Inpatient Withdrawal Management

Level 4WM: Medically Managed

Level 3.7WM: Medically Monitored

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the PA HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania laws, including Title 55, Chapter 1101; Title 28, Part V Department of Drug and Alcohol Program requirements; the American Society of Addiction Medicine (ASAM) guidelines; as well as all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan Behavioral Health of Pennsylvania, Inc. in order to be eligible for payment for services.

Please routinely visit the link below and look for the "Compliance Alerts" accordion to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

ASAM Level 4WM, is a Medically Managed Intensive Inpatient Withdrawal Management level of care. Services are delivered under a defined set of physician-approved policies and physician-managed procedures and medical protocols. 4WM provides care to members whose withdrawal signs and symptoms are sufficiently severe enough to require primary medical and nursing care services.

ASAM Level 3.7WM is a Medically Monitored Inpatient Withdrawal Management level of care. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. 3.7WM provides care to members whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. Twenty-four-hour observation, monitoring, and treatment are available, however, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Scope of Services

ASAM Level 4WM occurs in an acute care general hospital, an acute psychiatric hospital or unit within an acute general hospital, or a licensed addiction treatment specialty hospital with acute medical care and nursing staff. 4WM features the availability of specialized medical consultation, full medical acute care services, and intensive care, as needed. At a 4WM facility, services may be offered in any appropriately licensed acute care setting that offers addiction treatment services in conjunction with intensive biomedical and/or psychiatric services.

ASAM Level 3.7WM may occur in a free-standing withdrawal management facility. Required support includes the availability of specialized clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; the availability of medical nursing care and observation as warranted, based on clinical judgment; direct affiliation with other levels of care; and the ability to conduct or arrange for appropriate laboratory and toxicology tests.

Service Description

Level 4WM treatment is provided 24 hours a day in a permanent facility with inpatient beds. The full resources of a general acute care or psychiatric hospital are available. Although treatment is specific to substance use and other addictive disorders, the skills of the interdisciplinary team and the availability of support services, including medical consultation services, allow the joint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed. 4WM facilities are staffed by physicians, who are available 24 hours a day as active members of an interdisciplinary team of trained professionals that also includes Physician Assistants, Registered Nurses, and/or Licensed/Credentialed Nurses who provide medical management and care 24 hours a day. Counselors are available 8 hours per day to administer planned interventions according to the needs of the individual. Social Workers and Psychologists may also be available to treat a member who has a substance use disorder, or a person who has an addiction along with a concurrent acute biomedical, emotional, or behavioral disorder.

3.7WM programs provide 24-hour inpatient care settings with detoxification services. A physician is available for assessments within 24 hours of admission and must provide on-site monitoring of care. A Registered Nurse must be available to provide a nursing assessment upon admission. The nursing department within a 3.7WM program will offer hourly monitoring of progress and medications. Counselors are available 8 hours per day to administer planned interventions according to the needs of the individual. Social Workers and Psychologists may also be available to treat a member who has a substance use disorder, or a person who has an addiction along with a concurrent acute biomedical, emotional, or behavioral disorder. A withdrawal management specialist and/or a licensed/certified clinician will provide clinical treatment and coordination for clients and their families if needed.

Upon arrival at a withdrawal management facility, a member will obtain:

- An assessment that includes the addiction history such as history of use, first and last use, etc.
- A physical examination by a physician or nurse practitioner within 24 hours of admission.
- A biopsychosocial screening is conducted to determine required supports in order to prioritize treatment.
- An individual treatment plan will be developed.
- A discharge/transfer plan will begin at admission for a smooth transition into a different level of care or back into the community.
- WM staff will also make referrals/ arrangements to connect people to community services such as outpatient treatment, recovery support services, and medication assisted treatment, etc.

Service Exclusions

Minors under the age of 18 and anyone who is not at immediate risk of withdrawal symptoms that need medical monitoring are not eligible for 4WM or 3.7WM care. While receiving either 4WM or 3.7WM services, a member is not eligible for any other 24-hour level of care including medical or substance use hospitalization, as this is considered a duplication of services. Furthermore, if a member meets medical necessity for 4WM or 3.7WM based on the ASAM screening tool, they cannot meet medical necessity for any other ASAM level of care at the same time. Laboratory and all other ancillary services are included in the rate and cannot be billed separately.

