Magellan Healthcare, Inc.*

2025 Handbook for the National Provider Network

*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc.–Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively "Magellan").

Magellan HEALTHCARE℠

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SECTION 1: INTRODUCTION

Welcome

Welcome to the Magellan National Provider Network Handbook. This handbook is your reference guide for navigating Magellan. As a contracted Magellan provider of behavioral health clinical care, it is your responsibility to be familiar with and follow the policies and procedures outlined in this handbook, and those within applicable handbook supplements.

Each section of the handbook outlines our philosophy, our policies, your responsibilities to Magellan and our responsibilities to you, and is a part of your contractual agreement with Magellan. The appendices in this handbook contain more extensive information, including clinical practice guidelines, credentialing criteria, claim submission tips and more.

This handbook also provides information about the provider self-service features available to you. By accessing the online provider tools located at www.MagellanProvider.com or the sites of Magellan's contracted vendors as directed, you can accomplish virtually all the business tasks you'll need to complete with Magellan.

We hope you find this handbook a helpful resource in working with Magellan to provide quality care to members. We welcome your feedback on how we can make our handbook even better and more helpful to you. Email comments to Editor@MagellanHealth.com.

About Magellan Healthcare

Magellan Healthcare, Inc., the healthcare business unit of Magellan Health, Inc., offers solutions for complex conditions in the areas of behavioral health and medical specialty treatment. Magellan Healthcare serves commercial health plans, employers, state and local governments, and the federal government, including the Department of Defense. For more information, visit MagellanHealthcare.com.

Our Behavioral Health Products

Magellan Healthcare offers customers a broad array of mental health and substance abuse clinical management services that combine the best of traditional approaches to healthcare delivery with innovative, emerging solutions. Magellan's behavioral health product offerings include:

Magellan *Total Wellbeing:* This product is an industry-first whole person wellbeing solution, designed as a multi-layered journey to help employees improve their wellbeing. In addition to including traditional employee assistance and Life Management services, this reimagined product allows for

proactive identification and access to services through high-tech and high-touch experiences, including a digital emotional wellbeing tool to support members wherever they are in their journey.

Magellan *Employee Assistance*: This product focuses on problem resolution by combining traditional employee assistance and life management tools with work-life services such as child and elder care referrals, and financial and legal assistance. It also includes our digital emotional wellbeing tool to support members as they build their resilience and find pathways to whole health.

Magellan *Autism Connections*: This solution goes beyond traditional care by combining our expertise in applied behavior analysis and the care of children diagnosed with autism with innovative technology and targeted efforts to engage and serve caregivers on their journey—ensuring everyone impacted receives the care they need through an array of services.

Magellan *Behavioral Care Management*: Designed to promote our members' behavioral health and wellness while responsibly managing our customers' healthcare dollar, our approach is based on a clinical philosophy of providing timely access to high-quality, clinically appropriate, affordable behavioral healthcare services tailored to members' individual needs.

The primary mission of care management activities is to facilitate positive treatment outcomes through proactively identifying members who would benefit from more intensive services to achieve, consolidate and maintain treatment gains. The goals of care management are to optimize the physical, social, and mental functioning of our members by increasing community tenure, reducing readmissions, enhancing support systems, and improving treatment efficacy through advocacy, communication and resource management.

Key features of our program include:

- Assigning each member in a higher level of care to a care manager or transition of care specialist who works with the member throughout their clinical journey.
- Working closely with medical insurers to coordinate and integrate behavioral healthcare with medical care.
- Coordinating access to a full continuum of mental health and substance abuse services, with care delivered in the most clinically appropriate, least-restrictive settings.

Magellan values and cultivates a strengths-based, culturally competent, and recovery-oriented system of care that allows individuals to achieve their wellness goals. We ground our programs in the principles of recovery, resiliency and cultural competence to further the attainment of a meaningful life in the community for each person we serve.

Services Guided by Recovery and Resiliency

At Magellan, we use the phrase “recovery and resiliency” as an organizing term. The principles of recovery and resiliency are not just for those who live with a mental health or substance use condition but for every staff member, customer and plan member we serve. People in recovery and their families who have navigated mental health and substance use treatment systems have incredible insight into guiding how systems and services should be designed and implemented. We ensure these voices are an integral part of our business by employing lived-experience experts in our corporate structure and in our health plans.

Our behavioral health products help individuals understand and improve their own health with the right support provided at the right time. As a Magellan Healthcare provider, you play a vital role in improving the health, welfare and productivity of the people we jointly serve.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Network Provider Participation

Our Philosophy

Magellan is dedicated to selecting behavioral healthcare professionals, groups, and facilities to provide member care and treatment across a range of services offered by Magellan.

Our Policy

To be an in-network provider of clinical services with Magellan, you must comply with the requirements of your provider participation agreement, including credentialing requirements. Depending on your credentials and our customers' requirements, you may be eligible to provide services for all members, or only for certain customers, products or business segments.

What You Need to Do

Your responsibility is to:

- Provide medically necessary covered services to members whose care is managed by Magellan;
- Follow the policies and procedures outlined in this handbook, any applicable supplements, and your provider participation agreement(s);
- Provide services in accordance with applicable state and federal laws, and licensing and certification bodies;
- Agree to cooperate and participate with all care management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures;
- As a first step to being considered for Magellan network participation, go to www.MagellanProvider.com, click *Join the Network* and follow the instructions for Magellan's network inclusion screening process;
- Follow Magellan's credentialing and recredentialing policies and procedures;
- Ensure that only group practitioners who are currently credentialed with Magellan render services to Magellan members; and
- Complete your initial Provider Profile and practice data information online using the provider portal, which includes a Form W-9 for the contracting entity and financial address, as well as your service demographics, practice information, etc. Keep this information current by reviewing your data quarterly and updating it as changes occur, to facilitate timely and accurate claims payment and processing.

What Magellan Will Do

Magellan's responsibility is to:

- Offer assistance with your administrative questions during normal business hours, Monday through Friday;

- Assist you with understanding and adhering to our policies and procedures, the payer's applicable policies and procedures, and the requirements of applicable accreditation agencies that may include the National Committee for Quality Assurance (NCQA) and URAC;
- Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, patient type, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability, or any other status protected by applicable law; and
- Develop and implement recruitment activities to solicit providers reflective of the membership we serve, subject to applicable state laws.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Types of Providers

Our Philosophy

Magellan is dedicated to recruiting and retaining individual practitioners and institutional providers with the behavioral healthcare credentials to provide member care and treatment across a range of products and services. Magellan's network of providers includes practitioners in private practice, practitioners in group practices, and provider organizations including facilities and agencies.

Our Policy

Magellan's contracted provider network includes the following categories:

- Individual Practitioner – a clinician who provides behavioral healthcare services and bills under their own Taxpayer Identification Number.
- Group Practice – a practice contracted with Magellan as a group entity, and as such, bills as a group entity for the services performed by its Magellan-credentialed clinicians.
- Organization – a facility or agency licensed and/or authorized by the state in which it operates to provide behavioral health services. Examples of organizations include, but are not limited to: general hospitals with psychiatric and/or substance abuse treatment programs, freestanding behavioral health facilities, community mental health centers and agencies. Please refer to the Organizational and Facility Providers Handbook Supplement for additional information about facility/organizational providers, including credentialing criteria.

What You Need to Do

Your responsibility is to:

- Ensure your contract with Magellan is appropriate for your provider practice type.

What Magellan Will Do

Magellan's responsibility is to:

- Provide you with information and guidance to ensure your contractual relationship with Magellan is appropriate to your provider category.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Credentialing and Recredentialing

Our Philosophy

Magellan is committed to promoting quality care for its members. In support of this commitment, practitioners must meet and maintain a minimum set of credentials to provide services to members.

Our Policy

To be eligible to provide services as a Magellan network practitioner, you must successfully complete the credentialing review process. Magellan credentials practitioners in accordance with established credentialing criteria (see the *Appendix* for details) and ensures compliance with applicable regulatory agencies and customer requirements. Magellan network practitioners are required to have their credentials re-reviewed periodically through the recredentialing process. Recredentialing is conducted at least every 36 months, unless otherwise required, and includes evaluation of practitioner performance in the Magellan network, including, but not limited to: clinical care, service and outcomes, member service, and adherence to Magellan policies and procedures.

Magellan's Regional Network and Credentialing Committee (RNCC) utilizes a peer review process to evaluate practitioners' credentials and appropriateness for inclusion in the provider network. Throughout the credentialing process, practitioners have the right to review information submitted to support their provider participation application, correct erroneous information, and upon request, learn the status of their application.

For more information about facility/organization credentialing and recredentialing, see the Organizational and Facility Providers Handbook Supplement.

What You Need to Do

Your responsibility is to submit the necessary documents to facilitate the credentialing review:

- A completed provider participation application;
    - Magellan promotes use of the CAQH® Provider Data Portal (an online universal credentialing application formerly known as ProView™). Be sure to give Magellan access to your application information and review and attest to its accuracy and completeness. Call CAQH ProView Customer Service at 1-888-599-1771 or contact CAQH ProView via chat service at

https://proview.caqh.org/PR for answers to your questions related to the CAQH Provider Data Portal or website.

- If requested of group members, a Group Association Form (GAF), completed and signed by the group administrator;
- Evidence of professional liability insurance coverage, which may include a copy of the current malpractice insurance face sheet; and
- Subject to your professional level and service location, supplemental attestations/documentation.

What Magellan Will Do

Magellan's responsibility is to:

- Notify you promptly if any required information is missing from your provider participation application;
- Forward your application to the Regional Network and Credentialing Committee (RNCC) for review once the credentialing verification process is complete. The RNCC consists of the medical director, participating network providers and Magellan clinicians, and uses a peer review process to make recommendations on credentialing and recredentialing decisions and ongoing Magellan provider network participation. The RNCC reviews your credentialing information, including, but not limited to:
  - Education, training and experience,
  - Specialty practice areas,
  - Current and prior actions on licensure, certification, facility privileges, participation in Medicare, Medicaid, and other federally funded healthcare programs, and
  - Malpractice settlements made on behalf of the practitioner;
- Respond to requests for credentialing or recredentialing status in a timely manner (providers can request their application status by calling Magellan's Provider Services Line at 1-800-788-4005);
- Provide practitioners access to information obtained from outside sources during the credentialing process, subject to limitations. *Note: Magellan is not required to make certain information available, including references, recommendations, and peer review protected information*; and
- Notify you when the initial credentialing process is complete. Although Magellan may notify practitioners of successful recredentialing, if no notification is received, successful recredentialing can be assumed.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Updating Practice Information

Our Philosophy

We are committed to maintaining current, accurate provider practice information in our database so that members have correct information when choosing a provider, and to enable our providers to receive important communications from Magellan in a timely manner.

Our Policy

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

Providers are required to notify Magellan and/or confirm any changes in administrative practice information using our online portal. By using the portal, providers can update information online, a method more efficient and accurate than other forms of communication. Providers who do not update their data when changes occur, or do not attest to data accuracy as required, may be put "on hold" for new referrals and will not display in our electronic or paper directories for use by commercial and employer plan members. If you miss validating your practice information for a given quarter and later go back to do so, your validated practice information will again appear in our provider directories within two business days of receipt of your validation.

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

What You Need to Do

Your responsibility is to:

- Update changes in your administrative practice information listed below and attest to the accuracy of your practice information **at least quarterly** using our secure online portal at www.MagellanProvider.com (or the sites of Magellan's contracted vendors, as directed);
- Notify us within 10 business days of any changes in your practice information, including, but not limited to, changes of:
  - Service, mailing or financial address,
  - Telephone number,
  - Business hours,
  - Email address,
  - Taxpayer Identification Number,
  - Practice website URL,
  - Practice specialty or areas of clinical expertise;
- Promptly notify us if you are unable to accept referrals for any reason, including, but not limited to:
  - Illness or parental leave,
  - Practice full to new patients,
  - Professional travel, sabbatical, vacation, leave of absence, etc.;
- Promptly notify us of any changes in group practices, including, but not limited to:
  - Practitioners departing from your group practice,
  - Practitioners joining your group practice,
  - Service, mailing or financial address,
  - Practice ownership, including a change in Taxpayer Identification Number and/or National Provider Identifier,
  - Telephone number,
  - Business hours,
  - Email address,
  - Practice website URL;
- Promptly notify us of any changes to information reviewed during the credentialing process, including, but not limited to:
  - Licensure or certification, including state licensing board actions on your license,
  - Board certification(s),
  - Hospital privileges,
  - Insurance coverage,
  - New information regarding pending or settled malpractice actions;
- Promptly respond to us regarding member or other inquiries about the accuracy of your practice information, including, but not limited to, the

information listed above. Failure to respond to inquiries regarding the accuracy of your information may impact your network participation status;

- See the Magellan Organizational and Facility Provider Supplement to this Provider Handbook for submitting changes in facility/organizational information;
- Contact your Magellan field network coordinator or area contract manager if the change may require a contract amendment before you can initiate or bill for services;
- Update and maintain your Provider Profile information (enables you to enhance your profile that members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.);
- Each time you make any changes noted above using our online provider portal or in response to any request from Magellan, it is important to attest that your data is current and accurate. Even if you have no changes, *Magellan requires that you review your practice information and attest that your information is correct, including appointment availability, at least quarterly.* Failure to update administrative practice information may impact your network participation status; and
- You may request removal or suppression from provider directories if you wish to receive referrals but do not want your name and contact information published in directories. Contact your Magellan field network coordinator or area contract manager to discuss. You will be asked to provide a written request to Magellan containing your NPI, location, and a detailed reason for requesting removal from a provider directory.

What Magellan Will Do

Magellan's responsibility for provider data changes is to:

- Maintain an online portal for providers to update information, with no additional verification requirements, except for clarification or if a new service may require a contract amendment;
- Contact you for clarification, if needed;
- Notify you when Magellan members tell us that they believe your provider data is outdated or otherwise incorrect;
- Monitor and follow up on the completion of required quarterly provider data accuracy attestations; and
- Notify you if your change in information impacts your referral and/or network participation status.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Contracting with Magellan

Our Philosophy

Magellan's provider agreements protect members, providers, and Magellan by defining:

- The rights and responsibilities of the parties;
- The application of Magellan's policies and procedures to services rendered to members;
- The programs/services available to members;
- The provider network for member use; and
- The reimbursement for covered services.

Depending on a provider's type of practice and location, Magellan will issue a provider agreement with applicable addenda and exhibits.

Our Policy

Magellan network providers are required to have an executed Magellan provider agreement in order to bill Magellan for the provision of covered services. An additional attestation or amendment may be required to provide specific services (e.g., transcranial magnetic stimulation [TMS], office-based opioid treatment [OBOT], etc.). Providing or billing for services in any of these situations should NOT commence until you have notified Network staff and received confirmation that Magellan has received and processed all required documentation.

