

Magellan Healthcare, Inc.*

2024 Handbook Supplement for Organizational and Facility Providers



*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”). LLC; 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”).

Table of Contents

| | |
|---|-----------|
| SECTION 1: INTRODUCTION | 4 |
| Welcome | 4 |
| SECTION 2: ORGANIZATIONAL AND FACILITY BEHAVIORAL HEALTHCARE NETWORK | 5 |
| Credentialing and Recredentialing | 5 |
| Contracting with Magellan | 7 |
| Communication | 8 |
| Value-Based Collaboration and Compensation | 10 |
| SECTION 3: THE ROLE OF THE ORGANIZATIONAL AND FACILITY PROVIDER | 12 |
| Before Services Begin | 12 |
| Eligibility | 14 |
| Appealing Care Management Decisions | 15 |
| SECTION 4: THE QUALITY PARTNERSHIP | 16 |
| Site Visits | 16 |
| Use of Seclusion and Restraints | 18 |
| SECTION 5: PROVIDER REIMBURSEMENT | 20 |
| Claims Filing Procedures | 20 |
| Billing Codes and HIPAA Compliance | 22 |
| Electronic Claims Submission | 24 |
| APPENDIX A | 26 |
| Organization Site Review Preparation Guide | 26 |
| APPENDIX B | 27 |
| What You Need to Know About Organization Credentialing and Contracting | 27 |
| APPENDIX C | 30 |
| Benefit Certification: Admission | 30 |
| APPENDIX D | 32 |
| Benefit Certification: Continued Stay | 32 |
| APPENDIX E | 33 |
| Benefit Certification: Discharge and Post-Discharge Continuity of Care | 33 |
| APPENDIX F | 34 |
| Frequently Asked Questions | 34 |
| APPENDIX G | 36 |
| Claims Tips and Information | 36 |

Coordination of Benefits (COB) Procedures..... 39
Checklist for Submitting Electronic Transactions to Magellan..... 40
APPENDIX H..... 41
Organizational Provider Selection Criteria..... 41

SECTION 1: INTRODUCTION

Welcome

Welcome to the Organizational and Facility Provider Handbook Supplement. This document supplements the Magellan National Provider Handbook, addressing policies and procedures specific for the organizations in our behavioral health provider network, including facilities, agencies and community mental health centers (CMHCs).

Use this provider handbook supplement in conjunction with the [National Provider Handbook](#), as applicable. When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, the policies and procedures in the organizational and facility supplement prevail.

SECTION 2: ORGANIZATIONAL AND FACILITY BEHAVIORAL HEALTHCARE NETWORK

Credentialing and Recredentialing

Our Philosophy

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

Our Policy

Magellan employs credentialing criteria and decision-making processes in the review and selection of behavioral healthcare organizational providers prior to their acceptance as a Magellan network provider. Magellan credentials providers in accordance with established credentialing criteria (see Appendix H: [Organizational Provider Selection Criteria](#)) and ensures compliance with applicable regulatory and customer requirements.

What You Need to Do

Your responsibility is to:

- Complete and submit all required application materials and related documents.
- Be in good standing with state and federal regulatory entities, as applicable.
- Hold current licensure or certification without contingencies or provisions in accordance with applicable state and federal laws.
- Hold appropriate current accreditation from a Magellan-accepted accreditation agency, or
- If not accredited, participate in a Magellan-performed site visit upon request, or
- If Magellan has approved the state licensure or Centers for Medicare & Medicaid Services (CMS) criteria as meeting our standards, we may substitute a CMS or state licensing / certification site review in lieu of our Magellan site visit when:
 1. The CMS or state review is not greater than three years old at the time of verification; and
 2. Your organization submits a site visit report to verify that the review was performed and has met Magellan standards, or a letter from CMS or the state that shows that your organization was reviewed, and inspection passed. We may request supplemental information from your organization in addition to verification of the state or CMS site visit.