Face-to-face, telehealth or telephonic visits with any outpatient behavioral health professional support would also not be funded during this treatment episode as it would be a duplication of service. The 4WM and 3.7WM programs are responsible for providing all necessary services during a member's treatment stay.

Referral Process

If a member seeks a 4WM or 3.7WM level of care, the member can be assessed at any site that completes ASAM assessments. A list of providers can be found on the Magellan website, www.magellanofpa.com, or by calling 1-866-780-3368. A member may also call a provider directly to get instructions on how to access services at their facility. Members may also go to the closest Emergency Room (ER) or local hospital if in need of support in seeking treatment and are either currently in withdrawal or at risk of going through withdrawal from alcohol or other substances. Once a member has been assessed and the level of care has been determined, the assessor or a designated professional from the facility would contact Magellan to seek a pre-certification for the recommended level of care. As highlighted in ASAM, a comprehensive nursing assessment is completed at the time of admission, and the admission is approved by a physician. Also, the comprehensive history and physical examination are performed within 12 hours of admission.

Admission Process

For both 4WM and 3.7WM, admission would be indicated when an individual is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on the history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.
Medical Necessity Criteria (MNC) for 4WM is determined by ASAM Dimension 1 while paying considerable attention to Dimensions 2 and 3. Dimensions 4-6 are also to be assessed and considered relative to a member's disposition. Specifically:

- Dimension 1: Acute intoxication and/or withdraw potential is severe with present signs and symptoms of withdrawal; OR based upon substance use history, previous withdrawal history, present symptoms and physical condition, a severe withdrawal syndrome is imminent.

- Dimension 2: Biomedical conditions and complications can be managed in the 4WM level of care as these services are provided in an acute care general hospital or a licensed addiction treatment specialty hospital.
- Dimension 3: 4WM describes any emotional, cognitive, or behavioral condition as significant and/or acute and that such is best managed in an acute 24-hour medical facility or hospital due to the care and treatment that may be required. It is also stated that the severity of these symptoms has potential to impact withdrawal management.

Medical Necessity Criteria (MNC) for 3.7WM is determined by ASAM Dimensions 1, 2, and 3. Dimensions 4-6 are assessed and considered relative to the member's disposition. Specifically:

- Dimension 1: Acute intoxication and/or withdrawal potential is high
- Dimension 2: Biomedical conditions and complications can be managed in 'free-standing withdrawal management centers', not connected to a hospital
- Dimension 3: Describes any emotional, cognitive, or behavioral condition as mild to moderate, and having the potential to complicate withdrawal management.

An initial prior authorization of 5 days of WM are generally approved upon initiation of the service. Providers are encouraged to request additional days from Magellan if a member meets ASAM criteria for continued stay in WM. Clinical Opiate Withdrawal Scale (COWS), Clinical Institute Withdrawal Assessment (CIWA), and/or Clinical Institute Narcotic Assessment (CINA) scales can be useful objective tools to measure and assess withdrawal severity for members. They are one of the tools that can guide practitioners toward the management of withdrawal symptoms as well as what level of care is most appropriate for the member.

Treatment or Service Plan

Providers should have a written plan (i.e., service description) describing how and when initial treatment plans will be completed along with other admission criteria. Per DDAP regulations (Title 28 Chapter 710), an initial treatment plan is developed within 24 hours of admission to 4WM and 3.7WM levels of care which includes SMART goals appropriate for the withdrawal management level of care. The primary counselor and member are responsible for developing the treatment plan which should be updated at a minimum of every 15 days, or as described in the agency's approved service description. Treatment plan updates must be signed and dated by the member's primary counselor, and it is recommended that the supervisor also co-sign the update. The member should also sign the treatment plan and agree with the identified goals. Goals must be specific, appropriate, measurable, reachable, time-limited objectives, which will include modalities/interventions and frequency of services, as well as member's strengths.