Magellan does not allow sub-contracting or sub-delegation of the provider agreement.

What You Need to Do

Your responsibility is to:

- Read, understand and sign a Magellan provider agreement;
- Return your signed provider agreement and any attestations, amendments, and/or addenda required for specific services to Magellan for contract execution, which may be via electronic signature;
- Comply with the terms of the Magellan provider agreement, including the policies and procedures contained within this handbook and applicable supplements;
- Honor reimbursement provisions for covered services rendered to members;
- Not sub-contract or sub-delegate your provider agreement;

- Accept your Magellan contracted rates for services rendered on an ad hoc basis to Magellan members with plans for which you are *not* contracted;
- Not bill members for covered services other than for copayments or coinsurance, as outlined in the benefit plan, i.e., no "balance billing;" and
- Adhere to the termination notification period as specified in the provider agreement, if necessary.

What Magellan Will Do

Magellan's responsibility is to:

- Submit a Magellan provider agreement to providers identified for participation in the Magellan provider network;
- Indicate our customers, products or plans covered by the agreement based on the reimbursement schedules provided; and
- Execute the agreement (and attestations, amendments, and/or addenda, when applicable) after it has been signed and returned by the provider, and the provider has successfully met contractual requirements. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Service Delivery by Non-Licensed or Non-Credentialed Providers

Our Philosophy

As a matter of value and quality, we promise our customers that only licensed providers that meet Magellan's credentialing and contracting standards will deliver services to benefit-eligible members.

Our Policy

Participating providers are prohibited from allowing interns, non-licensed and/or non-credentialed staff members to treat or be a rendering service provider to any Magellan member. Magellan does not allow "incident-to" billing. The term "incident-to" is a Medicare-specific term; "incident-to" billing may not be used for services rendered to Medicare Advantage members with benefits managed by Magellan.

What You Need to Do

Your responsibility is to:

- Understand your obligations and comply with the terms of your Magellan provider agreement;
- Refrain from allowing interns, non-licensed or non-credentialed staff to deliver services to our members unless otherwise authorized; and
- See the *Appendix: Frequently Asked Questions* for further information about credentialing and contracting with Magellan.

What Magellan Will Do

Magellan's responsibility is to:

- Communicate our expectations to you that only fully credentialed participating providers may deliver service to our members; and
- Review treatment records to confirm compliance.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Business Associate Agreement

Our Philosophy	Magellan network providers are not "business associates," as defined by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the accompanying regulations.
Our Policy	Network providers do not need business associate agreements with us.
What You Need to Do	For Magellan providers rendering behavioral healthcare services to our members, no action is required.
What Magellan Will Do	Magellan will not issue business associate agreements to providers in our network for rendering behavioral healthcare services to our members.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Appealing Decisions That Affect Network Participation Status

Our Philosophy

Participating providers have a right to appeal Magellan actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network. Customer requirements and applicable federal and state laws may impact the appeals process; therefore, we outline the process for provider appeals in the written notification that details the changes in a provider's participation status.

Our Policy

Magellan offers participating providers an opportunity for a formal appeal hearing when Magellan takes action to terminate network participation due to quality concerns. Providers receive written notice of the action. Notification includes: the reason(s) for the action, the right to request an appeal, the process to initiate a request for appeal, summary of the appeal process and the appropriate timeframe to submit the request. Providers may participate in the appeal hearing and may be represented by an attorney or another person of the provider's choice. Providers are notified in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing. Specifics of the appeal and notification processes are subject to customer, state or federal requirements.

Professional providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid, or other federal healthcare programs, or appearance on the CMS Preclusion List, are offered an internal administrative review unless otherwise required by customer, state or federal requirements.

Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to request an internal administrative review and the appropriate timeframe to submit the request. The provider is notified in writing of the outcome within 30 calendar days of the administrative review.

What You Need to Do

Your responsibility is to:

- Follow the instructions outlined in the notification letter if you wish to appeal a change in the conditions of your participation based on a quality review determination.

What Magellan Will Do

Magellan's responsibility is to:

- Notify you in a timely manner of the determination that your participation is changed due to issues of quality of care or service;
- Consider any appeals submitted in accordance with the instructions outlined in the notification letter, subject to applicable accreditation and/or federal or state law; and
- Notify you in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing.

SECTION 2: MAGELLAN'S BEHAVIORAL HEALTH NETWORK

Contract Termination

Our Philosophy

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

Our Policy

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

- Provider advocating on behalf of a member;
- Provider filing a complaint against Magellan;
- Provider appealing a decision of Magellan; or
- Provider requesting a review of or challenging a termination decision of Magellan.

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

- Failure to submit materials for recredentialing within required timeframes;
- Suspension, loss, or other state board actions on licensure;
- Provider exclusion from participation in federally or state-funded healthcare programs or appearance on the CMS Preclusion List;
- Quality of care or quality of service concerns as determined by Magellan;
- Failure to meet or maintain Magellan's credentialing criteria;
- Provider-initiated termination; or
- No current business need within the provider's geographic area, subject to applicable state and federal law.

What You Need to Do

Your responsibility is to:

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

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

- Submit your notice of termination in writing, in accordance with the terms of your provider agreement, to:

  Magellan Healthcare
  Attn: Network Operations
  P.O. Box 1899
  Maryland Heights, MO 63043
  Fax 1-888-656-0429
- Group provider practices shall immediately notify Magellan, in writing, in the event that a healthcare professional ceases to be affiliated with the provider group for any reason. The group practice must ensure that members under the care of the terminating practitioner are transferred to another group member who is credentialed with Magellan.
- If you are a group member practicing under a group agreement and terminate your affiliation with the group, Magellan expects you to facilitate transition of members in your care to another group member who is credentialed with Magellan; and
- If you are an individual provider, and Magellan agrees that continuation of treatment is necessary for the member to continue to receive care through the current period of active treatment or for 90 calendar days, whichever is less, you must comply with the following:
  - Accept your current reimbursement schedule as payment in full and not balance bill the member,
  - Continue treatment for an appropriate period of time (based on transition plan goals),
  - Adhere to Magellan's quality assurance utilization review requirements and provide Magellan with the necessary medical information related to the member's care, and
  - Adhere to Magellan's policies and procedures, including, but not limited to, procedures regarding referrals, obtaining preauthorization and submitting treatment plans approved by Magellan.

What Magellan Will Do

Magellan's responsibility is to:

- Respect your right to advocate on behalf of members;
- Not terminate your contract for advocating on behalf of members, filing a complaint, appealing a decision, or requesting a review of or challenging a termination decision of Magellan;
- Notify you when recredentialing materials must be submitted and monitor your compliance;
- Communicate quality concerns and complaints received from members;

- Notify you of the reason for contract termination and your appeal rights, as applicable, if your contract is terminated; and
- Notify members in your care and facilitate care transition plans if your contract is terminated.

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

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Care Management Overview

Our Philosophy

Magellan's care management process centers on member needs, as we partner with our members and their providers during the member's journey to wellness. Magellan care managers connect with members in advance and during acute phases of need to make sure members receive appropriate care and services in a timely manner and experience desirable treatment outcomes.

Our Policy

Care management services actively facilitate referrals and provide outreach to assist members with accessing services, coordinating care, and/or transitioning care. We educate and assist members in optimizing their benefits to meet their behavioral healthcare needs. Employees who conduct benefit certification, appeal and dispute processes are not rewarded or offered incentives to encourage non-certification/non-authorization or under-utilization of behavioral healthcare services. We do not pay incentives to providers to reduce or forego the provision of clinically necessary care.

What You Need to Do

Your responsibility is to:

- Comply with the member's insurance benefit certification requirements (the synonymous term is authorization) before initiating services. In most cases, this requirement excludes clinically necessary emergency services and most traditional outpatient behavioral healthcare. Depending on member benefits, this requirement may include specialized services such as psychological testing, electroconvulsive therapy, transcranial magnetic stimulation and higher levels of care such as intensive outpatient (IOP), residential, or inpatient admission and requests for additional bed days;
- Contact Magellan at the number on the member's benefit card or online at www.MagellanProvider.com (or the sites of Magellan's contracted vendors, as directed) to request benefit certification when required prior to delivery of services;
- When you assess a member at risk for higher levels of care, contact Magellan to enroll the member in our care management services; and
- Encourage members to be in touch with their Magellan care management and/or peer support staff during acute phases of care delivery.

What Magellan Will Do

Magellan's responsibility is to:

- Accept referrals for members at risk of admission to higher level of care, as well as outreach to enroll members in care management services in a timely manner, coordinating with the referring provider;

- Provide timely access to appropriate staff;
- Conduct the benefit certification process with the least amount of intrusion into the care experience;
- Process benefit certifications from the initial request to notifying the requesting provider of the benefit certification determination, or appeal or dispute decision, in accordance with the requirements, allowances and limitations of the member's benefit plan;
- Base benefit certification determinations, or appeal or dispute decisions, on approved clinical criteria such as Magellan's Care Guidelines or other customer-required clinical criteria, and existence of coverage; and
- Require Magellan employees to attend company compliance training regarding Magellan's policy of disallowing incentives for non-certification/non-authorization or under-utilization of services.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Before Services Begin

Our Philosophy

When members contact Magellan for a referral, our philosophy is to direct them to practitioners who best fit their needs and preferences, including provider location, service hours, specialties, spoken language(s), gender and cultural considerations.

Our Policy

Our policy is to offer several provider options for the member to select, and/or refer members to providers who best fit their needs and preferences. We also confirm member eligibility and help to optimize the use of behavioral health insurance benefits.

What You Need to Do

Your responsibility is to:

- Obtain benefit certification by signing in to our secure provider portal (or the sites of Magellan's contracted vendors, as directed), or call Magellan using the number on the back of the member's benefit card to determine member eligibility and obtain authorization for requested services before rendering care to a referred member, when required by the member's benefit plan;
- View your authorizations (synonymous with certifications), if required by the member's plan, on our provider portal (or the sites of Magellan's contracted vendors, as directed);
- Contact Magellan as soon as possible following the delivery of emergency services to certify admission to inpatient care or to initiate ambulatory services;
- *Contact Magellan at least one day before the end of the period of time covered by the current benefit certification* when additional treatment time may be needed for members in an inpatient setting or in an intermediate ambulatory service (e.g., partial hospitalization, intensive outpatient);
- Contact Magellan if, during the course of treatment, you determine that services other than those authorized are required, or if you believe the member to be at risk for admission to a higher level of care and want to refer the member for care management services;
- Be prepared to provide Magellan with a thorough assessment of the member, for members presenting for services other than routine outpatient care, including but not limited to the following:
    - Symptoms,
    - Precipitating event(s),

  - Potential for risk, such as harm to self or others,
  - Level of functioning and degree of impairment (as applicable),
  - Clinical history, including medical, behavioral health and alcohol and other drug conditions or treatments,
  - Current medications,
  - Plan of care, and
  - Anticipated discharge date and discharge plan (as appropriate).
- Be aware that certain non-routine outpatient services, such as psychological testing, transcranial magnetic stimulation and psychotherapy for crisis, may require authorization.

What Magellan Will Do

Magellan's responsibility is to:

- Actively assist with securing appointments for members needing emergent or urgent care. *Note: those needing emergent care are referred to network facility providers as appropriate*;
- Arrange timely outreach to members for care management referrals and coordination with referring providers on the status of referrals;
- Notify and coordinate with treating providers for all members enrolled in care management;
- Identify appropriate referrals based on information submitted by our providers through the credentialing process;
- Make benefit certification determinations based upon the information provided by the member and/or the provider during the benefit certification process;
- Include the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the benefit certification determination information;
- Communicate the benefit certification determination (when necessary) by telephone, online and/or in writing to you as required by regulation and/or contract.

  Note: while most certification/authorization approval notices will only be communicated online, denial notices and other legally mandated correspondence is sent via U.S. Mail and/or fax (where applicable); and
- Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested level of care based on clinical criteria.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

The Appropriate Level of Care

Our Philosophy

Magellan believes that the member should be treated in the most supportive, most integrative and least restrictive level of care necessary to improve their health.

Our Policy

Magellan Care Guidelines are applied to requests for authorization to ensure the level of care requested is supported by the clinical information provided.

What You Need to Do

Your responsibility is to:

- Review and be familiar with the Magellan Care Guidelines *(See Section 3: Magellan Care Guidelines for additional information)*;
- Apply your understanding of the level of care definitions to the member's clinical presentation when making a referral to or providing a level of care;
- Understand that referral to any level of care generally will not receive authorization if the patient's needs are primarily custodial, recreational or respite; and
- Be aware that all levels of care guidelines are available at your request.

What Magellan Will Do

Magellan's responsibility is to:

- Apply the appropriate Magellan Care Guideline to the request to ensure the level of care is medically necessary;
- Promptly review your completed request in accordance with applicable federal, state and contractual requirements;
- Respond in a timely manner to your request;
- Call you directly if further information is needed; and
- Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested level of care based on clinical criteria.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Psychological Testing

Our Philosophy

Magellan's philosophy is that treatment should be rendered at the most appropriate, least intensive level of care necessary to provide safe and effective treatment that meets the individual member's biopsychosocial needs. Psychological testing is authorized when it meets the criteria of Magellan Care Guidelines. Psychological testing is not a routine outpatient service, and therefore, requires a precertification review under most benefit plans.

Our Policy

Our policy is to authorize psychological testing when the clinical interview alone is not sufficient to determine an appropriate diagnosis and treatment plan.

What You Need to Do

Your responsibility is to:

- Conduct a complete member assessment;
- Be familiar with Magellan's Care Guidelines for psychological testing; and
- Request prior authorization online at www.MagellanProvider.com (or the sites of Magellan's contracted vendors, as directed) or by fax/mail to the Magellan care management center with which you customarily work.

What Magellan Will Do

Magellan's responsibility is to:

- Promptly review your completed request in accordance with applicable federal and state regulations;
- Respond in a timely manner to your request;
- Call you directly if further information is needed; and
- Offer you the opportunity and contact information to discuss the determination with a Magellan peer reviewer if we are unable to authorize the requested testing based on clinical criteria.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Options After an Adverse Benefit Determination

Our Philosophy

We support the most appropriate services to improve healthcare outcomes for individuals and families whose benefits we manage.

Our Policy

Options to request a redetermination of an adverse benefit determination are given to the member and the requesting provider by telephone and/or in writing. The type of insurance and applicable government regulations define available options and processes.

What You Need to Do

If you disagree with an adverse benefit determination, you may:

- Promptly initiate a dispute (called an appeal, grievance or dispute depending on the type of insurance and/or regulatory requirements); or
- Act promptly on behalf of the member and invoke the member's appeal rights if permitted by state or federal law, or health plan type. The member's permission may be required *(Exception – In expedited cases, a healthcare professional with knowledge of the member's condition is permitted to act as the member's authorized representative as governed by insurance type and/or regulation)*;
- For adverse benefit determinations involving a Medicare Advantage enrollee, an additional option of "reopening" will be applied, when meeting the reopening criteria;
- Clearly identify which redetermination option you are requesting: a dispute or invoking member rights to appeal; and
- Be readily available and have documentation relative to an adverse determination to support the reversal discussion with a peer reviewer.

