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AvMed Overview

- AvMed has been operating in FL for more than 45 years.
- Nearly 350,000 members, 800 employees
- Corporate headquarters in Miami, with regional offices in Gainesville, Fort Lauderdale, Jacksonville, Orlando and Tampa
- Fully-insured and self-funded commercial plans, as well as Medicare Advantage in Miami-Dade and Broward counties
- Consistently rated above other Florida health plans for overall satisfaction with health plans, according to NCQA. It is one of only a few health plans in the United States that enjoys dual "Excellent" accreditation status for both its Commercial and Medicare health plans.
- It was rated “Highest Member Satisfaction among Commercial Health Plans in Florida, Four Years in a Row” by J.D. Power.
AvMed’s Mission

“AvMed’s mission is to help our members live healthier. We provide members with quality, cost-effective plans and excellent member services. Our vision is to be our members' trusted health partner for life. As one of the state’s oldest and largest not-for-profit health plan, our corporate culture is defined by compassionate, collaborative and ethical behavior focused on delivering superior member service. As a not-for-profit, we reinvest earnings to continually enhance services for members.”
What Does it Mean to be a Magellan Provider?

Being a Magellan provider means you share Magellan’s commitment to providing quality care; this commitment is demonstrated by:

• Complying with credentialing requirements in a timely manner
• Obtaining authorization of care as required by the member’s benefit plan
• Rendering care in accordance with Magellan’s clinical practice guidelines when clinically appropriate
• Participating in treatment record reviews when requested
• Informing members of their rights and responsibilities and the importance of collaborating with their primary care providers and others involved in their healthcare
• Initiating and maintaining ongoing communication with the primary care provider when authorized by the member
• Submitting complete claims in a timely manner
**Updating Practice Information**

Updating your practice data is critical to all transactions with Magellan.

Practice data impacts:
- Authorization notifications
- Recredentialing notifications
- Network/contractual-related communications
- Provider directories
- Claims payment

*Office managers/group administrators must be cautious when updating practitioner information, particularly when the provider maintains a solo practice and/or works for other group practices.*
Updating Practice Information (continued)

What You Need to Do – Solo Clinicians

Notify Magellan within ten business days of any changes in your individual practice information including:

- **General Information**
- **Contact Information**
- **Access**
  - Promptly notify us if you are unable to accept referrals for any reason including:
    - Illness
    - Practice not accepting new patients
    - Professional travel, sabbatical, vacation, leave of absence, etc.
- **Specialties**
- **Service, mailing or financial address**
Updating Practice Information (continued)

What You Need to Do – Group Practices

Notify Magellan within ten business days of any changes in your practice information including:

- General Information
- Contact Information
- Access
  - Promptly notify us if you are unable to accept referrals for any reason including:
    - Illness
    - Practice not accepting new patients
    - Professional travel, sabbatical, vacation, leave of absence, etc.
- Specialties
- Service, mailing or financial address
- Practitioners departing the group practice
- New practitioners joining the group practice
Updating Practice Information (continued)

What You Need to Do

• Magellan’s **mandatory** online Provider Data Change Form (PDCF) allows you to update your information in real time
  ▪ Go to [www.MagellanProvider.com](http://www.MagellanProvider.com)
  ▪ Sign in to the secure network
  ▪ Click Display/Edit Practice Information from left-hand menu
• Training is available online under the Education heading on the provider website
• Magellan network staff members are also available to assist with provider training
Provider Profile

• This feature on our provider website allows providers to enhance the information that members see in our online Provider Search tools; you can:
  ▪ Upload a photo
  ▪ Include a personal statement
  ▪ Share awards and distinctions
  ▪ Share top attributes

• Being able to make more in-depth information about network providers available to members helps support consumer choice and ultimately contributes to the best care and positive clinical outcomes for members

• Practitioners who are part of a group now have the ability to sign into the provider website and update their profile

• To access the provider profile:
  ▪ Sign into the website with your secure username and password at www.MagellanProvider.com
  ▪ From the left-hand My Practice menu, select Display /Edit Practice Information
  ▪ Click the Provider Profile tab
Provider Profile

Manage Your Profile

Enhance your profile - visible to Magellan members via our Provider Search tool - and attract new member referrals! You can upload a photo, enhance your biographical information, and share your professional attributes.