In withdrawal management programs, elements of the assessment and treatment plan include the following, per the ASAM criteria:

- A comprehensive nursing assessment, performed at admission.
- Approval of the admission by a physician.

- A comprehensive history and physical examination performed within 12 hours of admission(4WM) or 24 hours of admission (3.7WM), accompanied by appropriate laboratory and toxicology tests.
- An addictions-focused history, obtained as part of the initial assessment and reviewed by a physician during the admission process.
- Sufficient biopsychosocial screening assessments to determine placement, and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- Discharge/transfer planning, beginning at admission.
- Referrals to alternate providers, made as needed.
- An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives.
- Daily assessment of patient progress through withdrawal management and any treatment changes.

Per ASAM criteria, treatment providers should provide a holistic approach for determining individualized and outcome-driven treatment plans for members. Using the criteria as a guide, practitioners can:

- Assist a patient from assessment through treatment
- Work with the patient to determine goals
- Help rank and rate all the patient's risks, using the criteria's multidimensional approach to determine where to focus treatment and services
- Determine intensity and frequency of services needed using the criteria's detailed guides of levels of care

Expectations of Service Delivery

In 4WM, providers are expected to utilize evidenced-based practices to support a member through the withdrawal management phase of treatment. Withdrawal management protocols as well as personalized management of any co-occurring medical or psychiatric conditions are primary targets in 4WM level of care.

If a member needs to transition to an alternative level of care or treatment during 4WM or 3.7WM, the provider is to notify Magellan of the transition and seek prior authorization for the proposed level of care if it is a level of care managed by Magellan. If the member is sent to an ER, hospital, or other medical setting, Magellan is to be notified within twenty-four hours.

Care Coordination

4WM

In 4WM level of care, each facility should have the availability for specialized medical consultation, full medical acute services, and intensive care as needed. It is the expectation of Magellan that providers

collaborate ongoing with all relevant and existing professional or natural supports. Efforts should be made to obtain signed consents for natural supports as well as current providers to update on member status and include in care coordination. For example, if a member has acute medical conditions and is admitted to a 4WM level of care, efforts should be made to educate a member on the benefits of informing their Primary Care Physician (PCP) of presence in treatment as well as securing an aftercare appointment. If a member does not have a PCP, it is the expectation that provider will offer the member linkage to a PCP as part of discharge plan, if member is leaving inpatient treatment following completion of 4WM.

If a member is in 4WM and wishes to transition to 4, 3.7 or 3.5 and the current facility does not have any available beds or said facility is declining to keep member at the facility, it is the expectation of Magellan that the provider locates a bed for the member for the level of care that is met based upon ASAM criteria. Specifically, a member should not be discharged to the community to get a level of care assessment.

4WM is a time-limited level of care, typically three to seven days. An outpatient provider, certified recovery specialist or certified peer specialist service should remain active while member receives WM care if expected to return to outpatient provider following withdrawal management care. If a member signs a consent for the provider, collaboration via phone contact is suggested to provide treatment updates and transition of care planning**.**

3.7WM

While in 3.7WM level of care, each member will have access to medical and nursing staff, as well as clinical staff which often include a counselor and a case manager. The two teams work together to identify the member's needs and help coordinate care after completion of the 3.7WM program. This care coordination includes but is not limited to referral to a lower level of care within a 24-hour setting such as 3.5, 3.1, 4.0; or community-based care such as housing, outpatient treatment, pharmacotherapy/medically assisted treatment, case management, peer support, medical care or special needs, etc.

When a member is in 3.7WM, it is the expectation of Magellan that providers collaborate ongoing with all relevant and existing professional or natural supports. If a member is in 3.7WM, efforts should be made to obtain signed consents for natural supports as well as current providers to update on member status and include in care coordination. For example, if a member has acute medical conditions and is admitted to a 3.7WM level of care, efforts should be made to educate member on benefits of informing their Primary Care Physician (PCP) of presence in treatment as well as securing an aftercare appointment. If a member does not have a PCP, it is the expectation that provider will offer the member linkage to a PCP as part of discharge plan if member is leaving inpatient treatment following completion of 3.7WM.