What Magellan Will Do

Magellan's responsibility is to:

- Offer you the decision rationale if we are unable to authorize the requested level of care or quantity of care based on clinical criteria;
- Promptly process your request to discuss, dispute or invoke the insured's right to appeal;
- Respond in a timely manner verbally, online and/or in writing to your request;
- Call you directly if additional clinical information is needed; and
- Notify you of the adverse benefit determination dispute or appeal outcome, including additional options available to you as the requesting and/or treating provider.

Magellan HEALTHCARE℠

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Member Access to Care

Our Philosophy

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

Our Policy

Our Access to Care standards enable members to obtain behavioral health services from an in-network provider within a timeframe that reflects the clinical urgency of their situation.

What You Need to Do

Your responsibility is to:

- Provide access to services 24 hours a day, seven days a week;
- Inform members of how to proceed if 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, email and other communication messages from Magellan and/or members in a timely manner;
- Consistently adhere to the following Access to Care standards:

Behavioral health service (Non-Medicare Advantage members)	Timeliness standard
Provide **emergency services** when necessary to evaluate or stabilize a potentially life-threatening situation	Immediately
Provide services in **an emergent situation that is *not* life-threatening** but has the potential to deteriorate quickly if services are not provided	Within 6 hours of referral from Magellan
Provide services in an **urgent clinical situation**	Within 48 hours of referral from Magellan, or within 24 hours if required by a specific customer benefit plan
Provide services for **routine clinical situations**	Within 10 business days of referral
Provide **follow-up services to routine care** (does not include medication management or group therapy)	• Non-prescribers, within 30 days after an initial behavioral health visit • Prescribers, within 90 days after an initial behavioral health visit
Provide **outpatient services**	Within 7 days after the day of a member's discharge from an inpatient stay

Behavioral health service (Medicare Advantage members)	Timeliness standard
Provide **urgently needed** or **emergency services**	Immediately
Provide services that are **not emergency or urgently needed**, **but the member requires medical attention** such as prompt behavioral health intervention or medication refills	Within 7 business days
Provide **routine and preventative care services**	Within 30 business days

- For continuing care, continually assess the urgency of member situations and provide services within the timeframe that meets the clinical urgency;
- Refer members at risk for admission to a higher level of care to Magellan's care management services.
- 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.

What Magellan Will Do

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.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Telehealth Services

Our Philosophy

Members must have timely access to appropriate mental health, substance abuse and/or employee assistance program (EAP) services from an in-network provider 24 hours a day, seven days a week. Telehealth is an acceptable channel to improve access under certain circumstances. During a natural disaster or national/regional crisis, Magellan follows CMS and state guidance.

Our Policy

Magellan defines telehealth as a method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. Telecommunications are the combination of audio and live, interactive video or can be live audio-only as permitted. The Magellan member must have a covered mental health benefit that permits telehealth in order for providers to receive payment for telehealth services.

What You Need to Do

Your responsibility is to:

- Complete Magellan's telehealth services provider attestation if you are interested in providing behavioral health services via telehealth;
- Meet the specific requirements outlined in the telehealth services attestation surrounding the provision of telehealth services, including the ability to provide all telehealth sessions through secure and HIPAA-compliant technology; and
- Direct questions to your Magellan field network representative or call our national Provider Services Line at 1-800-788-4005.
- Educate members on the availability of telehealth services and how to use them.

What Magellan Will Do

Magellan's responsibility is to:

- Answer your questions about the delivery and payment of telehealth services, including proper coding requirements. (See our telehealth web page for additional information.)

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Continuity, Coordination and Collaboration

Our Philosophy

We appreciate the importance of the therapeutic relationship and strongly encourage continuity, collaboration and coordination of care. Whenever a transition of care plan is required, whether the transition is to another outpatient provider or to a higher or lower, less intensive level of care, the transition is designed to allow the member's treatment to continue without disruption whenever possible. We also believe that collaboration and communication among providers participating in a member's healthcare is essential for the delivery of integrated quality care. We believe that engaging Magellan's care management services with members in acute care shortly after admission, and collaborating with facility staff and the member to assist with discharge planning, leads to improved member adherence and outcomes. *(See Section 3: Care Management for additional information.)*

Our Policy

Our commitment to continuity, collaboration and coordination of care is reflected in a number of our policies, including, but not limited to:

- Ambulatory follow-up – This policy requires that members being discharged from an inpatient stay have a follow-up appointment scheduled prior to discharge, and that **the appointment occurs within seven days of the discharge date**.
- Timely and confidential exchange of information – Through this policy, it is our expectation that, with written authorization from the member, you will communicate key clinical information in a timely manner to all other healthcare providers participating in a member's care, including the member's primary care physician (PCP).
- Timely access and follow-up for medication evaluation and management – Through this policy, our expectation is that members receive timely access and regular follow-up for medication management.

Note: While Magellan advocates for transition of care plans that offer the minimum amount of disruption possible, the transition process to or from Magellan is determined by our customers' requirements and applicable state and federal laws.

What You Need to Do

Your responsibility is to:

- Collaborate with our care management and transition of care teams to develop and implement discharge plans, and encourage the member to

speak with Magellan staff prior to the member being discharged from an inpatient setting;

- Cooperate with follow-up verification activities and provide written verification of kept appointments via submission of claims or medical records when requested, subject to applicable federal, state and local confidentiality laws;
- Collaborate with us to establish discharge plans that include a post-discharge scheduled outpatient appointment within seven days of the discharge date;
- Notify us immediately if a member misses a post-discharge appointment;
- Promptly complete and submit a claim for services rendered confirming that the member kept the aftercare appointment;
- Explain to the member the purpose and importance of communicating clinical information with other relevant healthcare providers, including the member's PCP;
- At the initial treatment session, obtain the names and addresses of all relevant healthcare providers involved in the member's care;
- Obtain written authorization from the member to communicate significant clinical information to other relevant providers;
- Subject to applicable law, include the following in the Authorization to Disclose document signed by the member:
    - A specific description of the information to be disclosed,
    - Name of the individual(s), or entity authorized to make the disclosure,
    - Name of the individual(s), or entity to whom the information may be disclosed,
    - An expiration date for the authorization,
    - A statement of the member's right to revoke the authorization, any exceptions to the right to revoke, and instructions on how the member may revoke the authorization,
    - A disclaimer that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected,
    - A signature and date line for the member,
    - If the authorization is signed by the member's authorized representative, a description of the representative's authority to act for the member;
- Upon obtaining appropriate authorization, communicate in writing to the PCP, at a minimum, at the following points in treatment:
    - Initial evaluation,
    - Significant changes in diagnosis, treatment plan or clinical status,

  - After medications are initiated, discontinued or significantly altered, and
  - Termination of treatment;
- Collaborate with primary care and applicable medical practitioners to:
  - Support the appropriate and safe use of psychotropic drugs, especially for children and teens on antipsychotics,
  - Promote annual screening or monitoring with blood glucose, HbA1c and LDL-C tests for individuals of all ages on an antipsychotic for the treatment of a serious mental illness such as schizophrenia; and
- Provide suggestions to Magellan's regional medical or clinical directors on how we can continue to improve the collaboration of care process.

What Magellan Will Do

Magellan's responsibility is to:

- Work with you, the member, and the member's family to make any necessary transition of care as seamless as possible;
- Facilitate timely communication with the member's PCP whenever possible including providing you with the name and address of the member's PCP, if the information is available and the member is unable to do so;
- Solicit your input regarding behavioral health pharmacy benefits and formularies;
- Work with the facility provider's treatment team to arrange for continued care with outpatient providers after discharge;
- Audit medical records to measure compliance with this policy; and
- Actively solicit your input and consider your suggestions for improving the collaboration of care process.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Care Management

Our Philosophy

Our philosophy is that chronic behavioral conditions with or without comorbid or co-occurring medical conditions often yield better overall health outcomes when traditional treatment is supported by personalized ongoing care management. Through Magellan's telephonic and field-based care management programs, health coaches and care managers provide supplemental education, support and telephonic coaching services to our members to help them self-manage their conditions on a day-to-day basis. Our dedicated care managers provide outreach services; refer to additional clinical and community resources; educate members on their behavioral health condition; facilitate coordination of care among all physical health and behavioral health providers; promote adherence to physical health and behavioral health provider treatment plans, including medication adherence and treatment interventions; and are available to respond to questions or requests for documented educational information, coordinating services across all treating providers.

Our Policy

Magellan's policy is to provide educational information, access to and assistance with self-help tools, and telephonic personal care coordination to members identified and enrolled in our care management programs across multiple levels of care. This coordination includes speaking with members in acute care settings. These services are provided in support of, and do not replace, the advice and treatment provided by doctors and behavioral healthcare specialists.

What You Need to Do

Your responsibility is to:

- Become familiar with the program;
- Contact a Magellan care manager by calling the number for mental health services on the member's benefit card if you have questions about the program or an enrolled member whom you are treating, or to refer one of your eligible members to the program;
- Encourage program-eligible members in treatment with you to take advantage of care management services; and
- Respond to outreach and partner with Magellan care managers to coordinate the transition of care and discharge planning when members are admitted to acute care settings.

What Magellan Will Do

Magellan's responsibility is to:

- Notify you when a member you are treating is enrolled in the program;
- Inform you of how Magellan coordinates interventions with treatment plans for individual members;
- Support you in your interactions with members and decisions regarding care and treatment; and
- Monitor clinical outcomes.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Recovery Support Navigation

Our Philosophy

Magellan is committed to evidence-based peer support values and practices, including providing peer support services and employing peer specialists in leadership positions. Peer support is an essential component of a trauma-informed and recovery-oriented system of care. Peer support in mental health- and substance use-serving systems is delivered by people in recovery who are receiving or who have received mental health or substance use services, or by a parent or caregiver of a child who is or who has in the past received services from a child-serving system for mental health related issues.

Our Policy

Magellan utilizes peer support specialists within our model of care, and we support our provider network in delivering evidence-based peer support services.

Recovery Support Navigation, offered by our internal teams of peer support specialists, includes opportunities for individuals to:

- Engage in a one-to-one relationship with their peer support specialist, as applicable by benefit design;
- Learn about and develop a wellness plan and whole health goal; and
- Explore and build recovery capital to sustain their recovery.

Family Support Navigation, facilitated by our internal teams of family support specialists, includes opportunities for families/caregivers to:

- Engage in a relationship with their family support specialist, as applicable by benefit design;
- Fully understand and participate in the treatment process; and
- Recognize strengths and identify wellness, self-management and crisis prevention strategies.

What You Need to Do

Your responsibility is to:

- Become familiar with peer support services in the community and Magellan's Support Navigation program where available;
- Call the number for mental health services on the member's benefit card if you have questions about the program or to suggest the program for one of your eligible members;

- Encourage program-eligible members receiving services from you to take advantage of community-based peer support and Support Navigation services; and
- Support the member's wellness plan and goals.

What Magellan Will Do

Magellan's responsibility is to:

- Provide education and technical assistance to you on peer support services, including through the Magellan Center for Recovery and Resiliency;
- Outreach to members who are eligible for Recovery Support Navigation and Family Support Navigation;
- Facilitate a warm transfer to peer support services in the community when those services are available; and
- Use best practices in peer support including wellness plans to improve member self-sufficiency and community inclusion.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Magellan Care Guidelines

Our Philosophy

Magellan is committed to promoting treatment at the most appropriate, least intensive level of care necessary to provide safe and effective treatment to meet the individual member's biopsychosocial needs. Magellan's care guidelines are applied based on the member's individual needs including, but not limited to, clinical features and available behavioral healthcare services.

Our Policy

Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 28th edition MCG *Guidelines*® for behavioral health services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains for specialty behavioral outpatient services. Magellan also uses American Society of Addiction Medicine (ASAM) criteria for management of substance use services and LOCUS, CALOCUS-CASII and ECSII where required by state or customer contract; and we use applicable National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) for Medicare members. *(See* Section 6: Medicare Beneficiaries *in this handbook for details about the application of care guidelines for Medicare enrollees.)*

All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to determine the medical necessity and clinical appropriateness of services.

Magellan makes the criteria available to providers online at www.MagellanProvider.com, by email in response to requests to MCGGuidelineRequest@MagellanHealth.com, or by hard copy upon request, as permitted by the publisher. *(Call the mental health number on the back of the member's benefit card.)*

What You Need to Do

Your responsibility is to:

- Review and be familiar with care guidelines used by Magellan;
- Keep apprised of Magellan's care guideline implementation dates and care guideline changes via communications posted on www.MagellanProvider.com;

- If you have questions about which Magellan Care Guideline applies to a specific benefit plan, contact the applicable care management center; and
- Submit suggestions for revisions to the Magellan Care Guidelines using the comment form on www.MagellanProvider.com, or by submitting your feedback in writing to the applicable Magellan care management center's medical director.

What Magellan Will Do

Magellan's responsibility is to:

- Make Magellan Care Guidelines available to you free of charge;
- Invite and consider your comments and suggestions for revisions to the Magellan Care Guidelines;
- Conduct a comprehensive annual review of the Magellan Care Guidelines using scientific literature, expert advice from regional provider advisory boards, other committees, and suggestions from the provider and member community;
- Implement updated Magellan Care Guidelines annually. All plans use the most recent version of the Magellan Care Guidelines unless noted in the State/Client-Specific Criteria section on www.MagellanProvider.com *(Note: The NCDs and LCDs may be updated off cycle)*; and
- Monitor use of the Magellan Care Guidelines to make sure they are applied consistently.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Clinical Practice Guidelines

Our Philosophy

To promote the delivery of quality behavioral healthcare to our members, we adopt and make available clinical practice guidelines (CPGs) that serve as an evidence-based framework for practitioners' clinical decision-making in the treatment of our members.

Our Policy

Our policy includes offering our network providers relevant clinical practice guidelines to assist in delivering quality care. The clinical practice guidelines that Magellan adopts or develops are consistent with current scientific evidence and best practices.

What You Need to Do

Your responsibility is to:

- Review and adhere to Magellan's adopted clinical practice guidelines;
- If your clinical judgment leads to a decision that varies from recommendations in a guideline, thoroughly document the reasons in the member's clinical record; and
- Provide the Magellan regional medical director, provider advisory group (PAG) or other stakeholder committees with suggestions for improving our guidelines.