Note: To make revisions to your other practice information, please select the Provider Data Change Form tab above.

To begin, please select the TIN/MID for this profile: Please select...
Member Eligibility and Benefits

• Benefits are not the same for all members with the same health plan

• Call the appropriate toll-free number to verify eligibility and benefits before treating a member

• Verify coverage and member co-payments, coinsurance and/or deductible

• When required, obtain authorization prior to treating the member

• Obtain a copy of member’s card at first visit

• Routinely verify insurance information with member and re-verify eligibility

• Transition of care period for AvMed members begins on Oct. 1, 2016 through March 31, 2017
Member Access to Care

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

You must:

- Provide access to services 24 hours a day, seven days a week.
- Inform members of how to proceed, should they need services after business hours.
- Provide coverage for your practice when you are not available, including but not limited to an answering service with emergency contact information.
- Respond to telephone messages in a timely manner.
- Provide immediate emergency services when necessary to evaluate or stabilize a potentially life-threatening situation.
- Provide services within 6 hours of a referral in an emergent situation that is not life-threatening.
- Provide services within 48 hours of a referral in an urgent clinical situation.
- Provide services within 10 business days of referral for routine clinical services.
Outpatient Solutions

• Magellan Healthcare’s outpatient care management model
  ▪ Reduces provider administrative tasks
  ▪ Expedites direct access to care
  ▪ Identifies and addresses gaps in behavioral health services and coordination

• Our objective is to work with providers to make sure that the members we jointly serve have the best opportunity to return to whole health and productivity
Key Components of Outpatient Solutions

The model works through:

- Removal of administrative processes often perceived as access barriers, such as preauthorization and treatment request forms
- Use of proprietary evidence-based, clinically-driven claims algorithms to identify only those cases needing care management support or other intervention
- Review of all submitted claims against the clinical algorithms
What Does it Mean for Providers?

• You can initiate routine outpatient services, including counseling and medication management visits, for members without calling Magellan or obtaining preauthorization through our website.

• A decrease in the time you spend on the phone or online with Magellan to obtain authorization for routine outpatient care that meets criteria for continuation.

• Reduction of your administrative burden, providing more time for you to spend with your patients and your practice.

• You may receive a call from Magellan staff for care management support based on results of algorithms.
Services Still Requiring Preauthorization

- Higher levels of care such as inpatient, residential, and partial hospitalization services; Magellan requires notification within 24 hours for inpatient services.

- Preauthorization can be obtained by calling 1-800-424-4810 and follow the prompts.

- Non-routine outpatient care such as intensive outpatient treatment, psychological testing, outpatient ECT, transcranial magnetic stimulation (rTMS), Office Based Opioid Treatment (OBOT), and applied behavior analysis (ABA).

*When covered by applicable plan.*
Concurrent Authorization Process

Concurrent authorizations are required for inpatient, residential, partial hospitalization and intensive outpatient services

- Complete concurrent reviews by calling 1-800-424-4810
- Click on the prompt for “provider”
- Click on the prompt for “concurrent review”
Retrospective Review

Commercial/Medicare-Non Urgent Requests (OP Services, Intensive Outpatient)

• Providers can request a retrospective review up to five days from the service date for initial authorization service requests.

• Providers can request a retrospective review up to 14 days from the last date of service for ongoing (concurrent) service requests.

• If authorization request is untimely, Providers are instructed to file a claim and pursue the claims appeals process as applicable.