If a member is in 3.7WM and wishes to transition to 3.7 or 3.5 and the current facility does not have any available beds or said facility is declining to keep member at the facility, it is the expectation of Magellan that the provider locate a bed for the member for the level of care that is met based upon

ASAM criteria. Specifically, members should not be discharged to the community to get a level of care assessment. While in 3.7WM, members are unable to access community-based services, however it is the expectation that all community-based services and supports that are currently in place would be involved in aftercare planning.

Discharge Planning and Transition

According to ASAM criteria, members may continue in a Level 4WM program until withdrawal signs and symptoms are sufficiently resolved so that the individual can be safely managed at a less intensive level of care.

When a member is no longer assessed as meeting ASAM criteria for 4WM level of care, the expectation is that member is offered a clinical recommendation as to what level of care would be most appropriate for them according to ASAM criteria. Examples would be 4.0 (Medically Managed Intensive Inpatient Services), 3.7 (Medically Monitored Intensive Inpatient Services), 3.5 (Clinically Managed High-Intensity Residential Services), 2.5 (Partial Hospitalization Services), 2.1 (Intensive Outpatient Services), or Level 1 (Outpatient Services).

When a member is no longer assessed as meeting ASAM criteria for 3.7WM level of care, the expectation is that member is offered a clinical recommendation as to what level of care would be most appropriate for them according to ASAM criteria. Examples would be 3.5 (Inpatient Rehab), 3.1 (Halfway House), 2.5 (Partial Hospitalization Services), 2.1 (Intensive Outpatient Services), or Level 1 (Outpatient Services.)

Throughout this process it is the expectation that Magellan members are actively involved in discharge and aftercare planning process and are agreeable to all locations, dates and times of scheduled appointments. These appointments would include but are not limited to medication management, physical health, behavioral health, medication assisted therapy, etc.

Aftercare outpatient appointments for behavioral health treatment are expected to be within 7 days of discharge. Walk-in appointments do not meet Magellan expectations of adequate discharge planning. If a member chooses a walk-in appointment, this should be documented. If an outpatient provider declines to offer a scheduled appointment, assertive efforts should be attempted to secure one with other outpatient providers. If this is not successful or member declines aftercare appointments, providers should document this barrier and inform the Magellan Care Manager.

If a member needs ongoing medication management for a physical or psychiatric diagnosis and is discharged directly to the community, it is the expectation that the member is offered support by having a scheduled aftercare appointment to facilitate ongoing access to prescribed medications.

It is also expected that members are educated on Pharmacotherapy for Substance Use Disorders, such as Vivitrol, Suboxone, Subutex, Sublocade, Methadone, Naltrexone, Antabuse, or Campral.

Linkage to a Medication Assisted Treatment Provider is expected if this form of treatment is part of the member's established recovery plan.

All discharges should be reported to Magellan via a telephonic review as soon as the treatment episode is complete but no later than within 48 hours of discharge. This includes, Against Medical Advice (AMA) Discharges, whereby offering a discharge appointment within the standard of seven days remains a provider's responsibility.

For all unplanned discharges, it is the expectation of the provider to communicate with Magellan what efforts the clinical team made in order to motivate member to remain in treatment. Furthermore, it is a state regulation that providers notify member's emergency contacts upon any unplanned discharge, when the provider has a signed consent from the member to do so.

Information expected at the time of a discharge review includes, but is not limited to:

- Date of discharge
- Type of discharge- Treatment Complete, Medical, Intervening Conditions, Medical AMA, Administrative, etc.
- If the discharge was AMA, an explanation as to who was involved in any AMA block and what clinical efforts were made to prevent the outcome.
- Address at time of discharge, and how member left facility.
- Phone number, if available.
- Did member leave with any medications, refills, and was there a plan to obtain the medications if sent to a pharmacy.
- Was member discharged on any form of Pharmacotherapy, details of aftercare appointment.
- Progress made in treatment overview.
- Follow up appointment with behavioral health provider – provider name, date, and time
- Follow up appointments with other providers/supports involved with member
- Safety plan
- Location of discharge

Evidence of discharge planning from admission is to be included in progress notes and treatment planning. Additionally, preliminary discharge plans, barriers to planning, progress of discharge planning, and rationale for any change in discharge plans should also be documented.

