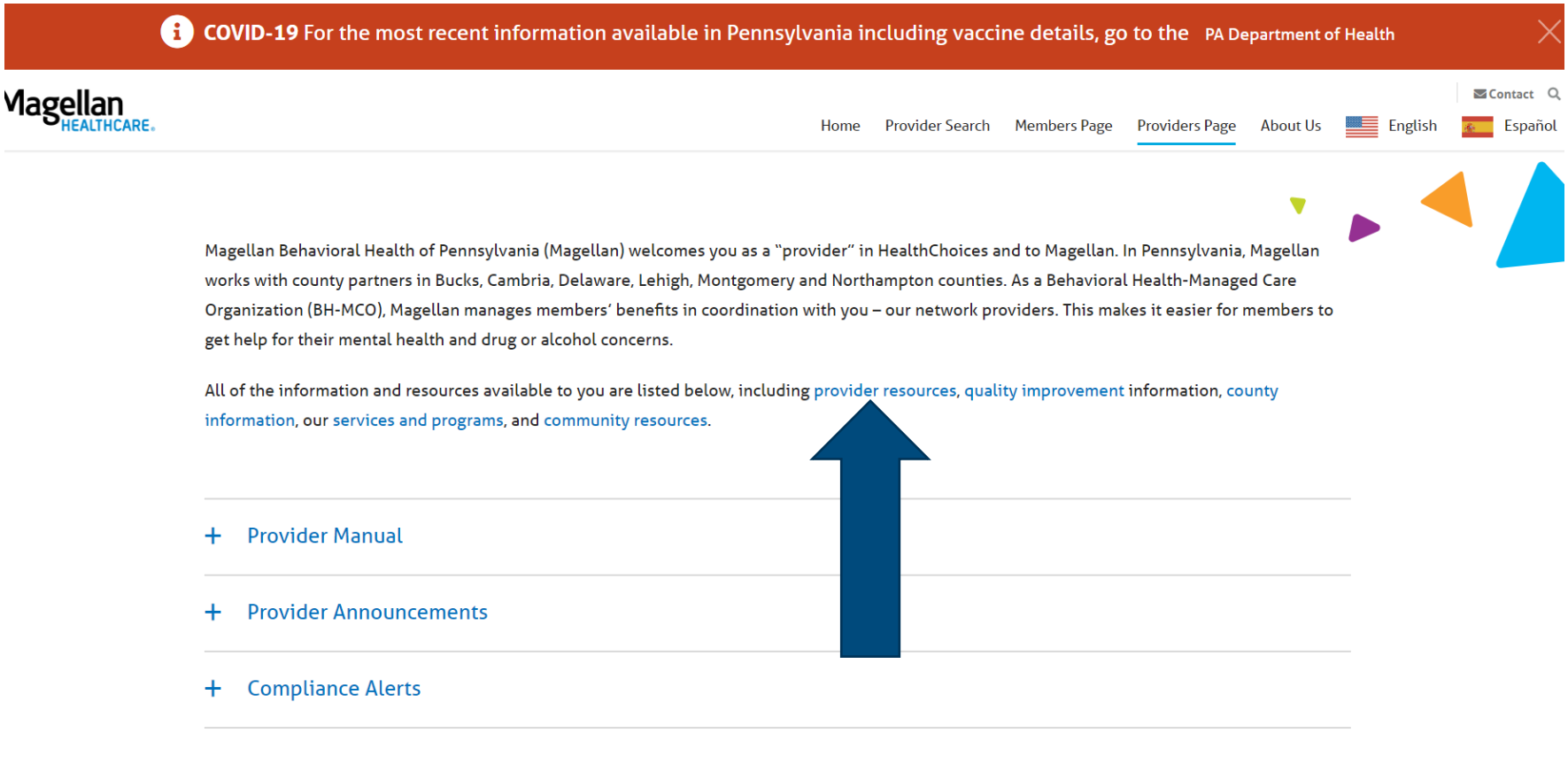
- John Bottger, Appeals and Comments Manager, at 215-504-3982