What Magellan Will Do

Magellan's responsibility is to:

- Provide access to Magellan's adopted Clinical Practice Guidelines online at www.MagellanProvider.com, by email in response to requests to CPG@MagellanHealth.com, or by mail upon request, as permitted;
- Provide you with website addresses for obtaining adopted practice guidelines published by other organizations, e.g., the American Psychiatric Association, American Society of Addiction Medicine (ASAM), American Academy of Pediatrics;
- Review each of our practice guidelines for consistency with current published evidence-based medicine and our other policies at least every two years;
- Monitor your adherence to practice guidelines and provide constructive feedback when appropriate;
- Encourage you to submit your suggestions for improving our clinical practice guidelines to your regional medical director; and
- Consider your suggestions for modifications to our guidelines.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

New Technologies

Our Philosophy

We believe it is important to regularly assess innovations in the treatment of behavioral health disorders. These assessments follow industry-standard criteria designed to exclude interventions in the investigational phase, and to make sure that the benefits of well-studied interventions exceed the risk. Just as it is important that we work to enhance each member's care, it is equally important that we do no harm in the process.

Our Policy

Magellan reviews emerging new technologies for assessing and treating behavioral health disorders. The purpose of these organized reviews is to apply consistent, systematic procedures for identification, clinical assessment, and evaluation of proposed improvements and/or new applications of established technologies.

What You Need to Do

Your responsibility is to:

- Understand that Magellan's criteria for rendering determinations on new technologies is as follows:
  - The technology has final approval from government regulatory bodies as appropriate,
  - The scientific evidence is sufficiently definitive to permit conclusions about the technology's effect on health outcomes,
  - The technology is as safe and effective as existing alternative treatments,
  - The technology improves the net health outcome, i.e., provides evidence that the benefits outweigh the risks, and
  - The improvement in health outcome is reliably attainable outside of investigative settings;
- Understand that Magellan does not recommend or endorse the use of experimental and/or investigational treatments; and
- Understand that most health plans contain exclusions of coverage for experimental and/or investigational treatments.

What Magellan Will Do

Magellan's responsibility is to:

- Consider requests to conduct technology assessments on innovative behavioral health treatments;
- Continue to remain current on innovations in the treatment of behavioral health disorders; and
- Conduct technology assessments when indicated.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Provider Websites

Our Philosophy

Magellan is committed to reducing administrative burdens on our providers by offering web-based tools for retrieving and exchanging information.

Our Policy

Magellan's provider website, www.MagellanProvider.com, is our primary site for provider communication, information and business transactions. We may also direct you to Magellan program-specific sites and/or the sites of Magellan's contracted vendors to perform secure online transactions. Magellan continually updates our websites to provide easy access to information and greater convenience and speed in exchanging information with Magellan. We encourage you to use provider portals often as self-service tools for supporting your behavioral health practice. We require your use of our online tools to enter and maintain the accuracy of your provider practice data.

What You Need to Do

To realize the benefits of the provider website(s), you should:

- Have access to a computer, internet service provider, and current web browser software;
- Sign in to Magellan's website and the sites of our contracted vendors to access secure applications (e.g., eligibility, authorizations and claims) using secure usernames and passwords*;
- Click applicable links (e.g., *Forgot Password* or *Forgot Username*) if you need to retrieve your sign-in information;
- Visit MagellanProvider.com and the sites of our contracted vendors frequently to take advantage of new capabilities and access resources; and
- Provide us with feedback on any difficulties you may experience in using our online resources or on ideas you have for enhancements.

**For group practices, the first individual to sign in will be designated "Group Administrator." The group administrator is responsible for providing access to Magellan online services to appropriate group practitioners.*

What Magellan Will Do

Magellan's responsibility is to:

- Maintain operation of online services 24 hours a day, seven days a week;
- Inform users of service problems if they occur;
- Use your feedback to continually improve our website capabilities;

- Contingent upon Magellan customer approval and availability of information, provide online access to the following functionality via a Magellan website and/or an external contracted vendor's portal:
    - Member eligibility inquiry,
    - Request for initial and subsequent outpatient authorization (when required by the member's benefit plan),
    - Request for initial authorization of inpatient, partial hospitalization and residential services,
    - Authorization inquiry and reports,
    - Authorization approval letters,
    - Claims submission (for professional services only for which Magellan is the designated claims payer),
    - Claims inquiry and online explanation of payment (EOP),
    - Request to join the Magellan network,
    - Check network participation status,
    - Edit practice information (monitor and ensure the accuracy of your practice data – including appointment availability and staff rosters – and change your TIN using electronic Form W-9),
    - Provider Profile (enhance your profile, which members see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.),
    - Electronic funds transfer (EFT) signup, and
    - Other tools and information beneficial to providers serving Magellan members.

SECTION 4: THE QUALITY PARTNERSHIP

A Commitment to Quality

Our Philosophy

Magellan is committed to a culture of Continuous Quality Improvement (CQI), which is at the core of our mission to deliver the highest standards of care and service. Our company-wide commitment to quality and outcomes is designed to rigorously assess, plan, measure, and re-evaluate critical aspects of our operations. Our comprehensive quality approach ensures that every facet of our care delivery is continuously refined to meet and exceed industry benchmarks.

Our Policy

In support of our commitment to quality excellence, providers play a crucial role as key partners in our continuous improvement efforts. It is essential that providers are well-acquainted with our guidelines and standards, applying them consistently in their clinical work to ensure care that is safe, effective, member-centered, timely, efficient and equitable. By doing so, we collectively deliver care that upholds the highest standards of quality and is culturally sensitive to the diverse needs of our members.

What You Need to Do

Your responsibility is to:

- Adhere to policies by following the procedures outlined in the "What You Need to Do" sections of this handbook;
- Obtain member authorization to collaborate with medical providers for better management of coexisting medical and behavioral conditions;
- Participate in quality improvement activities, including performance measurement data collection and clinical and service quality improvement efforts;
- Address and resolve member and provider complaints promptly;
- Maintain provider directory accuracy by keeping your provider directory information up to date, including office location, contact details, specialty, affiliations, certifications, languages spoken, and availability for new members;
- Meet treatment record standards as detailed in the Treatment Record Review Tool in the handbook Appendix;
- Comply with quality-of-care standards by providing treatment records as requested, adhering to clinical practice guidelines, and complying with NCQA's HEDIS® measures;
- Engage in reviews by participating in treatment plan reviews, site visits, and other quality improvement initiatives;
- Implement evidence-based best practices in your clinical work;

- Uphold the principles of member safety in all aspects of care;
- Attend or log into Magellan's provider training and orientation sessions;
- Participate in creating and implementing correction plans if quality of care concerns arise;
- Promote the use of standardized outcome tools, such as the CAGE, at intake and during treatment, and review reports with members;
- Use secure technology to enhance member access to services (e.g., email, electronic scheduling, telehealth, reminders, electronic referrals, and online health records);
- Assist with care transitions if a member's benefits are exhausted, if you leave the network, or if a member's provider exits the network;
- Help investigate member complaints and adverse incidents;
- Engage in committee participation by attending quality committees and provider advisory group meetings, if requested;
- Review member-specific clinical reports when available;
- Complete and return provider satisfaction and member experience of care surveys; and
- Be knowledgeable in quality improvement methods and tools, including HEDIS® measures.

What Magellan Will Do

Magellan's responsibility is to:

- Consider your feedback on clinical practice guidelines, prevention/ screening programs, member safety policies and new technology assessments;
- Encourage committee collaboration by including your input in quality committees and provider advisory groups;
- Develop methods to compare treatments, outcomes, and costs across the provider network to reduce the need for case-by-case care reviews;
- Provide data on individual provider performance, care management, clinical outcomes, and other metrics to providers, members, and stakeholders;
- Offer outcome assessment tools and reports for member use, when available;
- Facilitate peer-to-peer discussions upon request;
- Monitor and address provider satisfaction with policies and procedures that affect your practice;
- Ensure that claims are paid within applicable timeframes;
- Support site visit preparation by providing detailed information on how your practice will be assessed during site visits and treatment record reviews;

- Collaborate on remediation by working with you to develop and implement clear correction plans to improve quality of care when necessary;
- Provide timely decisions on credentialing and recredentialing processes; and
- Resolve complaints and appeals within appropriate timeframes.

SECTION 4: THE QUALITY PARTNERSHIP

Health Equity and Cultural Sensitivity

Our Philosophy

Magellan is committed to maintaining a strong health equity and cultural sensitivity program that provides effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices and that advance health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. All people entering the behavioral healthcare system must receive equitable, inclusive and effective treatment in a respectful manner. Populations in need include people:

1) With limited English proficiency or reading skills;
2) Of an ethnic, cultural, racial, or religious minority;
3) With disabilities;
4) Who identify as lesbian, gay, bisexual, or other diverse sexual orientations;
5) Who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex;
6) Who live in rural areas and other areas with high levels of deprivation; and
7) Otherwise adversely affected by persistent poverty or inequality.

Magellan also understands the value of a culturally competent workforce, inclusive of those living with disabilities.

Our Policy

Magellan staff is trained on cultural competency, bias and inclusion, and sensitivity in order to connect members with providers who are most appropriate to their needs and preferences. Magellan also provides online resources to help providers enhance their provision of high-quality, culturally appropriate services. Magellan continually assesses provider network composition by actively recruiting, developing, retaining, and monitoring a diverse provider network compatible with the member population.

What You Need to Do

Your responsibility is to:

- Provide Magellan with information on languages you speak;
- Provide Magellan with information about your practice specialties, including those developed to address the needs of diverse communities, broadly defined;

- Provide Magellan members with access to care regardless of the member's culture, race, age, gender, sexual orientation, socioeconomic status, family status, ethnic background, religion or disability;
- Provide information to Magellan members about resources such as 711 relay, TTY/TDD services, and/or translation services; and
- Review the cultural competency provider resources on the Magellan provider website.

What Magellan Will Do

Magellan's responsibility is to:

- Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions, gender identifications and those living with disabilities;
- Offer and provide language assistance services, including bilingual staff and interpreter services at no cost to any member with limited English proficiency at all points of contact, in a timely manner during all hours of operation.;
- Make available easily understood member-related materials, including education on complaint and appeal resolution materials, in the languages of the commonly encountered groups and/or groups represented in the service area.
- Develop and maintain procedures to identify and offer digital health education to member with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits.
- Provide access to 711 relay services for the deaf community and those with hearing impairment;
- Monitor gaps in services and other cultural, ethnic, racial and linguistic provider service needs. When gaps are identified, Magellan will develop a provider recruitment plan and monitor its effectiveness;
- Promote diversity in recruiting and hiring within Magellan; and
- Foster a diverse, equitable and inclusive workforce.

SECTION 4: THE QUALITY PARTNERSHIP

Member Safety

Our Philosophy

Magellan believes in the delivery of high-quality, safe behavioral healthcare services. We reinforce this commitment by embedding objective and systematic monitoring mechanisms into our policies and procedures.

Our Policy

Magellan monitors the safety of members receiving treatment from our providers. Monitoring includes, but is not limited to, member feedback, performance indicator reviews, site visits, treatment record reviews and surveys.

What You Need to Do

Your responsibility is to:

- Have a written member safety plan based on member needs and circumstances, including consideration of the member's culture;
- Enhance and monitor the safety of members as related to their treatment while in your care;
- Be familiar with Magellan clinical guidelines related to member safety and use them in treatment decisions and management;
- Be familiar with activities encouraged by Magellan as stated in the Patient Safety Activity Survey to promote safe and effective coordination and transition of care;
- Communicate to Magellan your plan and outcomes related to member safety when requested; and
- Complete the annual Patient Safety Activity Survey when requested.

What Magellan Will Do

Magellan's responsibility is to:

- Provide information about the data being requested and the rationale, methods and standards employed in the review process;
- Work closely with you to improve performance on indicators that are below standard; and
- Communicate the results of member safety monitoring to our providers, customers and members.

SECTION 4: THE QUALITY PARTNERSHIP

Accreditation

Our Philosophy

Excellence in clinical care and service can be affirmed through recognition by national accrediting bodies, such as the National Committee for Quality Assurance (NCQA) and URAC.

Our Policy

Our policies, procedures and quality initiatives are guided by both NCQA and URAC national accreditation standards, including, but not limited to:

- Provider accessibility standards;
- Site visits and treatment record reviews;
- Credentialing and recredentialing requirements;
- Clinical practice guidelines;
- Collaboration and coordination of care;
- Care management and case management review processes;
- Prevention/screening programs;
- Member experience (satisfaction) surveys;
- Member safety policies and initiatives;
- Complaint, appeal and grievance policies and procedures;
- Confidentiality policies and procedures;
- Medical integration and coordination policies and procedures;
- Provider quality remediation and review;
- Member communication, including distribution of the Members' Rights and Responsibilities statement;
- Provider participation and/or input on our quality improvement committees and activities;
- Quality improvement and care management program descriptions and evaluations;
- Member requests to change providers and transition of care tracking; and
- Claim and encounter verification elements for annual HEDIS® reporting.

What You Need to Do

Your responsibility is to:

- Follow the policies and procedures outlined in this handbook; and
- Collaborate/cooperate with quality improvement activities and initiatives.

What Magellan Will Do	Magellan's responsibility is to: • Advise you of our policies and procedures; • Inform you of our accreditation results and any opportunities for improvement that may affect our providers; and • Inform you when changes in specific accrediting bodies' standards will impact provider practice.

SECTION 4: THE QUALITY PARTNERSHIP

HEDIS® and Performance Measurement

Our Philosophy

We support and promote the use of evidence-based performance measures that help drive the adoption of recommended care and improvements in population health. HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is owned by the National Committee for Quality Assurance (NCQA, www.ncqa.org). HEDIS comprises the most widely used measure set driving healthcare quality rating systems, as well as individual measures that are increasingly used by employers, health plans and government agencies to drive pay-for-performance quality programs. The number of HEDIS measures related to the management of behavioral health disorders treatment has increased since the inception of HEDIS.

Measures that are dependent on accurate claims submission from behavioral health providers to determine eligibility and/or compliance include:

- *Follow-Up After Hospitalization for Mental Illness (FUH),*
- *Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM),*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) (must be a practitioner with prescribing authority),*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET),*
- *Follow-Up After Emergency Department Visit for Substance Use (FUA),* and
- *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI).*

Additional measures triggered by at least one medication fill, requiring patient adherence to the medication for a defined period of time, and/or recommended monitoring/testing include:

- *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA),*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM),*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD),*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD),* and
- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC).*

A third group of measures impacting behavioral health providers and not listed above include:

- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP),*
- *Pharmacotherapy for Opioid Use Disorder (POD),*
- *Diagnosed Mental Health Disorders (DMH),*
- *Diagnosed Substance Use Disorders (DSU),*
- *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E),*
- *Depression Remission or Response for Adolescents and Adults (DRR-E),* and
- *Unhealthy Alcohol Use Screening and Follow-Up (ASF-E).*

Many HEDIS measures require collaboration with the primary care provider. *(See Section 3 of this handbook – Continuity, Coordination and Collaboration.)*

Our Policy

Provider participation in HEDIS-related data collection for identified members is mandatory. **Magellan's network providers are contractually required to submit claims in a timely manner.** We must have this documentation so that we fulfill our state and federal regulatory and accreditation obligations, and obtain the most accurate data reporting possible.