There should be evidence of active involvement of the member and family in discharge planning in notes and a discharge summary that includes providing education on the importance of follow-up appointments to member and/or family, when appropriate.

Documentation

The documentation in an individual's record allows mental health and substance use professionals to evaluate and plan for treatment, monitor health care over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate

and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the individual on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be count-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as treatment plans, must be entered in the record. Drugs prescribed as part of treatment, including quantities and dosages, must be entered in the record. If a prescription is telephoned to pharmacist, the prescriber's records require a notation to this effect.
- The record must indicate the progress at each session, change in diagnosis, change in treatment and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered into the record.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.
- The documentation of treatment or progress notes for all services, at a minimum, must include:
    - The specific services rendered.
    - The date the service was provided.
    - The name(s) of the individual(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 session, any change in diagnosis, changes in treatment and response to treatment.
    - The actual 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 a.m. to 11:00 a.m.

Magellan has also established some documentation guidelines for providers and services that are reimbursed under an all-inclusive daily rate. Specifically:

- A completed American Society of Addiction Medicine (ASAM) Summary Form (https://www.magellanofpa.com/media/5448/ddap-efm-1002-asam-placement-summary-sheet.pdf) must be present in a member's record prior to or at the start of a level of care/program to receive payment.

- Daily progress notes must be present for all dates of service billed. Clear and concise documentation is required for substantiating payments made to the provider and must meet the required standards as set forth above.
- Progress Notes/ Daily Entries must document the interventions used, the individual's response, and relate to the treatment plan goals. Interventions should be individualized and specific; use of vague language such as "listened and provided positive feedback" or "watched a video" would not be considered sufficient.
- Group therapy notes should include a brief description of the group. They must also include individualized information for each participant including their behavior during the group session, level of participation and response to interventions/ information discussed.
- 4WM and 3.7WM Providers must implement behavioral health/ substance use interventions for each day of service billed, including all weekends and holidays. Staffing patterns must align with all DDAP Regulations, ASAM Requirements and any applicable MA Bulletins to allow for meaningful treatment to be provided every day that the member is physically in the facility.
- In accordance with this requirement that interventions are provided daily, it is Magellan's expectation that each date of service that is billed have corresponding documentation in the member's record. This documentation should include all interventions, both formal and direct treatment (i.e. structured individual and group sessions) as well as those interventions that are less traditional. Please note that the intervention may be delivered by any inpatient staff member and there is no minimum time requirement for the intervention if it is documented; however documenting medication dosing only for detoxification or rehabilitation is NOT considered sufficient substantiation of payment for a day of service. Providers must also provide all services and programming as outlined in their approved Service Descriptions.

Outcomes

All providers of Level 4WM and 3.7WM services should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Average length of stay
- Member satisfaction
- Follow up with aftercare services following discharge
- Re-admission within 30 and 90 days after discharge

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. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Grievance Process

Magellan and the Pennsylvania HealthChoices 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.

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.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health 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.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member's admission or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality of care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.

- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.
- Assist in the investigation and timely response of adverse incidents.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective that respects individual member preferences, needs and values, and is sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices deeply rooted in cultural competence and prioritize health equity and inclusion. These practices include focusing on continual training and education to support staff. Cultural Competence and Diversity, Equity, and Inclusion (DEI) resources are available on www.Magellanofpa.com to help develop provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, and materials/communication approaches in non-English languages or alternative formats. Providers are encouraged to maintain staff training to support Members with language assistance needs and ensure that their team is prepared to respond to provide the best possible treatment outcomes. For practitioners, Magellan makes in-person, video or telephonic interpretation services available, as needed. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. 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, and Other.

Magellan requires an electronic submission process. This can be accessed at Magellanofpa.com.