Retrospective Reviews

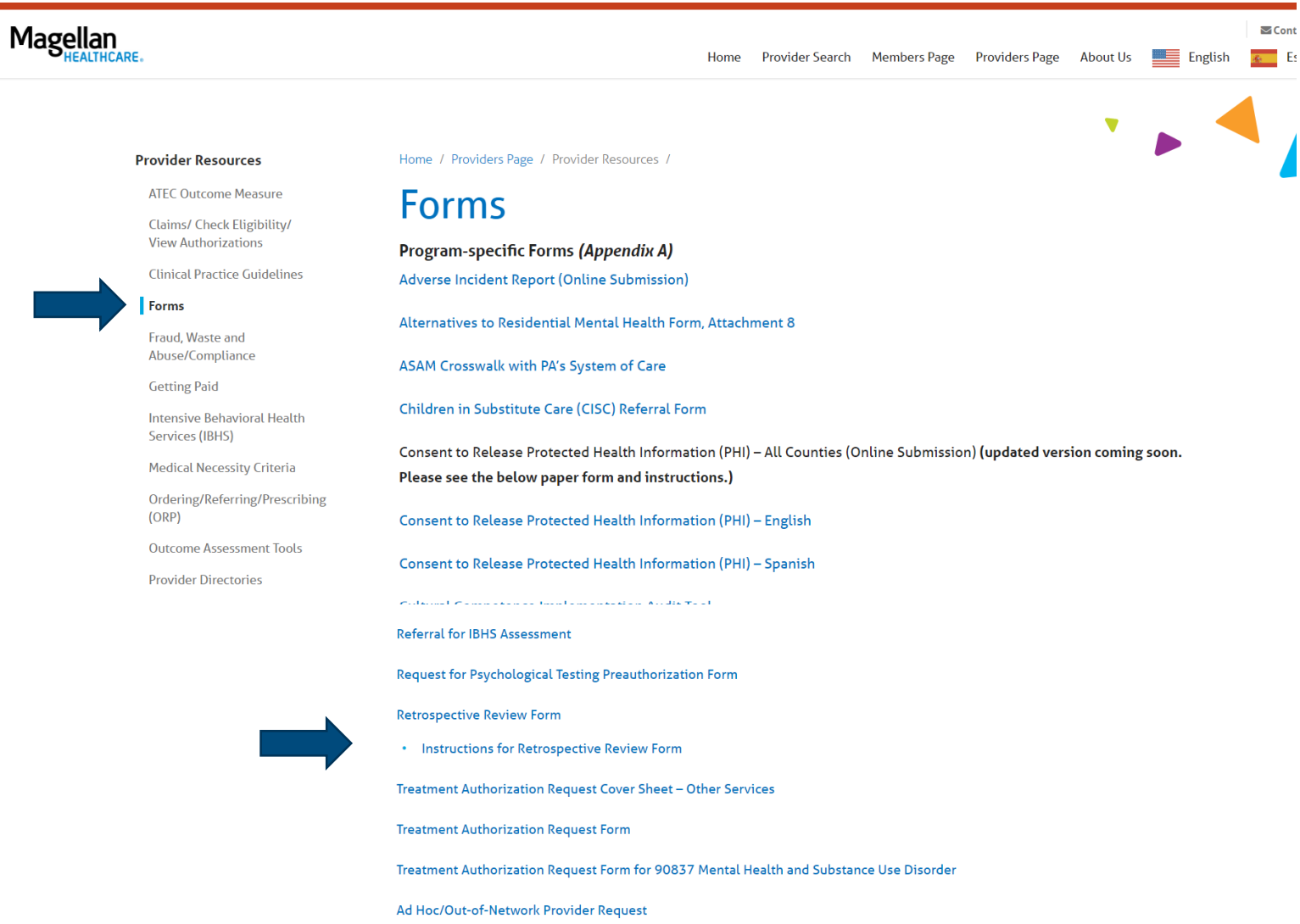
Retrospective Review Procedures

- As always, Magellan will consider Retrospective Review authorization requests from Providers who were unable to seek prior authorization for services provided to members due to a medical emergency, retroactive HealthChoices enrollment, or when a member's primary insurer has declined coverage.
- To support Providers in pursuing Retrospective Review requests efficiently, Magellan has a form for providers to use.
- The form contains detailed information regarding situations that qualify for review and instructions on what information must accompany the request.
- The form also has drop-down fields to identify the services for which authorization is being requested.
- The form may be found on www.magellanofpa.com, under the "For Providers" tab.

Locating the Retro Review Form



Locating the Retro Review Form



Magellan HEALTHCARE

Retro Review Form Fields

Magellan HEALTHCARE

Magellan Behavioral Health of Pennsylvania, Inc.
Retrospective Review Form

A retrospective review is an evaluation of the medical necessity of treatment services after the treatment has been rendered without preauthorization. **Payment cannot be made for an out-of-network provider who is not enrolled in the Pennsylvania HealthChoices Medicaid Assistance Program. Payment will only be considered for the ASAM 4.0 level of care for out-of-state providers.**

Fax the completed form, and additional documentation noted at the bottom of this form, to the attention of *Retrospective Review* at 888-656-2380. **The entire form must be completed in full to be considered. Incomplete forms will not be processed.**

Member's Name: _____

Medical Assistance ID # (3 digit county suffix followed by 10 numeric digits): _____

County of Eligibility: Select One

Date of Submission: _____

Provider Name: _____

Provider MIS #: _____

If Out-of-Network: MPI #: _____

Tax ID #: _____

Address for Service Provision: _____

Contact Person: _____

Contact Person's Phone #: _____

Contact Person's Email Address: _____

Contact Person's Mailing Address: _____

Retro Review Request Submission Process

Electronically completed forms and required supportive documentation may then be sent to Magellan by facsimile to 888-656-2380.

If unable to send via facsimile, requests may be sent to Magellan at:

Attention: Retrospective Review,
Magellan Behavioral Health of Pennsylvania, Inc.,
105 Terry Drive, Suite 103,
Newtown, PA 18940

Requests that do not include the Retrospective Review Form or required documentation will not be able to be considered.

Questions regarding the new form may be directed to: John Bottger, Appeals and Comments Manager at 215-504-3982.