What You Need to Dos

Your responsibility is to:

- See members either in-person or via telehealth (when this is a covered method of service):
  - Within seven days after the day of discharge from an inpatient stay related to mental health or discharge from an acute inpatient admission, residential treatment, or withdrawal management visit for a substance use disorder,
  - Within 14 days after a new diagnosis of a member with substance use disorder,
  - Within 30 days of a newly prescribed ADHD medication with a practitioner with prescribing authority, or
  - Within seven days after discharge from an emergency department with either a mental illness or substance abuse disorder;
- Collaborate with Magellan staff to coordinate care for members, including:

  - See your existing members recently discharged from an inpatient setting within the timeframes listed above,
  - Respond in a timely manner to requests from Magellan to see new members discharging from an inpatient setting by indicating your availability, if any, or
  - Assist by referring members and Magellan staff to your other in-network practice clinicians if they have availability;
- Coordinate needed lab tests to monitor members (including children and adolescents) prescribed antipsychotic medications; and
- Submit your claims in a timely manner for all services provided (within 30 days of the encounter).

What Magellan Will Do

Magellan's responsibility is to:

- Assist facilities and members to coordinate post-hospitalization aftercare with lower levels of care or outpatient providers;
- Collect and communicate all discharge information if provided by the inpatient facility;
- Provide education and information as needed and requested regarding HEDIS and other performance measures for which we request your cooperation and assistance;
- Share performance data on your adherence to the guidelines above, as it is available; and
- Collect and submit required HEDIS and other performance measurement data according to population, product line and service areas to health plans that report to NCQA and/or state and/or federal entities to meet contract requirements.

SECTION 4: THE QUALITY PARTNERSHIP

Prevention/Screening Programs

Our Philosophy

Reducing the occurrence and severity of substance use and mental disorders, detecting them early in their course, and providing appropriate, high-quality treatment are the goals of our prevention/screening programs. In support of this philosophy, we have developed and implemented prevention/screening programs that are designed to sustain, quickly restore, or enhance that wellbeing. These programs include, but are not limited to:

- Depression Screening Program using the Patient Health Questionnaire-9 (PHQ-9);
- Depression and Co-existing Substance Abuse Screening Program using PHQ-9, CAGE and or AUDIT-C tools;
- Screening Members with Significant Medical Issues for Depression using the PHQ-9 tool;
- Autism Spectrum Disorders Co-Morbid Depression Screening Program for adolescent members seeking ABA treatment using the Whooley Depression, PHQ-A or Patient Health Questionnaire Two-Item Scale (PHQ-2) tools;
- Trauma and Adverse Childhood Experiences (ACEs) Screening Program;
- Alcohol and Substance Use Screening Program using the CAGE or Audit-C tools;
- Child and Adolescent Needs and Strengths (CANS) Screening Program;
- Columbia Suicide Severity Rating Scale (C-SSRS) Screening Program;
- Behavioral Health and Co-Morbid Substance Use Screening Program using the SmartScreener; and
- Global Appraisal of Individual Needs-Short Screener (GAIN-SS).

Our Policy

We develop prevention/screening programs that improve physical and mental wellbeing, encourage members to seek help early, and overcome stigma. Programs are research-based and developed with the input of healthcare experts. Our care management centers select which programs to implement based on the unique needs of the members in their area.

What You Need to Do

Your responsibility is to:

- Contact the applicable Magellan care management center or our Quality team at HPCOEQuality@MagellanHealth.com to get further information on prevention/screening programs in your region, and to provide input into the development and revision of the programs and interventions;

- Consider participating in the prevention/screening programs (e.g., serving as a consultant, distributing prevention/screening materials in your office, administering screening tools as part of routine care); and
- Practice prevention/screening-minded treatment, e.g., consider the prevention/screening needs in the member's entire family, not just the member presenting for treatment.

What Magellan Will Do

Magellan's responsibility is to:

- Inform you about the prevention/screening programs we offer;
- Advise on how you can participate in our prevention/screening programs;
- Continue to develop and improve our prevention/screening programs;
- Inform you about the effectiveness of our prevention/screening programs; and
- Seek and consider your input on our prevention/screening programs.

SECTION 4: THE QUALITY PARTNERSHIP

Quality Outcomes

Our Philosophy

Measuring service outcomes is a vital aspect of delivering high-quality care, especially when engaging members in their treatment planning. Research consistently shows that providing continuous, measurable feedback to members during treatment leads to better outcomes and higher satisfaction.

Our Policy

Magellan fully endorses and supports the use of evidence-based measurement instruments to enhance the safety and effectiveness of the care and services provided to our members.

What You Need to Do

Your responsibility is to:

- Incorporate SAMHSA or other nationally recognized screening and assessment tools in treatment planning, progress assessment and discharge planning.
- Encourage member participation by motivating members to complete relevant clinical screenings and assessments at intake and periodically throughout treatment, and actively involve them in discussions about the results.
- Promote self-management by empowering members to take an active role in managing their health and wellness.
- Stay informed by regularly reviewing information about outcomes tools available on our website.
- Participate in quality improvement activities, outcomes research and other quality initiatives as requested.

What Magellan Will Do

Magellan's responsibility is to:

- Support evidence-based practices by endorsing and advocating for the use of scientifically sound outcome measurement instruments.
- Measure program effectiveness by conducting quality improvement activities that assess the effectiveness of program interventions in improving outcomes.
- Collaborate on research by partnering with leading universities and institutions on research and outcome studies.
- Communicate clearly by keeping you informed about the purpose and implications of quality studies and outcomes research that may impact your practice.

SECTION 4: THE QUALITY PARTNERSHIP

Outcomes and Reimbursement

Our Philosophy

Magellan believes that provider reimbursement, in addition to market and geographical considerations, should reflect clinical performance and outcomes. The latest clinical research demonstrates that clinicians who use outcomes information in their practice, e.g., measurement-based care, provide more efficient and effective treatment for individuals in their care. We strongly encourage you to incorporate member-reported outcomes and satisfaction into your ongoing practice.

Our Policy

Magellan develops provider reimbursement practices that support the use of evidence-based measurements and produce positive clinical outcomes achieved in the most efficient and effective manner. To promote transparent and collaborative care, we include outcomes, quality process, efficiency, and effectiveness data in the information we may share publicly about our panel of clinicians through ratings in our Provider Search. This information may impact the reimbursement rates and/or quality-related incentives providers receive.

What You Need to Do

Your responsibility is to:

- Encourage your members in care to complete clinical assessment tools you deem appropriate during intake and periodically during the course of treatment, as well as involve them in discussions about findings, as applicable. *Refer to the previous section – Quality Outcomes – for further details.* We may include this aspect of your practice in the information we share about your efficiency and effectiveness as a clinician on our panel. Your use of outcomes tools in your clinical practice may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentive payments we may offer;
- Update and maintain your provider profile information by signing in to MagellanProvider.com or, if directed, via sites of Magellan's contracted vendors. This enables you to enhance your profile, which members see in online provider searches, by uploading your photo and listing your professional awards, etc.;
- Review any dashboard/performance scorecards Magellan may provide to you, to understand your practice patterns with Magellan members and take appropriate actions to identify opportunities for improvement, wherever possible, based on the information presented; and

- Participate in quality studies, outcomes research and other initiatives, as requested. Your participation may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentive payments we may offer.

What Magellan Will Do

Magellan's responsibility is to:

- Endorse and support the use of scientifically sound outcome measurement instruments;
- Offer online tools for you to update your practice information and provider profile which is seen by others who access our online Provider Search;
- Share performance data pertinent to your practice, as available; and
- Develop reimbursement methods that reflect your use of evidence-based practice and achievement of efficient and effective outcomes.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

Our Philosophy

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

Our Policy

We obtain providers' input on our programs and services through provider satisfaction surveys, provider advisory groups, our provider website and through special requests for feedback, such as for our clinical practice guidelines, Magellan Care Guidelines and prevention/screening program development.

Magellan welcomes compliments about our staff members or a positive experience you have had with us. We also welcome suggestions and offer providers the opportunity to file a formal administrative complaint. A formal administrative complaint is defined as: an issue you need to have addressed in order to provide efficient and effective care and services to your clients and our members. Examples of a formal administrative complaint may include dissatisfaction with an administrative process, an interaction with a Magellan staff member, the timeliness of a response to an inquiry regarding credentialing and/or contracting status or process, the timeliness of a response to a general inquiry, or dissatisfaction with website applications. A formal administrative complaint is not a disagreement or dissatisfaction with a particular claim or authorization decision.

What You Need to Do

Your responsibility is to:

- Provide feedback on our clinical practice guidelines, Magellan Care Guidelines, prevention/screening programs, new technology assessments and other guidelines and policies, if requested;
- Complete provider satisfaction surveys, if requested;
- Attend our regional provider advisory group or other committee meetings, if requested;
- Provide feedback on special projects, including research studies, as requested; and
- Provide suggestions, compliments or file a formal administrative complaint by contacting Magellan using any of the following methods:
    - Online through sites of Magellan's contracted vendors (if directed) or the secure messaging function on the Magellan provider website at MagellanProvider.com;

- Call our national Provider Services Line at 1-800-788-4005 and inform them that you would like to file an administrative complaint, and they will direct you to the correct staff member to handle your complaint;
- Call or email the local or regional Network staff you are already familiar with; or
- Write a letter to:

  Magellan Healthcare
  Attn: Provider Administrative Complaints
  P.O. Box 1718
  Maryland Heights, MO 63043

What Magellan Will Do

Magellan's responsibility is to:

- Advise you of the forums available for your feedback;
- Actively request your input in the development and/or update of our policies and procedures;
- Consider your input while developing or reviewing new and established policies, procedures, programs and services; and
- Document all formal administrative complaints in the Magellan complaint system and promptly notify you of actions taken for a satisfactory resolution.

SECTION 4: THE QUALITY PARTNERSHIP

Member Rights and Responsibilities

Our Philosophy

Magellan protects the rights and responsibilities of all members. We are committed to having everyone involved in the delivery of care respect the dignity, worth and privacy of each member.

Our Policy

We have established member rights and responsibilities that promote effective behavioral healthcare delivery and member satisfaction, and that reflect the dignity, worth and privacy needs of each member.

What You Need to Do

Your responsibility is to:

- Review Magellan's Members' Rights and Responsibilities Statement with members in your care at their first appointment (available in the *Appendix* of this handbook);
- Sign and have the member sign the statement and retain a copy in the member's record;
- Give members the opportunity to discuss their rights and responsibilities with you;
- Review with the members in your care information such as:
    - Procedures to follow if a clinical emergency occurs,
    - Fees and payments,
    - Confidentiality scope and limits,
    - Member complaint/grievance process,
    - Treatment options and medication; and
- Obtain members' consent to share information with primary care physicians and other treating providers.

What Magellan Will Do

Magellan's responsibility is to:

- Make the Magellan Members' Rights and Responsibilities Statement available for distribution (See this handbook *Appendix*);
- Provide instructions on how and when to share the statement with members (See "What You Need to Do" above); and
- Make the Members' Rights and Responsibilities statement available in languages and formats that members can understand.

SECTION 4: THE QUALITY PARTNERSHIP

Confidentiality

Our Philosophy

Confidentiality is a key tenet of our operations and processes. To that end, we have developed policies and procedures that serve to protect the privacy of confidential health information that is used or disclosed by Magellan.

Our Policy

Magellan protects access to protected health information (PHI) in the following ways:

- Utilizing strict guidelines for how member PHI may be used and disclosed;
- Requiring all employees to be familiar with the process for responding to any unauthorized uses or disclosures of confidential member PHI;
- Requiring Magellan staff, employees, and consultants to complete training on the Health Insurance Portability and Accountability Act (HIPAA);
- Making sure a HIPAA-compliant Authorization to Use or Disclose Protected Health Information form is on file when required for certain uses or disclosures of member PHI;
- Monitoring member feedback regarding confidentiality through the complaint process, member satisfaction survey results, and internal quality audits;
- Complying with applicable state and federal laws and accrediting organization standards regarding privacy requirements;
- Establishing proper mechanisms for timely and appropriate responses to member rights issues, including but not limited to, member requests for confidential communications, access to PHI, amendments to PHI, and accounting of disclosures of PHI;
- Implementing technical barriers to systems by requiring authorization and passwords to access systems containing confidential information; and
- Requiring the minimum necessary information for routine uses and disclosures of health information.

What You Need to Do

Your responsibility is to:

- Comply with applicable state and federal laws and regulations that address member privacy and confidentiality of PHI;

- Utilize HIPAA-compliant authorization to use/disclose PHI forms and consent for treatment forms that comply with applicable state and federal laws*;
- Use only secure email (secure messaging) when requesting member PHI;
- Establish office procedures regarding communication of PHI with members (e.g., telephone and cellphone use, and written, fax and internet communication);
- Establish a process that allows members appropriate access to their records in a secure and confidential manner;
- Distribute the Magellan Members' Rights and Responsibilities Statement to members;
- Participate in and comply with Magellan's quality review, site visit process and contract obligations; and
- Report to Magellan any inadvertent access or disclosures of member information received from us in any way, including via fax, email, regular mail or on the Magellan provider portal.

What Magellan Will Do

Magellan's responsibility is to:

- Collaborate with you to protect member privacy and confidentiality;
- Request the minimum necessary PHI to perform needed healthcare operations and payment activities; and
- Only respond to electronic (internet) requests for PHI through secure channels.

SECTION 4: THE QUALITY PARTNERSHIP

Site Visits

Our Philosophy

Magellan conducts site visits with providers to assess the quality of care and services provided, evaluate adherence to policies and procedures, and to support various quality improvement activities.

Our Policy

Magellan conducts site visits at facilities and organizations, and at individual and group practices, to directly assess the physical appearance of the facility/office, adequacy of waiting and treatment room space, physical accessibility, appointment accessibility, staffing, and treatment record-keeping practices. Magellan's Network staff conducts administrative aspects of site reviews, while licensed clinicians and Quality Improvement (QI) staff review specific clinical documents, as needed. Provider site visits may be conducted as part of credentialing for participation in Magellan's network and on other occasions as determined by quality or clinical reviews. Site visits are conducted in-person, while desktop quality reviews can be completed virtually for organizations that have no physical site, e.g., telehealth agencies.

Site visits may include, but not be limited to, a review of the following:

- Routine appointment availability, and procedures for access;
- Availability of care in emergencies and after hours;
- Procedures to maintain confidentiality of member information;
- Procedures for disclosure of member information;
- Physical site environment, including appearance, accessibility, etc.;
- Staff orientation, training and supervision (as appropriate);
- Treatment record-keeping practices;
- Documentation in member records;
- Documentation of contact with PCP (when authorized by the member);
- Verifications of licensed clinical staff credentials and other human resources procedures for direct care staff; and
- Quality improvement and safety management programs.