• Notification of claim filing process after untimely pre-service request can be completed via verbal/written notification.
Follow-Up After Hospitalization

• Follow-up specialists from Magellan assist members and facilities in finding and keeping post-discharge appointments within **seven days** of member discharge.

• Their effort facilitates better coordination of care between members and providers after an inpatient stay.

• While a member is in an inpatient facility, Magellan care managers and follow-up specialists partner with the facility’s treatment team to make arrangements for continued care with outpatient care providers within **seven days**.
Laboratory Referrals

• Quest Diagnostics and AmeriPath are AvMed’s preferred laboratory partners.

• Members who require laboratory services must be referred to Quest Diagnostics or AmeriPath.

• Referrals to other laboratories require a written authorization from AvMed.
How Can an Outpatient Provider Office Help?

• Recognize that members who attend an appointment within seven days of discharge are significantly less likely to readmit

• Make the return-to-outpatient appointment convenient

• Encourage members to attend their after-care appointments

• Submit claims in a timely manner

• Remember that all providers—both in-network and out-of-network—are considered Magellan “business partners”; therefore it is HIPAA-compliant to give information about whether a member attended their seven-day ambulatory follow up outpatient appointment
Clinical Practice Guidelines

- Magellan’s clinical practice guidelines are available on our provider website at [www.MagellanProvider.com](http://www.MagellanProvider.com)

- We review and update each clinical practice guideline on a two-year cycle
Clinical Appeals

• Client requirements and applicable federal and state laws govern the clinical appeals process

• The procedure for appealing a clinical determination is outlined in the non-authorization letter
Commitment to Quality Improvement

In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards, and apply them in clinical work with members.

Key quality measures include:

- Clinical record documentation
- Coordination of care
- Member rights and responsibilities
- Notification of adverse incidents
- Monitoring of Atypical Antipsychotic Medication

We obtain provider feedback through various channels including provider satisfaction surveys, our National Provider Services Line and the Magellan provider website.
Credentialing/Recredentialing

Our Policy

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

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

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

Recredentialing Procedures

• Ensure that you complete and return your application in a timely manner; not meeting recredentialing timeframes is the most common reason for involuntary termination from the network.

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

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

Recredentialing Procedures (continued)

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

• We send a notice to providers only if we cannot access a CAQH application

• We mail a recredentialing notification six months prior to the credentialing anniversary, to the mailing address on record for the practitioner. The notification explains the three options available for completing recredentialing:
  ▪ Complete the recredentialing application on the Magellan provider website
  ▪ Request a CAQH ID number to complete an application
  ▪ Request a paper recredentialing application

• Magellan will make three outreach attempts to acquire any missing data e.g., updated malpractice information. If the provider does not respond, the recredentialing application will be closed and provider will be placed in suspended status with a future termination date.
Magellan Contract

Solo Practitioner Contracts

- To be an in-network individual solo practitioner, you must be contracted with Magellan and, in order to be referral-eligible, you must be individually credentialed by Magellan.

Group Contracts

- To be an in-network group provider, the group must be contracted with Magellan and in order to be referral-eligible, the practitioners within the group must be individually credentialed by Magellan.

- A group member who leaves the group practice and is not also contracted with Magellan under an individual provider participation agreement is no longer considered a Magellan participating provider.
Magellan Contract

Group Contracts (continued)

- When group membership changes (e.g., a practitioner joins or leaves your group):
  - You must update your group roster via the Magellan provider website
    - Note: adding a provider to the group roster does not automatically affiliate them to the group contract or initiate a credentialing application
  - If the new group member is not already Magellan-credentialed, have him/her begin the credentialing process; this must be completed before the provider is eligible to receive referrals
  - Make sure all necessary documentation is completed in order to affiliate a practitioner to your practice, including a Group Association Form and current malpractice information
Magellan Paid Claims Requirements

Timely filing of claims:
- Commercial: 180 days par and 180 days nonpar (calculated from *Date of Service*)
- Medicare: 180 days par and 365 nonpar (calculated from *Date of Service*)

Exceptions to timely filing requirements:
- COB claims where Magellan is the secondary payer *Same limits as above, except calculated from date of Primary Carrier EOB*

Accepted methods for submission of claims:
- Electronic Data Interface (EDI) via direct submit
- Electronic Data Interface (EDI) via a clearinghouse
- “Claims Courier” — Magellan’s web-based claims submission tool
- CMS-1500 or UB-04
Claim Submission Options

Three electronic submission options...