- If requested, provide verification of professional licenses of your medical and clinical staff members. This means contacting state licensing boards to verify that professionals hold a current license, education and training to practice without restrictions, sanctions, terms or conditions. Additional required queries include the National Practitioner Data Bank (NPDB) and the Office of Inspector General/General Services Administration (OIG/GSA) databases for Medicare/Medicaid sanctions, and state-specific Medicaid exclusions databases, as applicable. For physicians and other prescribing practitioners, verification of Board Certification, and current Drug Enforcement Agency (DEA) registration and, if applicable, state Controlled Dangerous Substance (CDS) registration may also be required.
- If requested, fulfill Magellan requirements for malpractice claims history review.
- Meet Magellan’s minimum requirements for professional and general liability insurance coverage, as outlined in your Provider Participation Agreement.
- Participate in a site visit upon request.
- Participate in recredentialing no less than every three years or in compliance with stricter regulatory and/or customer requirements.

**What Magellan
Will Do**

Magellan’s responsibility is to:

- Provide you with initial application and recredentialing materials with instructions for completion.
- Complete the credentialing and recredentialing process in a timely manner that is, at a minimum, within industry, state or customer-established timeframes.
- Have your credentialing or recredentialing application reviewed by a Magellan Regional Network and Credentialing Committee (RNCC).
- Notify you in writing upon completion of the credentialing process. While Magellan may notify you of successful recredentialing, if no notification is received, successful recredentialing can be assumed.
- Perform site visits as needed.

SECTION 2: ORGANIZATION AND FACILITY BEHAVIORAL HEALTHCARE NETWORK

Contracting with Magellan

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| Our Philosophy | A legally binding agreement between Magellan and its network providers serves to clearly outline each party's responsibilities. |
| Our Policy | Participating organizations must have an executed agreement with Magellan. The agreement sets out expectations on Magellan's policies and procedures, provider reimbursement, and terms and conditions of participation as a network provider. |
| What You Need to Do | <p>Your responsibility is to:</p> <ul style="list-style-type: none">• Review, understand and comply with your obligations under your participation agreement with Magellan, including participation in the credentialing process.• Be familiar with and abide by the policies and procedures contained within the Magellan National Provider Handbook, this organizational supplement and the applicable state- and plan-specific supplements. See www.MagellanProvider.com. |
| What Magellan Will Do | <p>Magellan's responsibility is to:</p> <ul style="list-style-type: none">• Provide a Magellan provider agreement to organizations identified for participation in the Magellan provider network.• Execute the agreement after you have signed and returned it to Magellan and your organization has successfully met contractual requirements (for all locations listed on the agreement).• Provide the fully executed agreement, signed by both parties, for your records.• Comply with the terms of the agreement, including reimbursement for covered services rendered. |

SECTION 2: ORGANIZATION AND FACILITY BEHAVIORAL HEALTHCARE NETWORK

Communication

Our Philosophy

Magellan believes that in order to serve our members effectively, providers should have access to key information. Providers' use of our self-service provider portal (or the sites of Magellan's contracted vendors, as directed) will positively impact healthcare system efficiency and costs.

Further, information about our providers must be kept up to date to facilitate referrals, attain capability for prior authorization online, and pay claims using the most efficient and effective process, e.g., using our online provider portal.

Our Policy

Magellan uses a variety of media to communicate with providers about policies, procedures and expectations, including but not limited to our provider portal, Magellan National Provider Handbook and handbook supplements. The day-to-day relationship between Magellan and our providers is managed through our Network, contact center and Clinical Management staff.

Magellan strives to maintain accurate information about providers in our IT systems. Providers are required to notify Magellan of changes in administrative practice information using our provider portal (or the sites of Magellan's contracted vendors, as directed). Providers that do not update their data, or do not attest to data accuracy as required, may incur disruptions in referrals and service until review and attestation of data accuracy is completed.

What You Need to Do

Your responsibility is to:

- Become familiar with the information in your participation agreement, the Magellan National Provider Handbook, this organizational/facility handbook supplement, and the applicable state-specific and plan-specific handbook supplements.
- Visit www.MagellanProvider.com regularly to remain up to date on news, information and policies relating to network participation and serving Magellan members.
- Sign in, become familiar with, and use the extensive self-service features available to you on Magellan's provider portal (or the sites of Magellan's contracted vendors, as directed).