What You Need to Do

Your responsibility is to:

- Comply with requests for site visits;
- Provide information in a timely manner, including any files and records as requested by the site visit reviewers;
- Be available to answer questions from the reviewers; and

- Participate in developing and implementing a corrective action plan if required.

What Magellan Will Do

Magellan's responsibility is to:

- Advise you in writing if a site visit is required;
- Advise you of what you need to do to prepare for the site visit;
- Notify you of the results of the site visit in a timely manner; and
- Work with you to develop a corrective action plan, if required.

SECTION 4: THE QUALITY PARTNERSHIP

Treatment Record Reviews

Our Philosophy

In support of our commitment to quality care, we request that our providers maintain organized, well-documented member treatment records that reflect continuity of care for members. We expect that all aspects of treatment will be documented in a timely manner, including in-person and telehealth encounters, telephone contacts, clinical findings, and interventions.

Our Policy

Magellan reviews provider treatment records of Magellan members to:

- Monitor documentation and record-keeping practices against Magellan's and other required standards;
- Measure adherence to Magellan-approved clinical practice guidelines and other important aspects of care and service;
- Review potential quality of care concerns;
- Investigate member complaints about a Magellan provider; and
- Evaluate appropriate documentation of services for which claims were submitted.

What You Need to Do

Your responsibility is to:

- Follow the detailed instructions provided if you are selected for a review;
- Make the requested records available for our review*;
- Cooperate with Magellan in developing and carrying out a quality improvement corrective action plan should opportunities for improvement in documentation be identified; and
- With the increasing use of electronic health records, we expect you to develop administrative policies to ensure that you and your staff use this technology appropriately to enhance efficiency in your clinical documentation, while mitigating inappropriate use of other features, such as copy-paste, which may increase the risk of fraud, waste and abuse.

What Magellan Will Do

Magellan's responsibility is to:

- Provide detailed information prior to the review concerning the rationale, methods and standards used in the review process;
- Request the minimum amount of necessary protected health information to perform treatment record reviews;
- Inform you of the results of the treatment record review;

- Request an action plan to correct deficiencies, if required;
- Suggest steps to be taken to improve quality of treatment record documentation;
- Work with you to review a corrective action plan; and
- Perform a follow-up review of treatment records to assure corrective action has been effective in improving your record documentation, if required.

**When the HIPAA Privacy Rule is applicable, it allows Magellan to use and disclose PHI for treatment, payment and healthcare operations activities.*

SECTION 4: THE QUALITY PARTNERSHIP

Member Experience of Care and Services Surveys

Our Philosophy

Supporting member satisfaction, and thus obtaining member input, is an essential component of our quality program. Members' ratings of their experience of care and services comprise one of our core performance measures.

Our Policy

At least once a year, we survey a representative sample of members who have received services to determine their level of satisfaction and experience with Magellan, and with key aspects of the care and/or services received from providers in our network.

What You Need to Do

Your responsibility is to:

- Provide timely, safe, high-quality care and service to members you treat;
- Implement actions identified from satisfaction survey results when informed by Magellan;
- Involve members in their treatment plan;
- Encourage members to provide feedback on the care and services received; and
- Regularly review and update your practice and provider profile information, which members see in online provider searches (see *Updating Practice Information* in this handbook).

What Magellan Will Do

Magellan's responsibility is to:

- Inform you of survey findings and respond to any questions you may have regarding the surveys;
- Use member survey findings to identify opportunities for improvement, maintain the quality of care and service delivered, and develop and implement actions for improving our policies, procedures and services; and
- Make tools available to you online so that you can update your practice information and provider profile.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Satisfaction Surveys

Our Philosophy

Successful collaboration and provider satisfaction are among our core performance measures. Obtaining our network providers' input is vital to our ability to collaborate and is an essential component of our quality program.

Our Policy

Up to once per year, we survey a representative sample of providers who are active in our network to determine their level of satisfaction with Magellan and with key aspects of the service they received from us while assisting our members.

What You Need to Do

Your responsibility is to:

- Complete the survey and return it using any one of the means made available (e.g., postal mail, email, website, text, telephone or facsimile);
- Contact Magellan with any comments, suggestions or questions; and
- Review the *Provider Input* area of this handbook for additional opportunities to share your feedback.

What Magellan Will Do

Magellan's responsibility is to:

- Monitor provider satisfaction with Magellan and Magellan's policies and procedures; and
- Use provider survey findings to maintain the quality of our collaborations, identify opportunities for improvement, and develop and implement actions for improving our policies, procedures and services.

SECTION 4: THE QUALITY PARTNERSHIP

Adverse Outcome Reporting

Our Philosophy

In our quest for our members to receive quality behavioral healthcare services, we routinely review quality of care concerns and adverse outcome occurrences to identify opportunities for improvement.

Our Policy

We initiate a quality of care review for known incidents in which an individual, who is a Magellan member at the time of the incident and who has been in treatment within six months of the incident, has an unexpected (adverse) occurrence in connection with services provided by Magellan, its subsidiaries and affiliates (Magellan), that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to the member receiving services through Magellan or a third party.

What You Need to Do

Your responsibility is to:

- Report within 72 hours (or less where state or federal regulations and/or customer requirements are more stringent) after the incident or upon learning of the incident by contacting the Magellan care management center that initiated the referral;
- Report any of the following types of incidents involving a Magellan-referred member currently in treatment, or a member who was discharged from treatment within 180 days prior to the incident, of:
    - Death,
    - Suicide or serious suicide attempt,
    - An incident of violence initiated by the member,
    - Other incident resulting in serious harm to the member or others, which includes but is not limited to serious complications from a psychotropic medication regimen that required medical intervention; and
- Adhere to these guidelines, as failure to meet the guidelines could result in the need for an action plan or other steps to prevent unreported or untimely reporting of future adverse incidents.

What Magellan Will Do

Magellan's responsibility is to:

- Serve as a resource to manage the clinical situation presented by the adverse incident or potential adverse incident;
- Investigate all adverse incidents in a timely manner, collect information and take appropriate action, which may include notification of

appropriate parties and/or a review of facility/practice safety procedures; and

- Document and review available data surrounding the event to identify potential areas for quality improvement that might prevent similar events in the future.

SECTION 4: THE QUALITY PARTNERSHIP

Inquiry and Review Process

Our Philosophy

Magellan is committed to developing and maintaining a high-quality provider network.

Our Policy

Magellan maintains a process for inquiry, review and action when concerns regarding provider performance are identified.

What You Need to Do

Your responsibility is to:

- Actively participate and cooperate with investigations and resolutions of any identified concerns as a condition of continued participation in the Magellan provider network.

What Magellan Will Do

Magellan's responsibility is to:

- Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised;
- Advise you if an on-site review, treatment record review and/or other type of review is required;
- Review all inquiries for adequate resolution of any performance concerns;
- Advise you when a corrective action plan and follow-up are required;
- Advise you of a change in the conditions of your network participation, if determined to be required;
- Advise you, in writing, if any action is taken as a result of the inquiry and review process; and
- Advise you of your right to appeal if the decision is to terminate your participation in the provider network due to quality of care or service issues. The procedure for appeals is included in written notification of such a determination (See *Appealing Decisions That Affect Network Participation Status*).

SECTION 4: THE QUALITY PARTNERSHIP

Fraud, Waste, Abuse and Overpayment

Our Philosophy

Magellan takes allegations of fraud, waste, abuse and overpayment seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. Magellan has made a commitment to actively pursue all suspected cases of fraud, waste, abuse and overpayment, and will work with law enforcement for full prosecution under the law.

Magellan promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their patients.

Our Policy

Magellan has implemented a comprehensive compliance program to ensure ongoing compliance with all contractual and regulatory requirements. Magellan's Compliance Program describes our comprehensive plan for the prevention, detection and reporting of fraud, waste, abuse and overpayment across various categories of healthcare-related activities and operations. The elements of the Compliance Program include:[I] Written Policies and Procedures; [II] Designation of a Compliance Officer and a Compliance Committee; [III] Conducting Effective Training and Education; [IV] Developing Effective Lines of Communication; [V] Auditing and Monitoring; [VI] Enforcement Through Publicized Disciplinary Guidelines and Policies Dealing With Ineligible Persons; [VII] Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and [VIII] Whistleblower Protection and Non-Retaliation policy.

Magellan does not tolerate fraud, waste, abuse or overpayment, either by providers or staff. Accordingly, we have instituted extensive fraud, waste, abuse and overpayment programs to combat these problems. Magellan's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste, abuse and overpayment in government programs and private insurance.

- Our policies in this area reflect that both Magellan and providers are subject to federal and state laws designed to prevent fraud and abuse in

government programs (e.g., Medicare and Medicaid, included in the *Appendix*), federally funded contracts and private insurance. Magellan complies with all applicable laws, including the Federal False Claims Act, state false claims laws (See *Fraud, Waste and Abuse* on our website), applicable whistleblower protection laws (see the *Appendix*), the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded healthcare programs, e.g., Medicare Advantage, State Children's Health Insurance Program (SCHIP) and Medicaid, and other payers. Visit our website to review these policies. See the CMS Fraud-Prevention/ Medicaid Program Integrity Educational Resource and the CMS Medicaid Program Integrity site for additional information.

- The 21st Century Cures Act of 2016 requires that, "*In order to participate as a provider in the network of a managed care entity, a provider that provides services to, or orders, prescribes, refers, or certifies services for" Medicaid/CHIP members must be enrolled with the State Medicaid/CHIP program*. As a result of the federal statutory provision referenced above, network providers that service Medicaid and/or CHIP members must be enrolled in the state-specific Medicaid or CHIP program, respectively. These network providers must maintain their provider enrollment status with Medicaid and/or the CHIP program while the provider contract is in effect.

What You Need to Do

Your responsibility is to:

- Comply with all federal and state laws and Magellan requirements regarding fraud, waste, abuse and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse;
- Ensure that you provide and bill only for services to members that are medically necessary and consistent with all applicable requirements, regulations, policies and procedures;
- Ensure that all authorization requests and claims submissions are accurate;
- Ensure that medical record documentation is complete and accurate, and support the services billed by complying with Magellan and other required record-keeping standards (e.g., including the rendering provider's name, session times, service rendered);

- Notify Magellan immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;
- Notify Magellan immediately when you receive information about changes in a Magellan member's circumstances that may affect the member's eligibility including:
  (i) Changes in the member's residence, and
  (ii) The death of a member;
- Maintain your Medicaid (and/or CHIP) provider enrollment with the state. Please notify Magellan immediately if your enrollment in the state's Medicaid and/or CHIP program is terminated by the state; and
- *Understand fraud, waste, abuse and overpayment*

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

  Waste means over-utilization of services or other practices that result in unnecessary costs.

  Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.

  Overpayment means any funds that a person receives or retains under Medicare, Medicaid, SCHIP, and other government-funded healthcare programs to which the person, after applicable reconciliation, is not entitled under such healthcare programs. Overpayment includes any amount that is not authorized to be paid by the healthcare program, whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse or mistake.

Some examples of fraud, waste, abuse and overpayment include:

- Billing for services or procedures that have not been performed or have been performed by others;
- Submitting false or misleading information about services performed, level of care or diagnosis to obtain authorization;
- Misrepresenting the services performed (e.g., up-coding or adding a modifier or add-on procedure code to increase reimbursement);
- Not complying with regulatory documentation and billing requirements;
- Lack of documentation to support services performed;
- Medical record, amendments and late entries not signed at all by the provider or in a timely manner, prior to billing claims.
- Creation of new records, back dating, post-dating entries, writing over, and/or adding to existing documentation without a valid amendment.
- Billing multiple members for the same family therapy session on the same day instead of the primary patient seeking treatment;
- Progress notes that appear cloned and not specific to the service rendered;
- Resubmitting a denied claim with false or misleading information in order to obtain reimbursement;
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment or submit a corrected claim if applicable, and unpaid overpayments also are grounds for program exclusion);
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute, the Stark Law, Exclusion Authorities Law or Civil Monetary Penalties Law constitutes a false or fraudulent claim under the False Claims Act;
- Routinely waiving patient deductibles or copayments;
- Providing or ordering medically unnecessary services and tests;
- Unbundling inclusive higher level of care services (e.g., IOP / PHP services billed as individual and group therapy codes with modifiers, when the facility has a contracted/inclusive per diem rate);
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient);
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the

same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient);
- Providing services over the telephone or internet and billing face-to-face codes;
- Inappropriate use of procedure code modifiers to circumvent claims edits or to increase reimbursement;
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session);
- Treating all patients weekly or multiple times per week regardless of medical necessity;
- Routinely exhausting members' benefits or authorizations regardless of whether or not the services are medically necessary;
- Inserting a diagnosis code not obtained from a physician or other authorized individual;
- Improper use of electronic health records (refer to the CMS Toolkit on Electronic Health Records at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html for additional information);
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals);
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs;
- Lying about credentials, such as degree, licensure or certification information; and
- Use of unlicensed or non-credentialed staff and billing under the name of a licensed/credentialed provider.

- *Report suspected fraud, waste, abuse and overpayment*
  Magellan expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayment. Magellan will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste, abuse or overpayment.

  To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from Magellan, **you are contractually obligated to report the overpayment and to return the**

overpayment to Magellan within 60 calendar days after the date on which the overpayment was identified. You must also notify Magellan in writing of the reason for the overpayment and identify the claims associated with the overpayment.

Reports may be made to Magellan via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit email: Compliance@MagellanHealth.com
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. An outside vendor maintains the hotline. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

- *Self-disclosure reporting*
  Regarding Medicare, Medicaid, SCHIP and other federally funded healthcare programs, providers can disclose self-discovered evidence of potential fraud, waste, abuse, and overpayments to federal and state regulatory agencies with oversight of the applicable healthcare program. Providers can also self-disclose information to Magellan. According to the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) website, "Providers who wish to voluntarily disclose self-discovered evidence of potential fraud to OIG may do so under the Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative litigation." Additional information regarding the HHS-OIG Provider SDP is available at https://oig.hhs.gov/compliance/self-disclosure-info/index.asp.
  States may also have state-specific Self-Disclosure Protocols. Additional information regarding state-specific procedures for Provider Self-Disclosures is typically available by visiting the website for the state's Office of Inspector General or the website of other applicable state regulatory agencies with oversight of the state's Self-Disclosure Protocol.

  Regarding non-government-funded healthcare programs, providers can disclose self-discovered evidence of potential fraud, waste, abuse and

overpayment to Magellan and other applicable state regulatory agencies including, but not limited to, the state's Insurance Agency.