PA HealthChoices Quality Improvement Contact List

For questions specifically about complaints or grievances, please contact:

John Bottger,
Appeals and Comments Manager
215-504-3982
JWBottger@magellanhealth.com

For questions about Incident Reporting, please contact:

Dawn Haurin,
Quality Data Specialist
215-504-3900 X63800
DMPrenoHaurin@magellanhealth.com

For other questions pertaining to the Quality Improvement Department, please contact:

Tracy Samuelson,
Quality Manager
215-504-3926
SamuelsonT@magellanhealth.com

Maria Brachelli-Pigeon, Director,
Quality Improvement
215-504-3935
MBrachelliPigeon@magellanhealth.com

Compliance Overview

Compliance Department Scope

What do we do?

- Conduct comprehensive provider education and training opportunities specific to fraud, waste, & abuse (FWA), and other compliance-related topics.
  - Dedicated provider trainings on compliance annually
  - Monthly E-mail Blasts
  - Maintain dedicated compliance resources on our website
- Collaborate and partner with the Special Investigations Unit, Magellan's dedicated subject-matter experts on mitigating and investigating FWA.
  - Routine Auditing and Monitoring including Data Mining Activities
  - Targeted Audits and Investigations based on issues or complaints
  - Monitor/Process Provider Self-Reports of Potential FWA
  - Respond to Member Service Verification Surveys
- Oversee Magellan's compliance with all federal and state confidentiality laws
- Manage and facilitate record requests
- Maintain inventory of state regulations
- Develop and ensure compliance with all Magellan Policies and Procedures

Fraud, Waste & Abuse

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Examples include:

- Intentionally billing for services that were not provided
- Falsifying signatures
- Rounding up time spent with a member
- Misrepresenting a diagnosis to justify payment
- Altering claim forms
- Using another person's Medicaid card/ information to obtain care
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for referrals of patients)

Fraud, Waste & Abuse

Waste refers to acting with gross negligence or reckless disregard for the truth in a manner that results in any unnecessary cost or any unnecessary consumption of a healthcare resource.

Examples include:

- Using excessive services or spending more time than is needed
- Providing services that aren't medically necessary
- Provider ordering excessive testing
- Conducting excessive non face-to-face services
- Multiple clinicians or provider staff billing for attending the same meeting or service
- Over-ordering of Assessments/ Evaluations

Fraud, Waste & Abuse

Abuse refers to provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples include:

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

❖ ***The state of mind is what separates Fraud from Abuse.***

PA HealthChoices – SIU

SIU Resources	• Local Investigator: Diane Devine, CFE • Local Auditors: Tina Davis CFE, Patty Marth CFE, Caitlin Vossberg, LSW • Corporate Support: Data Analysts, Investigators, Specialists
Coordination with Magellan Departments	• Compliance • Network • Clinical and Medical • Legal • Quality Improvement
Coordination with External Agencies	• Bureau of Program Integrity (BPI) • Medicaid Fraud Control Section (MFCS) • Licensing Boards • Customers and other external stakeholders

PA Medicaid Regulations

- Pennsylvania Code
  - Official publication of the Commonwealth of Pennsylvania. It contains regulations and other documents filed with the Legislative Reference Bureau.
    - Title 55 is reserved for Human Services
    - Title 49 is reserved for all the Professional and Vocational Standards.
- Pennsylvania Bulletin
  - Commonwealth's weekly gazette for information and rulemaking. The Pennsylvania Bulletin Online includes the following: Statewide and local court rules; the Governor's Proclamations and Executive Orders; Actions by the General Assembly; Rulemakings by State agencies; Proposed Rulemakings by State agencies; and State agency notices.
- The *Pennsylvania Code* and the *Pennsylvania Bulletin* make the existing body of official documents having force of law: http://www.pabulletin.com/secure/search.html
- DHS Bulletin Search: https://www.dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx
  - Pertinent bulletins specific to the PA Department of Human Services (DHS) and OMHSAS

Telehealth

- In 2011, OMHSAS first issued guidance on the use of telehealth through OMHSAS-11-09 Guidelines for the Approval of Telepsychiatry which limited the availability of telehealth to MA enrolled psychiatrists and licensed psychologists. In February 2020, right before COVID-19, OMHSAS issued OMHSAS-20-02 which expanded the use of telehealth to include CRNPs, PAs, LCSWs, LPCs and LMFTs.
- OMHSAS incorporated most of the flexibilities introduced during the COVID-19 pandemic into non-COVID-19 related policy with the issuance of OMHSAS-21-09, Guidelines for the Delivery of Behavioral Health Services Through Telehealth, issued August 26, 2021, and re-issued on September 30, 2021.
- On 7/1/22, OMHSAS issued updated Telehealth Bulletin OMHSAS-22-02 which replaced OMHSAS-21-09.
- OMHSAS-22-02 permits the use of Telehealth for all service types and practitioners as long as the individuals are otherwise qualified to render the services.

Telehealth

- On 8/16/22, OMHSAS issued an updated Telehealth FAQ based on 7/1/22 updated Telehealth Bulletin.
- On 8/25/22, Magellan issued a communication titled Telehealth Updates. This included links to OMHSAS-22-02, the OMHSAS Telehealth FAQ as well as important billing Magellan billing guidelines:
  - POS Coding: 02 vs. 10
  - Audio-only modifier FQ
- Magellan has Telehealth Provider Performance Standards posted on our website.
- Magellan has also issued Telehealth FAQs.