- Use our provider portal (or the sites of Magellan’s contracted vendors, as directed) to obtain member benefits and eligibility. If needed, you may contact Magellan for assistance by calling the number on the back of the member’s health benefit card.
- Get to know your Magellan area contract manager and other field network staff.
- Respond to contacts from Magellan’s care management and transition of care team members with specialized skill sets, to coordinate member care (e.g., outreach and member engagement, transitions of care).
- Notify Magellan of changes in your service or program information, including but not limited to, changes of name, address, telephone number, Taxpayer Identification Number, National Provider Identifier (NPI) and ability to accept referrals, including any program closure.
Note: some changes may require additional verification and/or a contract amendment.
- Submit changes to your organization’s administrative information using the online provider portal (or the sites of Magellan’s contracted vendors, as directed) or contact your area contract manager. Keep this information current by reviewing it quarterly and updating your organization’s record as changes occur, to facilitate timely and accurate claims payment and processing.

**What Magellan
Will Do**

Magellan’s responsibility is to:

- Communicate information about policies, procedures and expectations in a timely manner.
- Offer assistance regarding benefit eligibility 24 hours a day, seven days a week.
- Offer collaboration and partnership with clinicians and discharge planners to coordinate the transition in care from acute care settings.
- Offer assistance with claims payment questions through national and local customer service lines during business hours.
- Offer assistance regarding credentialing and contracting through national and local provider services lines during business hours.
- Offer assistance with using the features and functionality of the Magellan provider portal.
- Offer an online method for you to enter changes in administrative information about your organization.

SECTION 2: ORGANIZATION AND FACILITY BEHAVIORAL HEALTHCARE NETWORK

Value-Based Collaboration and Compensation

Our Philosophy

Magellan is committed to collaborating with our providers to create reimbursement arrangements based on the quality, rather than the quantity, of care they give to Magellan’s members. We have developed payment models that align incentives and reimbursement with value-based care.

Our Policy

Providers rendering high-quality services may be rewarded with improved reputations through public reporting, reduced administrative oversight, increased referrals and/or additional compensation.

What You Need to Do

Your responsibility is to:

- Collaborate with Magellan to improve the care and outcomes for our members. This includes but is not limited to: utilizing provider dashboards for trend monitoring, using outcomes tools, and participating in reviews of your facility or organization performance, where applicable.
- Use Magellan’s online provider tools, which are designed to decrease administrative burden, increase efficiencies, and reallocate resources to enhance the experience and outcomes of our members. Find these web-based tools at www.MagellanProvider.com (or the sites of Magellan’s contracted vendors, as directed).
- Utilize evidence-based practices or best practices.
- Encourage members to complete clinical assessments at the time of intake and periodically during the course of treatment, as well as involve them in discussions about findings, as applicable.
- Actively support coordination of care efforts with Magellan, other behavioral health providers, and physical health providers involved in a member’s care.
- Review all dashboards and performance scorecards that Magellan shares with you, to understand your practice patterns with Magellan members. Take action to improve measures based on the information presented.
- Understand that data about your efficiency and effectiveness may be included in the information we share publicly, and may impact the reimbursement rates you receive from us and your ability to participate in any quality/incentives that we may offer.

**What Magellan
Will Do**

Magellan's responsibility is to:

- Collaborate with you to increase quality and improve efficiencies by engaging in a transparent relationship built upon timely, accurate and actionable data about your facility or organization's provision of quality care, where applicable.
- Focus our value-based conversations, interventions, and network requirements on your organization's operational performance in terms of quality and cost.
- Provide you with performance improvement insights that are based upon pre-defined performance measures.
- Clearly define the requirements to be designated as a high-performing provider within specific networks.
- Endorse and support the use of scientifically sound outcome measurement tools.
- Offer online tools for you to update your practice information and enhance your provider profile, which members see in online provider searches (by uploading a photo, a mission statement, professional awards, etc.).
- Share your performance data, if available, via dashboards, performance scorecards or electronic delivery/access.
- Develop reimbursement methods that reflect your use of evidence-based practice and the achievement of efficient and effective outcomes.

SECTION 3: THE ROLE OF THE ORGANIZATIONAL AND FACILITY PROVIDER

Before Services Begin

Our Philosophy

We are committed to promoting treatment at the most clinically appropriate setting, to provide safe and effective treatment while addressing the member's biopsychosocial needs. All members admitted to a 24-hour setting are eligible for Magellan's care management services to promote transitions of care.