- *Remember!*
  Magellan will not retaliate against you or any of our employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits Magellan from discriminating against an employee in the terms or conditions of their employment because the employee initiated or otherwise assisted in a false claims action. Magellan is also prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

- *Cooperate with Magellan's audits and investigations*
  Magellan's expectation is that you will fully cooperate and participate with its fraud, waste, abuse, and overpayment audits and investigations. This includes, but is not limited to, permitting Magellan access to member treatment records, and allowing Magellan to conduct on-site audits or reviews. Lack of compliance with a request for records may result in Magellan Network staff outreach, retraction of the payment for services not supported, required reporting to a customer oversight agency, placement on a pre-payment review and/or termination from the network. Any overpayment identified will be referred to Magellan's Cost Containment department for recovery by refund check or future claims retractions in compliance with contractual and regulatory requirements.

- *What is the difference between an audit and investigation?*
  An *audit* is an 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. An *investigation* is usually undertaken in response to reports of misconduct. It is a process of detailed examination to achieve certain objectives.

- *What to expect during a fraud, waste, abuse or overpayment audit or investigation*
  Magellan's Special Investigations Unit (SIU) investigates all reports of fraud, waste, abuse, and overpayment. Allegations can come from

different internal and external sources. SIU takes every allegation of fraud, waste, abuse, and overpayment seriously and is required to assess every allegation. The investigative process varies depending on the allegation.

SIU may choose to conduct a *desk* or *on-site* audit during an audit or investigation.

During a *desk audit*, you will receive a request for member treatment records and other relevant documentation via certified mail, fax and/or email. You may also receive an "Audit Questionnaire" which asks additional questions regarding your practice, policies, staff, etc. You are expected to provide a timely response to information requests. Details on how to transmit the documentation will be provided to you in the initial record request letter. If you use electronic health records, SIU will ask you to complete the "Electronic Health Records Questionnaire."

An *on-site audit* can be *announced* or *unannounced* and can occur at any of your contracted service locations. Prior to an announced on-site audit, you will receive notice of audit via fax, email or mail. The notice will provide details and instructions about the audit. You will not receive advance notice of an unannounced audit. SIU staff will provide you with proper identification as well as a written audit notice providing further details and instructions.

During on-site audits, you will be expected to provide treatment records, personnel files, scheduling documentation, policies and procedures, or other documentation to SIU staff for review. If any of the information is maintained electronically, you will be expected to provide SIU staff with electronic access.

Extrapolation of SIU Findings

SIU may extrapolate findings when a statistically valid sample has been selected for audit. Sampling and extrapolation will occur in accordance with the most recently published Medicare program integrity manual and using statistical software approved by the U.S. Department of Health and Human Services. Extrapolation may be applied where permitted by regulation.

All documentation required to justify the dates of service under review must be present in each file at the time of the SIU audit. The time period selected for medical record review may vary. Additions to the documentation or the production of missing chart notes or files at a later date that do not meet medical record/addendum entry guidelines will not be accepted by the SIU for review, including during the SIU appeal timeframe.

Throughout the auditing process, Magellan may use several references to ensure accuracy and consistency. These may include but are not limited to the following:

- AMA CPT Manual
- International Classification of Diseases (ICD-10-CM Manual)
- CPT Handbook for Psychiatrists
- Healthcare Common Procedure Coding System (HCPCS) Level II code book
- Benefit and contract language
- Magellan National Provider Handbook and applicable State/Plan/EAP-specific supplements
- Magellan Reimbursement Guidelines
- Medical director, licensed clinician or certified professional coder (CPC) review.

SIU may also take the following steps during an audit or investigation:

- Review your submitted claims;
- Interview you and/or your staff;
- Review supporting documentation and conduct relevant background checks; and
- Interview members without provider interference.

- *What is the difference between progress notes and psychotherapy notes?*

  Progress notes are a required part of a medical record, and there must be a complete and filed note for each service in the record that supports the medical necessity and reimbursement of the service. These notes encompass a comprehensive overview of a patient's clinical status, including medical history, diagnoses, symptoms, treatment plans, and ongoing progress. They serve as a means of communication among healthcare providers, offering insights into the patient's evolving condition and treatment trajectory.

Psychotherapy notes should be maintained in a separate file to protect the privacy of those notes and should not be included with the rest of the patient's medical record. If, however, the psychotherapy notes are integrated into one record, the full record should be submitted.

HIPAA - 45 CFR § 164.501—*Psychotherapy notes* means notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Please be assured that Magellan takes patient privacy and confidentiality very seriously, as it is an integral part of our business. As you may know, HIPAA allows providers to disclose protected health information for the healthcare operations of the entity receiving the information as long as we both have (or had) a relationship with the patient, the information pertains to that relationship, and the disclosure of the information is for the purpose of healthcare fraud and abuse detection or compliance. See 45 CFR 164.506(c)(4).

What to expect at the conclusion of an audit or investigation

At the conclusion of an audit or investigation, SIU will report results to you in the form of a findings letter. We may ask you to sign an "Audit Findings Attestation" form attesting to your receipt and understanding of any education, resources and additional information provided by SIU as a result of the findings. SIU may also be required to report the findings to a customer and/or an oversight agency, place a provider on a pre-payment review, and/or a corrective action plan where permitted. A corrective action plan requires you to document the actions to be taken to correct and prevent deficiencies identified in the findings letter. Any overpayment identified as a result of an audit, investigation or self-audit will be referred to Magellan's Cost Containment department for recovery by refund check or future claims retractions in compliance with contractual and regulatory requirements.

- *SIU appeal procedures*
  The Special Investigations Unit provides a process by which a provider may appeal SIU's findings directly with the SIU in writing following the directive given in the SIU findings letter sent to the provider. If the affected provider communicates disagreement with the SIU's established findings or decides to provide additional documentation related to the claims in dispute, SIU will temporarily cease recoupment activities. The requester is asked to identify in writing the finding(s) for which a reconsideration is being requested, their perspective or response to the audit finding(s)), and to provide any additional information not already provided to the SIU in the original audit to support their appeal. Requesting reconsideration of the whole audit is not adequate and will not be considered without a documented appeal of the specific finding(s). The requester must provide the appeal and any additional information to the SIU within the appeal timeframe specified in the SIU findings letter. Be sure to respond to the auditor or investigator listed on the findings letter with any questions or concerns.

- *What to expect during pre-payment review*
  Magellan may place a provider on pre-payment review for the following reasons: audit/investigation findings substantiate inappropriate billing, multiple referrals, previous education or action plan provided, noncompliance with education on correct billing and documentation procedures, or a request from a customer plan. You will receive notification from Magellan SIU with information regarding when pre-payment review will begin, where to send records, and contact information for questions. It is important to submit records in a timely manner for SIU to review and determine if services are supported and if it is appropriate to discontinue the pre-payment review. Lack of compliance with a request for records during pre-payment review may result in Magellan Network staff outreach, required reporting to a customer oversight agency, or termination from the network.

- *Conduct routine self-audits*
  We encourage providers to conduct routine self-audits to measure and ensure internal compliance. Self-audits help identify and correct errors in your documentation and billing processes before they lead to overpayments or claim denials. Also, a provider may be required to complete a self-audit in response to findings from an investigation, audit, or data analysis activities, or in compliance with regulatory or contractual requirements.

What Magellan Will Do

Magellan's responsibility is to implement and regularly conduct fraud, waste, abuse and overpayment prevention activities whereby we:

- Monitor and audit provider utilization and claims to detect fraud, waste, abuse and overpayment;
- Investigate and pursue fraud, waste, abuse, overpayment and other alleged illegal, unethical or unprofessional conduct;
- Report suspected fraud, waste, abuse, overpayment and related data to customers and/or federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations;
- Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases;
- Conduct routine data mining activities to identify suspicious patterns in claims data;
- Verify eligibility for members and providers;
- Utilize internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs;
- Train all Magellan employees annually on Magellan's Corporate Code of Conduct and Compliance Program including, but not limited to, fraud, waste, abuse and overpayment prevention, detection and reporting; and
- Make the Magellan Provider Handbook available to our providers.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Exclusion from Federally or State-Funded Programs

Our Philosophy

Magellan promotes provider compliance with all federal and state laws on provider exclusion and CMS preclusion requirements.

The U.S. Department of Health and Human Services (HHS) through the Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federally funded healthcare programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online. According to the HHS-OIG, "The basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans. The effect of an OIG exclusion is that no Federal healthcare program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person. The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one healthcare profession to another while excluded. This payment prohibition applies to all methods of Federal healthcare program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system or other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded. Excluded persons are prohibited from furnishing administrative and management services that are payable by the Federal healthcare programs. This prohibition applies even if the administrative and management services are not separately billable." Additional information is available by reviewing the *U.S. Health and Human Services Office of Inspector Special Advisory Bulletin: "Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs" - Issued May 8, 2013 (http://oig.hhs.gov/exclusions/files/sab-05092013.pdf).*

In addition, the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits. The SAM Exclusion Database replaced the U.S. GSA web-based Excluded Parties List System (EPLS), which is no longer in use.

States also can exclude individuals and entities from participating in state-funded contracts and programs.

CMS also prohibits a Medicare Advantage plan from paying, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is included on the CMS Preclusion List. The Preclusion List is compiled by CMS and includes providers (individuals and entities) that fall within either of the following categories: (1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (2) Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Our Policy

Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan's policy is to ensure that excluded individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan's federally and state-funded healthcare contracts, including but not limited to, contracts issued under Medicaid (Title XIX), Medicare (Title XVIII), Social Services Block Grants (Title XX programs), or the State Children's Health Insurance Program (Title XXI). This policy is applicable to all Magellan lines of business.

Consistent with CMS requirements, any individual or entity identified on the Preclusion List is not reimbursed, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee.

What You Need to Do

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

- Screen all employees, agents and contractors to determine whether any of them have been excluded. Providers are required to comply with this

obligation as a condition of enrollment as a Medicare or Medicaid provider.

- Search the HHS-OIG LEIE website at http://www.oig.hhs.gov/, the U.S. General Services Administration's (GSA) web-based System Award Management (SAM) Exclusion Database website at https://sam.gov/content/entity-information, and other applicable state exclusion/termination/suspension/sanction lists to capture sanctions, terminations, suspensions, exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency any exclusion, termination, debarment, ineligibility or suspension information discovered.

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

- Check each month to ensure that you, your employees, agents, directors, subcontractors, officers, partners, managing employees, affiliates[1] or persons with an ownership or control interest in you, the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you, the provider entity, of 5 percent or greater are not terminated, debarred, suspended or otherwise excluded under the HHS-OIG LEIE at http://www.oig.hhs.gov/, the SAM Exclusion Database at https://www.sam.gov or any applicable state exclusion/ termination/suspension/sanctions list; and
- Immediately notify Magellan in writing of the sanction, termination, debarment, suspension or exclusion of you, your employees, managing employees, agents, subcontractors, directors, officers, affiliates, partners or persons with an ownership or control interest in you, the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you, the provider entity, of 5 percent or greater.
- Disclosure Requirements – Upon receipt of a request from Magellan, Medicaid providers are required to disclose information regarding:
  1. The identity of all persons with an ownership or control interest in the provider/disclosing entity; the identity of all persons with an ownership or control interest in any subcontractor in which the disclosing entity/provider has a direct or indirect ownership interest of 5 percent or more; information about the type of relationships

[1] Affiliate, as defined in the Federal Acquisition Regulation at

among the persons with ownership interest; and information about the provider's agents and managing employees in compliance with 42 CFR 455.104;

2. Certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105; and
3. Including you, the provider, the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.
4. Any and all affiliations that it or any of its owning or managing employees or organizations (consistent with the terms "person with an ownership or control interest" and "managing employee" as defined in § 455.101) has or, within the previous five years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event (as defined in § 455.101) in compliance with 42 CFR 455.107.

What Magellan Will Do

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

- Checking the SAM Exclusion Database, HHS-OIG LEIE, and applicable state exclusion lists during credentialing/recredentialing, prior to the employment of any prospective Magellan employee and prior to contracting with any vendor/subcontractor, and monthly thereafter;
- Ensuring that excluded/terminated/debarred/suspended/ precluded/ineligible individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan's product offerings. This policy is applicable to all Magellan lines of business; and
- Cooperating with law enforcement authorities in the prosecution of healthcare and insurance fraud cases, and reporting fraud-related data to federal and state agencies in compliance with applicable federal and state regulations and contractual obligations.

SECTION 4: THE QUALITY PARTNERSHIP

HIPAA Transaction Standards

Our Philosophy

To address the Health Insurance Portability and Accountability Act (HIPAA) and its regulations regarding standard interface between healthcare organizations and providers, we send and receive HIPAA Standard Transactions. HIPAA Standard Transactions define the required formats for encounter data, referrals, authorizations, enrollment and claims data between members, providers, healthcare organizations and others that require this information.

Our Policy

To receive and send standard electronic transactions, as defined by HIPAA legislation, Magellan has contracted with national clearinghouses*. For many of these transactions, Magellan also offers HIPAA-compliant website-based applications, including but not limited to, professional claims submission.

What You Need to Do

Your responsibility is to:

- Comply with HIPAA Standard Transactions requirements for all covered transactions submitted to Magellan;
- Apply for and use your National Provider Identifier (NPI) on all electronic transactions submitted to Magellan; and
- Use current standard procedure, diagnostic and revenue codes on all claim transactions submitted to Magellan.

What Magellan Will Do

Magellan's responsibility is to:

- Be able to receive and send these HIPAA Standard Transactions:

270/271	Eligibility Inquiry/Response
837P	Inbound – Professional Claim
837I	Inbound – Institutional Claim
835	Outbound – Electronic Remittance Advice
276/277	Claim Status/Response
820	Premium Payment
834	Enrollment
278	Authorization Request/Response

- Utilize preferred clearinghouse services or offer online services to provide the administrative functions required to establish HIPAA-compliant electronic communications; and
- Inform you about how to initiate electronic communications with us.

**Refer to Clearinghouse Contact Information on the Magellan provider website for current Magellan preferred clearinghouses.*

SECTION 4: THE QUALITY PARTNERSHIP

HIPAA Standard Code Sets

Our Philosophy

The coding standards established by the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set regulations establish industry standards for identifying procedures, diagnoses and medical supplies.

Our Policy

The HIPAA legislation specifically identifies the following procedure and diagnostic code sets as standards:

- ICD-10-CM
- CPT®-4 and modifiers
- HCPCS Level II and modifiers
- Revenue codes
- Place of Service codes
- Type of Bill codes.

Magellan requires the use of these standard code sets on both paper and electronic claim transactions.

What You Need to Do

Your responsibility is to:

- Make sure that both paper claims and electronic claims transactions submitted to Magellan utilize current standard codes in accordance with HIPAA requirements;
- Apply for and utilize a National Provider Identifier (NPI) on all claims submitted to Magellan;
- Obtain a current copy of Magellan's Universal Services List (USL – under **Facilities and Programs**) for standard codes for most facility and program services; and
- Research, be knowledgeable and comply with HIPAA requirements.