Telehealth Platforms

- Telehealth equipment must meet all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA). Effective August 10, 2023, all providers will be required to utilize HIPAA-compliant Telehealth platforms.
- U.S. DHHS includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA Business Associate Agreement.
    - Microsoft Teams (Skype for Business)
    - Updox
    - VSee
    - Zoom for Healthcare
    - Doxy.me
    - Google G Suite Hangouts Meet
    - Cisco Webex Meetings / Webex Teams
    - Amazon Chime
    - GoToMeeting
    - Spruce Health Care Messenger

Telehealth Policies & Procedures

- Providers are required to employ Telehealth Policies including not limited to:

Provider Required Telehealth Policies and Procedures
1. Policy on the operation and use of telehealth equipment
2. Policy around staff training to ensure telehealth is provided in accordance with the guidance in any applicable MA Bulletin, any MCO specific requirements as well as the provider's established patient care standards.
3. Policy around contingency plans for transmission failure or other technical difficulties that render the behavioral health service undeliverable, delayed or interrupted. Contingency plans should describe how the plan will be communicated to individuals receiving services.
4. Policy that addresses how to handle emergency situations, such as a risk of harm to self or others when services are being provided via telehealth.
5. Policy for how appropriateness for telehealth will be determined.
6. Policy that describes how interpretation services, including sign language interpretation, will be delivered for individuals being served through telehealth.

Documentation

Why do we document?

1. Serves as a legal record of services rendered.
2. Allows healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.
3. Facilitates communication and continuity of care among the physicians and other healthcare professionals involved in the patient's care.
4. Ensures accurate and timely claims review and payment.
5. Promotes appropriate utilization review and quality of care evaluations.
6. Research and education.
7. Serves as evidence that the services were provided as billed to a payer.

Documentation

Magellan has established minimum record-keeping requirements, which align with Pennsylvania HealthChoices Medical Assistance regulations. Specifically:

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

Documentation (cont.)

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

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

Telehealth Documentation

- Adherence to all other regulations and requirements still apply to the service being delivered as they would when delivered face-to-face. That includes but is not limited to following all of Magellan's Minimum Documentation Guidelines found in our Pennsylvania HealthChoices (PAHC) Provider Handbook Supplement.
- Providers must continue to adhere to the Unit Definition/ Description on their Magellan Reimbursement Schedule in order to bill a unit of service (e.g., 15 minutes, 30 minutes).
- Services must be provided in accordance with the member's Treatment/ Service/ Recovery Plan.
- In accordance with Magellan's Telehealth Guidelines that were issued during the COVID-19 disaster declaration, providers must clearly document a telehealth session. In addition to following the minimum documentation requirements in our PAHC Provider Handbook Supplement, the following information must be included in the record for each rendered telehealth service:
    - **At intake**, the documentation must include the member's consent to receive services in this manner.
    - The documentation must indicate the mechanism for how services were delivered (e.g., telehealth, phone).
    - The documentation must include the telehealth platform that was utilized, if applicable (e.g., zoom)
    - The documentation must include the member's phone number that was utilized, if applicable.

Encounter Forms

What is the purpose of an Encounter Form?

- *Offers an extra check and balance for an agency to ensure that services delivered to Medicaid Recipients are done so as billed. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.*

FACT!

- *Medicaid providers across the country surrender millions of dollars annually due to staff persons falsifying claims and/or billing for services not rendered. Thus, securing and monitoring encounter forms should be viewed as a mutual aid for our battle against Fraud, Waste & Abuse.*

In accordance with Medical Assistance (MA) Bulletin 99-89-05, a recipient signature is required for MA services unless the service is signature exempt (please reference details in the bulletin).

Encounter Forms (cont.)

- Per MA Bulletin 99-89-05, the following information must be recorded on the encounter form:
  - Certification Statement: "I certify that the information shown is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts may be prosecuted under applicable federal and state laws."
  - Provider Name and MA ID
  - Recipient Name and MA ID
  - Date of service
  - Member/ guardian signature
- Level-of-care specific state regulations and bulletins that indicate a requirement for encounter forms are limited and non-descript. In 2014, Magellan identified the need for consistent and comprehensive requirements in the attainment of signature verification for service encounters (i.e., encounter forms).
- As a result, Magellan requires providers of community-based services to obtain a signed encounter verification form for each face-to-face contact that results in a claim being submitted to Magellan.
- Additionally, signed encounter verification forms must also be present for Telehealth sessions (full compliance will be required after 1/1/24 per OMHSAS flexibilities).
- It is considered best and preferred practice to also include the session start and end times on all encounter forms. As a result, the member should not sign the encounter form until after the session is complete.
- Signed encounter forms should be available at the time of a Magellan audit or review. We will need to ensure that the signed encounter matches all other documentation (i.e., progress note) for the session.
- If a provider is unable to obtain a signature on the encounter form (including refusal), it must be documented why, and attempts should be made to obtain a signature the following session.

Auditors vs. Investigators

- **Audit**= objective and systematic assessment of how well a provider/ program is performing; as well as meeting expectations and applicable regulations. This is a routine process and can happen at any time. It's typically proactive and intended to provide technical assistance and education.
- **Investigation**= usually undertaken in response to reports of misconduct. It is a process of detailed examination to achieve certain objectives.