#1 Claims Courier

Claims Courier (Submit a Claim Online) is a web-based data entry application for providers submitting professional claims on a claim-at-a-time basis:

- Accessible after sign-in on Magellan’s provider website
- Claims Courier streamlines the claims process by eliminating the middleman
- Claims Courier provides information on accepted or rejected claims
- No charge to the provider
Claim Submission Options (continued)

#2 Direct Submit
Primarily for high-volume claim submitters, but there is no minimum number necessary for submission

- Magellan offers our providers the EDI Direct Submit testing application, which is an electronic claims tool available on an EDI-dedicated website at www.edi.MagellanProvider.com
- HIPAA-compliant 837 files can be sent directly to Magellan
- HIPAA-compliant 277 files can be sent directly to provider to review for accepted or rejected claims
- Direct Submit streamlines the process by eliminating the middleman
- No charge to the provider
Claim Submission Options (continued)

#3 Claims Clearinghouses

Act as a middleman between the provider and Magellan, and can transform non-HIPAA compliant format to compliant 837

Magellan accepts 837 transactions from the following clearinghouses:

- PayerPath (formerly Mysis and also known as Allscripts)
- Capario (formerly MedAvant Healthcare Solutions and ProxyMed)
- Availity (formerly THIN)
- Emdeon Business Services (formerly WebMD)
- NaviNet Claims (also known as AmpMed Corporation)
- RelayHealth (also known as McKesson)
- Gateway EDI

HIPAA-compliant 277 files enable providers to review for accepted or rejected claims

*Note that there may be charges from the clearinghouses*
Electronic Funds Transfer (EFT)

It is mandatory that providers sign up for Electronic Funds Transfer for Magellan-paid claims

What are the benefits of EFT?

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

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

• Sign into the secure network
• Click on Check Claims Status from the left-hand menu
• Click on the EOB Search on the top tab
Balance Billing Prohibition

• Members cannot be billed for the difference between your usual and customary charge and your contracted rate; this practice is called “balance billing” and is prohibited under the terms of your Magellan Provider Participation Agreement.

• Members may only be billed for missed appointments if you have a clear policy of your billing practice for missed appointments and the policy is signed by the member.
WELCOME PROVIDERS

This website offers user-friendly tools and essential information to support you in providing quality care to Magellan members.

Access Services
- Check Member Eligibility
- Submit a Claim
- Check Claims Status
- Request/View Authorizations
- Electronic Funds Transfer
- My Notifications
- Display/Edit Practice Info
- Manage Outcomes
- Free CE Courses

Get Information
- Provider Handbook and Supplements
- State-Plan-Specific Information
- EAP Information
- Provider Focus (newsletter)
- Clinical Practice Guidelines
- Clinical Practice Guidelines
- Quality Care Criteria
- Online Demos

Not a Magellan provider? Join our Network.
MagellanProvider.com (continued)

Features:

• User guides/demos
• National provider handbook and supplements
• Provider Focus newsletter
• Eligibility and benefits information
• Authorization inquiry
• Enhanced Provider Data Change Form
• Update Provider Profile
• Update appointment availability
MagellanProvider.com (continued)

• Claims inquiry
• *Claims Courier*
• Electronic claim submission information
• EDI Testing Center
• Companion guides for various transaction types
• HIPAA billing code set guides
• Recredentialing form for solo practitioners
• Clinical practice guidelines
• Medical necessity criteria
• CEUs and CMEs
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Thank You