What Magellan Will Do

To comply with HIPAA, Magellan will:

- Recognize standard procedure and diagnostic codes and will communicate those standards to providers;
- Be compliant with HIPAA's standard coding requirements;
- Accept only compliant codes in covered electronic transactions;
- Accept only covered electronic transactions that include an NPI;
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions;
- Advise you on how to contact us to initiate electronic communications;

- Provide notice on remittance vouchers for services submitted with invalid codes; and
- Maintain helpful information about HIPAA code sets on MagellanProvider.com.

SECTION 5: PROVIDER REIMBURSEMENT

Claims Filing Procedures

Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements to avoid administrative denials that delay payment and require resubmission of claims.

Our Policy

Magellan reimburses mental health and substance abuse treatment providers using fee schedules for professional services. Magellan's professional reimbursement schedules include the most frequently utilized HIPAA-compliant procedure codes for professional services. Most Magellan provider contracts require claims to be submitted within 60 days of the provision of covered services. Magellan will deny payment for claims not received within applicable state mandated or contractually required timely filing limits. A claim must contain no defect or impropriety, including a lack of any required substantiating documentation, HIPAA-compliant coding or other circumstance requiring special treatment that prevents timely payments from being made. If the claim does not contain all required information, it will be denied.

Note: If applicable state law defines "clean claim," Magellan applies the state-mandated definition.

Magellan does not pay for sessions that a member fails to attend, and the provider may not bill Magellan or covered payers for such sessions or services. A member who misses a scheduled appointment may be billed directly, but only if the provider has notified the member in writing of the missed appointment policy and the member has acknowledged that policy in writing. Members may not be billed in excess of the applicable network fee schedule for such services.

In addition, CMS' policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries and also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare

policy/guideline does not preclude the physician or supplier from charging the Medicare patient directly.

Magellan considers all payments final unless notice and claims appeal from the provider is received within 90 days of payment, subject to state and federal regulatory requirements and/or customer guidelines/requirements.

What You Need to Do

Your responsibility is to:

- Contact Magellan prior to rendering care if the member's benefit plan requires authorization for the service;
- Complete all required fields on the CMS-1500 or UB-04 (also CMS-1450) form accurately;
- Collect applicable copayments or coinsurance from members;
- Submit a clean claim for services rendered, including your usual charge amount. Do not automatically bill your contracted rate as the charge amount. Follow the detailed claim form completion standards in the *Appendix* of this handbook;
- Submit claims for services delivered in conjunction with the terms of your agreement with Magellan;
- Use only standard code sets as established by the Centers for Medicare & Medicaid Services (CMS) or the state of your licensure for the specific claim form (UB-04 or CMS-1500) you are using (see additional information under the previous section, *HIPAA Standard Code Sets*);
- Submit claims within 60 days of the provision of covered services, or as required by provider contract;
- Contact Magellan for direction if services are needed after the authorization has expired;
- Not bill the patient for any difference between your Magellan contracted reimbursement rate and your standard rate. This practice is called "balance billing" and is not permitted by Magellan;
- Refer to the "Dos" and "Don'ts" of claims filing in the *Appendix* of this handbook;
- Sign in on the provider portal, MagellanProvider.com, or the sites of Magellan's contracted vendors if directed, to obtain information on a member's plan and claim information;
- Contact the Customer Service number indicated on the member's ID card for assistance;
- You may directly bill a member who misses a scheduled appointment, but only if you have provided written advice notifying the member of your missed appointment policy and the member has acknowledged

that policy in writing. Members may not be billed in excess of the applicable network fee schedule for such services; and

- File any claims appeal within 90 days of payment for consideration, or in accordance with state and federal regulatory requirements and/or customer requirements.

What Magellan Will Do

Magellan's responsibility is to:

- Provide verbal notice, send an authorization letter and/or provide electronic authorization when we authorize services;
- Process your claim promptly upon receipt and complete all transactions within regulatory and contractual timeliness standards;
- Apply pre-payment claim edits to claim submissions in order to identify common industry standard billing errors or other identified issues. Magellan periodically updates its claims payment system to correctly apply coding edits, in addition to being aligned with national industry standards that include, but are not limited to:
  - Centers for Medicare & Medicaid Services (CMS) guidelines,
  - American Medical Association (AMA) Current Procedural Terminology (CPT®),
  - Health Care Common Procedure Coding System (HCPCS),
  - International Classification of Diseases, 10th Edition (ICD-10);
- Inform you of any reasons for administrative denials and action steps required to resolve an administrative denial;
- Make available online or send you an explanation of payment (EOP) or other notification for each claim submitted including procedures for filing an appeal;
- Provide appropriate notice regarding corrective action or information required if a claim is denied, and reconsider the claim upon receipt of requested information;
- Adjudicate claims based on information available;
- Regularly update the Universal Services List and HIPAA-compliant billing codes on the Magellan provider website;
- Review our reimbursement schedules periodically in consideration of industry standard reimbursement rates and revise them when indicated;
- Include all applicable reimbursement schedules as exhibits to your contract;
- Comply with applicable state and federal regulatory requirements regarding claims payment; and
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

SECTION 5: PROVIDER REIMBURSEMENT

Electronic Claims Submission

Our Philosophy

We offer a variety of methods through which providers can submit claims electronically to support our providers' submission preferences. This enhances our ability to pay providers in a timely and accurate manner.

Our Policy

Magellan is committed to meeting CMS and HIPAA compliance standards. We have several preferred, contracted clearinghouses through which providers can submit both facility-based and professional claims. Magellan also offers a claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. These options are available on Magellan's website (or the sites of our contracted vendors, as directed) and are offered at no cost to our providers.

What You Need to Do

Your responsibility is to:

- If you are able to transmit data in a HIPAA-compliant 837 format, submit claims directly to Magellan through a direct-submit upload process. To establish this process, you will need to go to our EDI Testing Center, create a unique username/password, download the Abbreviated Companion Guide, and upload a test file to run through HIPAA validation. You must repeat this test successfully twice. Once HIPAA validation has been successfully completed using this automated tool, Magellan will contact you to move the process into production status so you can submit actual claim files. If you have any questions or need assistance, contact us at EDISupport@MagellanHealth.com.
- Utilize the claims application on Magellan's website (or the sites of Magellan's contracted vendors, as directed). Consider using the services of one of our preferred, contracted clearinghouses* if you submit a high volume of claims, or for claims submitted on a UB-04 (also CMS-1450).

What Magellan Will Do

Magellan's responsibility is to:

- Maintain online claims applications and relationships with clearinghouses to assure flexibility in the claims submission process; and
- Provide electronic funds transfer (EFT) and electronic remittance advice (835) for electronic claims.

**Refer to Clearinghouse Contact Information on the Magellan provider website for current preferred Magellan clearinghouses.*

SECTION 5: PROVIDER REIMBURSEMENT

Electronic Funds Transfer

Our Philosophy

Electronic funds transfer (EFT) is the industry standard and a secure method that allows payments to providers in a timely manner. EFT significantly reduces administrative burdens and ultimately benefits your practice.

Our Policy

Magellan is committed to meeting CMS and HIPAA compliance standards, plus Affordable Care Act mandates. **Magellan requires network providers to sign up for EFT via the site of our contracted vendor (or the Magellan provider website, if directed) and receive all payments electronically**.

What You Need to Do

Your responsibility is to:

- Register for EFT. Follow the EFT enrollment directions on www.MagellanProvider.com. You may be directed to Magellan's contracted vendor's site to complete the enrollment;
- If you enrolled with Magellan's contracted vendor, notify them directly via phone or email using the contact information found on our provider website;
- If you enrolled with Magellan directly, notify us if you change your bank account by submitting a request to end the EFT for the original bank, and then creating an EFT request with your new bank account information. You can add a new EFT request from our secure EFT website application on the Magellan provider website (or via the sites of Magellan's contracted vendors, if directed); and
- Obtain explanation of benefit (EOB)/explanation of payment (EOP) information through Magellan's contracted vendors' websites.

What Magellan Will Do

Magellan's and our contracted vendor's responsibility is to:

- Conduct a secured transmission test with your bank to make sure payments are transferred properly;
- Perform at least one transaction test between Magellan/Magellan's contracted vendor and your bank;
- Provide EOB/EOP information through Magellan's contracted vendors' websites;
- Notify you if additional EFT options become available; and
- Provide support to providers – you may message Magellan via our provider website, call our Provider Services Line at 1-800-788-4005, or contact our contracted vendor directly via phone or email using the contact information found on our provider website.

SECTION 6: MEDICARE ADVANTAGE BENEFICIARIES

Medicare Advantage

Our Philosophy

As a contracted first-tier entity ("FDR") of behavioral healthcare management services to Medicare Advantage plans, Magellan manages benefits for Medicare enrollees. As a Medicare Advantage plan FDR/subcontractor, Magellan, along with our contracted provider network, is subject to the standards and procedures established by the Centers for Medicare & Medicaid Services.

Our Policy

Our Medicare Advantage (MA) network includes behavioral health providers permitted by CMS to provide services to Medicare enrollees. We actively evaluate the cultural diversity of our networks to include practitioners who can meet the cultural needs of our members. In addition, our provider agreements are consistent with CMS requirements.

What You Need to Do

Magellan encourages all providers in our Medicare Advantage provider network to actively pursue information relevant to their roles in treating Medicare Advantage enrollees. You can access CMS and Medicare/MA information directly at www.cms.gov.

As a provider in our Medicare Advantage network and to receive referrals of Medicare enrollees, you agree to:

- Be currently credentialed with Magellan;
- Have an executed provider agreement with Magellan that includes a Medicare Advantage addendum;
- Have a current National Provider Identifier (NPI) number;
- Not appear on a CMS "Preclusion List" (i.e., precluded from receiving payment for Medicare Advantage items and services);
- Be free of any sanctions from the Office of the Inspector General (OIG);
- Have not opted out of Medicare;
- Have not been excluded or precluded from participation in Medicare;
- Not appear on the U.S. General Services Administration's (GSA) web-based System Award Management Exclusion Database (SAM) or the U.S. Treasury Department Office of Foreign Assets List of Specially Designated Nationals and Blocked Persons;
- For hospitals, maintain accreditation by an accrediting body, including The Joint Commission, or certification by Medicare;
- Accept referrals of Medicare Advantage enrollees for covered services within the scope of your practice;

- Deliver services in accordance with the terms of your provider agreement, the Medicare addendum, and the policies and procedures outlined in this handbook and applicable supplements;
- Comply with any CMS, Magellan or Medicare Advantage health plan training requirements, including but not limited to, completion of Medicare Fraud, Waste and Abuse training (unless exempt based on enrollment in Original Medicare);
- Review and distribute to your employees any general compliance information communicated to you by Magellan, including Magellan's Code of Conduct and/or compliance policies and procedures, within 90 days of contract start date and annually thereafter;
- Inform Magellan prior to engaging with an offshore subcontractor who will receive, process, transfer, handle, store, or access protected health information (PHI);
- Maintain records during the term of your agreement and for a period of 10 years following the termination of your agreement, or if records are subject to an audit, maintain records for 10 years following the termination of your agreement or the completion of any audit, whichever is later;
- Render all services in your office or facilities or in mutually agreeable locations;
- Deliver services in a culturally competent manner;
- Render services that are consistent with professionally recognized standards of healthcare;
- Protect the confidentiality of enrollees' information;
- Involve enrollees in treatment decisions;
- Be aware of and comply with laws applicable to individuals or entities receiving federal funds;
- Render services in a timely manner, consistent with Medicare Advantage access standards:

Behavioral health service (Medicare Advantage members)	**Timeliness standard**
Provide **urgently needed** or **emergency services**	Immediately
Provide services that are **not emergency or urgently needed**, **but the member requires medical attention** such as prompt behavioral health intervention or medication refills	Within 7 business days
Provide **routine and preventative care services**	Within 30 business days

- For emergent cases (life-threatening or non-life-threatening), call Magellan upon stabilization of the enrollee. Preauthorization of emergency care is not required. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and is time-limited in intensity and duration;
- Render Urgently Needed Services (UNS) as needed. Preauthorization is not required. UNS are covered services provided when an enrollee is temporarily absent from a service area and when such services are medically necessary and immediately required:
    - As a result of an unforeseen illness, injury, or condition, and
    - When it is not reasonable, given the circumstances, to obtain services through Magellan;
- Be aware of, and document in the enrollee's record, whether a psychiatric advance directive exists;
- Make sure services rendered are consistent with Magellan's policies, quality improvement programs, applicable CMS local coverage determinations (LCDs) and national coverage determinations (NCDs), or other applicable clinical/care management guidelines and Magellan's Care Guidelines.
  Note: For Medicare Advantage enrollees:
    - Magellan follows CMS NCDs and LCDs where applicable. LCDs vary by state; Magellan uses the LCD from the state where the service is provided.
    - NCDs and LCDs supersede other state- and/or account-specific guidelines, including ASAM for Substance Use Disorders.
    - The guideline applied in an organization determination decision for a Medicare Advantage enrollee will be specified in the authorization or denial letter;
- You may request a copy of the guideline from our care managers or by calling 1-800-788-4005;
- Submit claims for services rendered to Medicare Advantage members within 90 days of the date of service;
- Participate in and cooperate with quality review and improvement activities related to services provided to enrollees;
- Adhere to Medicare appeals (reconsideration) procedures (including expedited appeals);
- Inform the enrollee or the enrollee's representatives of their right to appeal any treatment determination (even if the determination occurs "pre-service") before any service is delivered. You may be asked to provide information that is relevant to the reconsideration;

- Comply with CMS reporting requirements in a timely and accurate manner and certify to the truth and completeness of encounter data submitted to Magellan;
- Maintain appropriate clinical records in accordance with Health and Human Services (HHS) and all other applicable federal, state and local laws and regulations; and
- Adopt reasonable measures to prevent the unauthorized disclosure of Medicare records. Medical records must be maintained in a secure manner.

What Magellan Will Do

Magellan's responsibility is to:

- Pay clean claims promptly in accordance with CMS standards for quality and service;
- Pay claims in accordance with the reimbursement schedule outlined in your provider agreement;
- Maintain corporate policies and procedures to ensure that process controls are in place to meet specific requirements of the Medicare program and applicable federal laws;
- Provide and document mandatory compliance training for all new employees, physician advisors and healthcare professional advisors within 30 days of hire;
- Provide specialized compliance training to Magellan employees who support Medicare business related to issues posing compliance risks;
- Maintain confidential systems to receive, record and respond to questions or reports of potential or actual noncompliance with Medicare regulations.

Note: Magellan's care management centers serve Medicare Advantage enrollees across the country. For questions about a specific plan or case, call the care management center that referred the enrollee to you. For information about Medicare Advantage and related laws and regulations, we encourage you to obtain information directly from CMS.