Data Mining Audits

- On a quarterly basis, a select number of providers in the top tier based on either utilization or payment will be selected for audit of the identified level of care.

- Process:
  - Selected providers will receive an email requesting medical records
  - Medical records or access to the records (if EHR) is provided to the auditor(s)
  - Audits are conducted
  - Initial claims letters are emailed to the providers detailing the results of the audit
  - Providers have 10 business days to review and provide supporting documentation, if warranted
  - Final claims letters are sent to the provider and the county (if there are no discrepancies/overpayments, this will be the only letter that is received)
  - If discrepancies are identified, the auditor submits information to our Cost Containment Department (CCD) and future claims retractions are initiated
  - An Action Plan may also be issued to the provider, if applicable

Member Service Verification

- HealthChoices contractual requirement
- Quarterly surveys are sent to Members
- 1,500 members surveyed across five Magellan counties
- Members are asked to attest to receiving up to five paid services
- Magellan will follow-up on all “No” Responses
  - Member outreach if needed
  - Provider outreach for supporting documentation

- ✓ All Providers should have their own service verification process in place
- ✓ Implement both random and routine checks via phone, mail or electronically
- ✓ Quality indicators can also be included

Compliance Program Expectations

- PA MA Regulations and Magellan contractual requirements include the expectation that **all** providers develop and implement a Compliance Program/ Plan.
- An agency's Compliance Plan will vary depending on a variety of factors including, but not limited to, the size of the agency, the number of staff, amount of programs, etc. However, all providers must have policies and procedures in place which outline how they will maintain compliance with various federal, state and contractual requirements.
- An effective compliance program must be an ongoing process that includes prevention, detection, collaboration and enforcement.

8 Components of Effective Compliance Programs

1. Written policies and procedures
2. Designate a compliance officer and committee
3. Develop an effective compliance training, education and awareness program
4. Establish open lines of communication
5. Establish and maintain disciplinary policies
6. Establish and maintain a process for routinely evaluating and identifying potential and actual non-compliance (internal auditing and monitoring)
7. Establish and maintain a system for responding to compliance issues
8. Assessing effectiveness and developing a timeline for compliance program activities

Prevention **Detection** **Corrective Action**

Compliance Training

- ✓ Compliance training: at a minimum, training for staff should take place:
  - At hire
  - Annually thereafter
- ✓ Best practices would include ongoing training: team meetings; “e-mail blasts”; supervision
- ✓ **ALL** staff should receive some level of compliance training:
  - Board of directors- compliance starts at the top. This helps create a “culture of compliance”
  - Contractors
  - Billing and medical records personnel
- ✓ Always tailor the training to the audience
- ✓ Use humor
- ✓ Training should be educational-based. Use facts.
- ✓ Incorporating a real-life story that happened can be effective but don’t use scare tactics
- ✓ Incorporate a quiz or attestation with the trainings

Communication/ Reporting Mechanisms

- ***Anyone can report suspected fraud, waste, or abuse***
- Use the chain of command- staff should be encouraged to go to their Supervisors first
- A separate hotline should be made available for families and members to report potential non-compliance
- Families should be trained during intake regarding the hotline
- If you've never received an inquiry or call on your hotline, that's a problem
- Magellan Mechanisms for reporting:
  - SIU Hotline: 1-800-755-0850
  - SIU Mailbox: SIU@MagellanHealth.com
  - Compliance Hotline: 1-800-915-2108
  - Compliance Mailbox: Compliance@MagellanHealth.com

Self-Auditing

- Self-auditing is a good tool to measure internal compliance and ensures compliance with MA regulations.
- Self-auditing is an integral part of a strong Compliance Plan.
- The CMS Comprehensive Program Integrity Review of Pennsylvania identified "Expanded Use of Provider Self-Audits" as one of four *Effective Practices*. There are two types of self-audits:
  - Provider-initiated self-audits
  - Targeted provider self-audits
- Due to lack of uniformity of provider audits submitted for purposes of self-disclosure, DHS established a protocol for self-audits in 2001.
- The DHS "Pennsylvania Medical Assistance Provider Self-Audit Protocol" is posted on their website: http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/

Self-auditing requirement

The three types of provider self-audits include:

- *Option 1 - 100 Percent Claim Review*
- *Option 2 - Provider-Developed Audit Work Plan*
- *Option 3- Statistically Valid Random Sample (SVRS)*

** For options #2 and 3, the audit work plan must be submitted to Magellan for pre-approval prior to conducting the audit*

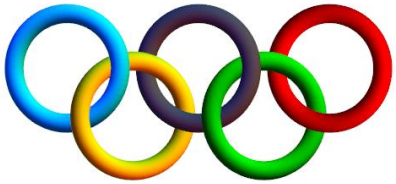
- **If you're not finding errors during your internal audits, you are doing something wrong.**

Self-Audits → Self-Reports

- Submit materials to: PAHCSelfreport@magellanhealth.com
- Please include:
  - Provider self-disclosure spreadsheet (as an excel document)
  - Investigation summary – Be sure to include:
    - How the issue was initially identified
    - Who conducted the audit
    - Type of audit (Option 1, 2, or 3)
    - The name of the staff person involved (if applicable)
    - The time frame audited
    - Describe the process of the audit
    - The results of the investigation
    - Actions taken to prevent reoccurrence (i.e. staff education, corrective action plan, termination, etc. If there is a termination, please include the date of termination.)

Compliance Culture

- **Creating a culture of compliance within your agency is CRITICAL to success**
- Compliance is about process improvement, NOT punishment for doing something wrong (staff should be feel comfortable raising concerns)
- Ask the questions:
  - What do we do well?
  - What don't we do well?
- Having a designated compliance officer (who has no other functions) helps create a culture of compliance
  - Many agencies combine the job functions of Compliance and Quality
- Compliance has overlap with a lot of departments. Some problems may be solely compliance related but most issues overlap with HR, finance, clinical, quality, etc.



Compliance Culture

- Know where to find/ get the information even if you don't know all the actual regulations or requirements.
- A successful compliance culture is strongly influenced by how much staff trust management.
- Compliance is more than just billing: training and culture helps make your team aware of all the components.

Increased compliance= increased quality

Increased quality= provider of choice

Records and Privacy

- Under the Pennsylvania HealthChoices' program: Bucks, Cambria, Lehigh, Montgomery and Northampton Counties, DHS, the Primary Contractors and Magellan have access to all Medical Assistance Member records.
- You must maintain each Member's record in a separate file. Include the Member's identifying information, such as the case number and PH-MCO, in the file. Keep Member charts in a locked file when not in use. Your office must also be locked when you are not on the premises. Only you and authorized staff employed by you are to have access to Member medical records.
- All provider staff must be informed of the protocol for confidentiality and be made aware of their responsibility to maintain the confidentiality of Members.
- Staff may not talk about Members or give out any information to anyone without the Member's explicit written authorization.
- Appointment books are to be treated as confidential and kept in a locked file when not in use.
- Separate entrances and exits, while not required, may help the effort to maintain confidentiality.
- When mailing confidential information, label the document as confidential.

Confidentiality

- Confidentiality of all information about a Member receiving mental health and/or substance abuse treatment service is of paramount importance. Confidentiality is an ethical obligation of all treatment professionals, and a legal right for every Member, regardless of the source or the format of the information.
- As a Magellan network provider, you are responsible for maintaining the confidentiality of all Member information. You must be knowledgeable of all applicable state and federal laws, including HIPAA, regarding confidentiality or having an impact upon a Member's right to confidentiality. This also includes any applicable reporting requirements for child or elder abuse, and the common law or statutory duty to warn.
- Any requirements under applicable federal and state laws regarding confidentiality must be followed regarding release of information with or without the Member's authorization.

Confidentiality (cont.)

- HIPAA (Health Insurance Portability and Accountability Act of 1996) guides what information can be shared and with whom.
- State Confidentiality Laws as well as State/ Federal Substance Abuse Laws may be more stringent than HIPAA. Magellan follows the most stringent law.
- Magellan does not use or disclose protected health information (PHI) for purposes other than payment, treatment or health care operations without valid authorization from the Member, unless permitted or required to do so by law.
- Magellan has some confidentiality and privacy resources available on our website: https://www.magellanofpa.com/documents/2021/07/fwa-confidentiality-resources.pdf/

Authorization to Use and Disclose Protected Health Information (AUD) Form

- Except as otherwise permitted or required by law, Magellan does not use or disclose a Member's PHI without first obtaining a valid Authorization to Use and Disclose Protected Health Information (AUD) Form.
- If the standard AUD Form is modified, prior approval must be obtained by Magellan before any PHI is used or disclosed pursuant to such form. When presented with Magellan's standard AUD Form, approval must also be obtained before any PHI is used or disclosed pursuant to such form.
- A valid AUD Form is obtained before disclosing information to a provider about the Member's previous hospitalization, substance abuse, and/or mental health treatment history, even at the time of referral, because many state laws are more stringent than HIPAA relevant to the privacy and confidentiality of behavioral health information.
- Please refer to the Magellan website for the most updated AUD form (https://www.magellanofpa.com/documents/2021/07/p-forms-consent-to-release-protected-health-information-phi-english.pdf/)
- Submission options:
  - Fax to: 1-866-667-7744
  - Mail to: 105 Terry Drive, Suite 103, Newtown, PA 18940
  - Online- See Release Forms & Member Access Portal on the Members Page: https://www.magellanofpa.com/for-members/

Consent to Treat

- Children under 14 years of age must have their parent's or legal guardian's permission to get mental health care. Children 14 years or older generally do not need their parent's or legal guardian's permission to get mental health care. All children can get help for alcohol or drug challenges without their parent's or legal guardian's permission.
- Minors between 14 and 17 can consent to mental health care and thus have the right to decide who can see their records if they consented to the mental health care. In addition, a parent or legal guardian can consent to mental health care for a child who is 14 years old or older, but under 18 years of age.
- As a general rule, where a minor has the authority to agree to his/her own treatment and the consent of the minor's parent/guardian is not needed, the minor controls the release of his/her records regarding that treatment.

Compliance Resources

- Magellan Special Investigations Unit: 1-800-755-0850; or SIU@MagellanHealth.com
- Magellan Corporate Compliance Department: 1-800-915-2108 or Compliance@MagellanHealth.com
- Magellan Website Compliance page: https://www.magellanofpa.com/for-providers/provider-resources/fraud-waste-and-abuse-compliance/
  - Find guidance including:
    - Preparing for an Audit
    - Trainings/ Education
    - FWA Resources
    - Making a FWA Referral
    - Audit Trends
    - Compliance Best Practices
    - Confidentiality Resources
  - Monthly E-mail Blasts on a compliance related topic- see Compliance Alerts for history going back to 2013: https://www.magellanofpa.com/for-providers/

Local Compliance Resources

- Magellan PAHC Compliance Manager/ Privacy Officer:
  - **Karli Schilling, MA (All Counties)**
    215-504-3967
    kmschilling@magellanhealth.com
- SIU Claims and Compliance Auditors:
  - **Patty Marth, CFE (Lehigh & Northampton Counties)**
    610-814-8009
    PMarth@magellanhealth.com
  - **Caitlin Vossberg, LSW (Bucks & Montgomery Counties)**
    215-504-3947
    vossbergc@magellanhealth.com
  - **Tina Davis, M.Ed., CFE (Cambria County)**
    814-961-0689
    TMDavis1@magellanhealth.com
- SIU Senior Investigator:
  - **Diane Devine, CFE (All Counties)**
    610-814-8052
    ddevine@magellanhealth.com

Member Services Overview

Member Services Scope

How can the Member Services Department be of assistance?

- We can assist you with looking up the status of your claim(s).
- We can assist Members with searching for a provider within our network; or providers within our network finding another treatment option.
- We can assist you with starting a pre-cert, confirmation of arrival, or checking a Member's eligibility.
- We will do our best to assist you with any general question(s) you might have for us.

Member Eligibility

- Magellan does not determine or control PA Medicaid Eligibility
- The COMPASS system is the fastest and easiest way to apply for benefits: www.compass.state.pa.us
- Information about PA Medicaid enrollment can be found at:
  - **Toll-free number**: 1-800-440-3989
  - **Or online at:** www.enrollnow.net
- Statewide Customer Service Center: 1-877-395-8930
- Each county also has at least one designated County Assistance Office (CAO):
  - Bucks County (Bristol): 1-215-781-3300
  - Cambria County (Johnstown): 1-814-533-2491
  - Lehigh County (Allentown): 1-610-821-6509
  - Montgomery County: (Norristown) 1-610-270-3500; or (Pottstown) 1-610-327-4280
  - Northampton County: 1-610-250-1700

Member Eligibility

- PA Medicaid eligibility is fluid and may change frequently.
- Providers are responsible for verifying a member's eligibility for HealthChoices coverage through the PA Medical Assistance (MA) Eligibility Verification System (EVS). It's recommended that providers confirm eligibility:
    - Prior to the first appointment
    - Throughout the course of treatment
    - Prior to submitting claims
- For information regarding the different options for checking EVS, go to the below PA HealthChoices website address: http://www.healthchoicespa.com/

Member Eligibility

- You may also check eligibility on Availity® (previously MagellanProvider.com). Please be advised that this is not real-time eligibility or by calling Magellan's customer service department:
  - Bucks County: 1-877-769-9779
  - Cambria County: 1-800-424-3711
  - Lehigh County: 1-866-780-3368
  - Montgomery County: 1-877-769-9779
  - Northampton County: 1-866-780-3368
- Authorization for service is based on eligibility at the time of the treatment request and does not guarantee payment.
- When applicable, hard copies of the EVS printout are to be maintained in the member's medical record. At times, changes to PA MA eligibility may be made retroactively and therefore providers should be able to validate that they confirmed eligibility when services were rendered.

Be ready when calling Member Services! We're here to help!

- Customer Care Associates are required to verify at least 3 elements of both the Member's information you are calling about; as well as a provider's information. Here are the items to have ready before calling in:
  - Member's Medicaid ID
  - Member's Name
  - Member's DOB
  - Member's Address
  - Your facility's tax ID number; and or MIS number
  - Your facility's address
- Please make sure you are calling the Provider line and not the Member line.

Additional Resources

- Our Magellan websites have a plethora of resources!
  - Dedicated Magellan HealthChoices website: https://www.magellanofpa.com/
  - Magellan Provider Website: https://www.magellanprovider.com
- We recommend using our websites for simple/ everyday questions – if you can't find the answer you're looking for, don't feel shy to call us!
- Also, please review our Online Community Resources page to locate local, state and national advocacy organizations: https://www.magellanofpa.com/for-providers/community/community-online-resources/
- Providers should also assist Members with accessing various tools and information on our Member website including but not limited to the Member handbook:
  - Main Member page: https://www.magellanofpa.com/for-members/
  - PA Member Handbook: https://www.magellanofpa.com/for-members/member-resources/pa-member-handbook/

Member Rights & Responsibilities

Member Rights & Responsibilities

Providers are expected to share with members their rights and responsibilities.

Evidence that providers have shared this information with members is expected to be in their record.

Rights and Responsibilities also need to be posted in a visible area within the contracted providers' office(s).

The list of member rights and responsibilities and the above noted requirements are shared in the Provider Manual found on the Magellan website.

Any page numbers referenced on the following slides indicate supportive materials in the Provider Manual.

Member Rights & Responsibilities

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

- Be treated with respect, recognizing their dignity and need for privacy, by Magellan staff and network providers.
- Have easy access to Understand about Magellan, its services, and the providers that treat them when they need it.
- Pick any Magellan network provider that they want for treatment. They may change providers if they are unhappy.
- Get emergency services when they need them from any provider without Magellan's approval.
- Get information that they can easily understand from their providers and be able to talk to them about treatment options, without any interference from Magellan.
- Make decisions about their treatment. If they cannot make treatment decisions independently, they have the right to have someone else help them make decisions or make decisions for them. They may refuse treatment or services unless they are required to get involuntary treatment under the Mental Health Procedures Act.
- Talk with providers in confidence and to have their information and records kept confidential.
- See and get a copy of their medical records and to ask for changes or corrections to your records.

Member Rights & Responsibilities

- Ask for a second opinion.
- File a Grievance if they disagree with Magellan's decision that a service is not medically necessary for them (Information about the process can be found beginning on page 47).
- File a Complaint if they are unhappy about the care or treatment they have received (Information about the process can be found beginning on page 42).
- Ask for a Department of Human Services Fair Hearing (Information about the process can be found beginning on page 52).
- Be free from any form of restraint or seclusion used to force them to do something, to discipline them, or as a punishment.
- Get information about services that Magellan or a provider does not cover because of moral or religious objections and about how to get those services.
- Exercise their rights without it negatively affecting the way the Department of Human Services, Magellan, or network providers treat them.
- Request case files prior to any proceedings. There is no cost to file.
- Receive a list of advocacy organizations that can assist them.

Member Rights & Responsibilities

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

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

Additional Resources

Magellan Website Resources

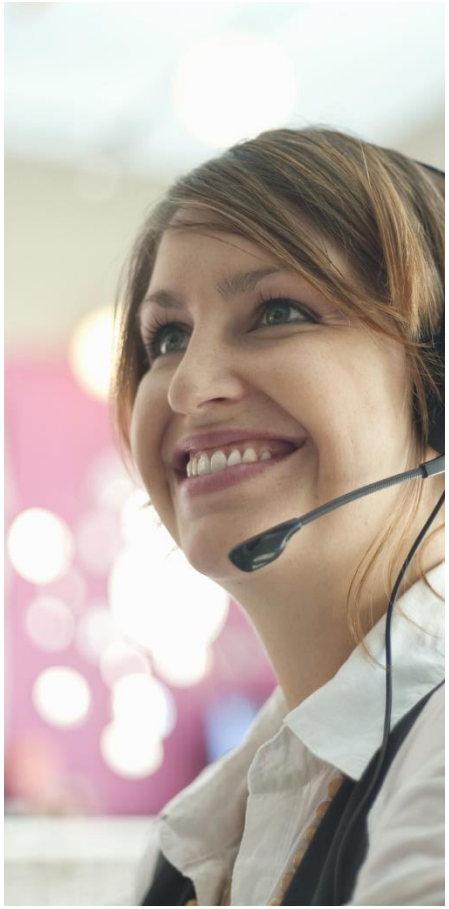
- www.magellanofpa.com - is your go-to resource for:
  - Provider Search & Directories
  - Provider Manual
  - Forms
  - AUD online submissions
  - Medical necessity and clinical practice guidelines
  - Magellan processes related to rights and responsibilities, complaints and grievances
  - Community information and events
  - e-Learning Center
  - Resources

For more information about Magellan in Pennsylvania, check out our website: www.magellanofpa.com

Other Website Resources

- Information about HealthChoices can be found at: www.healthchoices.pa.gov
- Information for Magellan Providers can be found at: www.magellanprovider.com
- My Life has a Facebook fan page (www.Facebook.com/MagellanRecoveryResiliencyMyLife). The page helps to educate, inform, engage and build support for My Life programs.
- Department of Human Services: www.dhs.pa.gov
- Department of Drug and Alcohol Programs www.ddap.pa.gov
- Pennsylvania Community Support Program (CSP) https://www.dhs.pa.gov/Services/Assistance/Pages/Community%20Support%20Program.aspx
- PA Recovery Child and Adolescent Social Service Program (CASSP) https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/CASSP.aspx

Phone Resources



Provider Services Contact Information

Bucks/Montgomery: (877) 769-9779

Cambria: (800) 424-3711

Lehigh/Northampton:(866) 780-3368

Fraud & Abuse: (800) 755-0850

Member Services Contact Information

Bucks: (877) 769-9784

Cambria: (800) 424-0485

Lehigh: (866) 238-2311

Montgomery: (877) 769-9782

Northampton: (866) 238-2312

Please remember to complete and submit your Training Attestation

Our Purpose:

Leading humanity to healthy, vibrant lives

Our Values:

OWN IT

If it is to be done, it's up to us to do it

DELIVER

We are relentless in the pursuit of value and results for our customers

WIN TOGETHER

We believe in the collective genius of our people and the magic of teamwork

CARE

We care deeply about each other, our customers and the communities we serve

STAND TALL

We always do the right thing

EVOLVE

We embrace learning as a means to reinvention – in all that we do

Magellan HEALTHCARE

THANK YOU!

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