Our Policy

Certification (synonymous with authorization) of benefits is based on clinical information relevant to the type and level of service requested, using the [Magellan Care Guidelines](#) or other state-specific or customer-specific clinical criteria for benefit certification. Facilities must contact Magellan to request benefit certification for admission and for continued stay beyond certified days. An exception is made in situations where patients are seeking emergency services and those services are needed to evaluate or stabilize the emergency situation.

We may utilize methods of certification other than a clinical review. For many higher levels of care, a Notice of Admission based solely upon member eligibility and coverage for requested service may be allowed at the discretion of Magellan and should not be expected by the provider.

What You Need to Do

Your responsibility is to:

- Become familiar with Magellan's clinical review documentation guidelines to prepare benefit certification/authorization information required for:
 - Admission (see [Appendix C](#)).
 - Continued stay or additional services (see [Appendix D](#)).
 - Discharge plan and post-discharge services for continuity of care (see [Appendix E](#)).
- Contact Magellan for initial benefit certification/authorization prior to admitting. Failure to comply may result in denial.
- Facilitate the benefit certification/authorization process when necessary for the Magellan physician advisor to have a "peer-to-peer" discussion with the attending psychiatrist or someone at the facility designated by the attending psychiatrist who is directly involved in the care of the member and can adequately represent the attending psychiatrist for a peer-to-peer discussion. Make pertinent medical records available prior to the discussion.

- When requesting an authorization by provider portal or by telephone call, provide Magellan with a thorough assessment of the member so that an appropriate certification/authorization determination can be made.
- Be familiar with the [Magellan Care Guidelines](#), or other approved clinical criteria for medical necessity if not Magellan-specific.
- View care authorizations on Magellan’s provider portal (or the sites of Magellan’s contracted vendors, as directed). Securely sign in to your password-protected account. Follow website instructions to submit or view your authorization request. **Note: Magellan only sends certification/authorization information by U.S. Mail by exception or when required contractually or by regulation.**
- Collaborate with the Magellan care management representatives by facilitating direct communication between the member and a care management team member prior to discharge, to assist you with developing a solid discharge plan shortly after a member’s admission to an inpatient setting or to extend an initial authorization.
- Contact Magellan for additional or other types of behavioral health benefits if needed prior to expiration of the current certification/authorization. Note that as Magellan expands its website capabilities, this contact may be available online.
- Contact Magellan before referring a member in care to *another* provider, including other Magellan network providers.
- Facilitate collaboration between your facility and Magellan’s care managers and transition of care specialists shortly after admission as part of the discharge planning process, and encourage members to agree to participate in care management and transition of care services.
- Note that members being discharged from an inpatient setting must have a post-discharge appointment scheduled and in place prior to the actual discharge. See [Appendix F](#) for a Q & A with additional details.
- Not bill a member for services that have not been certified/authorized by Magellan.

What Magellan Will Do

Magellan’s responsibility is to:

- Provide prompt, fair review of the information received.
- Notify you promptly of the decision electronically online at www.MagellanProvider.com (or the sites of Magellan’s contracted vendors, as directed).
- Facilitate your referrals to other providers and coordinate member changes in levels of care.
- Inform you of your appeal rights and process.

SECTION 3: THE ROLE OF THE ORGANIZATIONAL OR FACILITY PROVIDER AND MAGELLAN

Eligibility

Our Philosophy

Our philosophy is to collaborate with our customers to provide a benefit structure designed to meet the needs of the customer's eligible members. We rely on our customers to notify us of member eligibility.

Our Policy

Based on the member's benefit plan and eligibility information provided by our customers, we assist providers in determining member eligibility.

What You Need to Do

Your responsibility is to:

- Obtain the member's health benefit plan card at the time of admission and copy both sides of the card for the member's file.
- Check eligibility online or call the number listed on the member's health benefit plan card to check eligibility, benefits, copayment and claim submission information.*
- Document the phone number you called, date, time of day and name of person with whom you spoke.
- Provide Magellan with your name and professional credentials for our records.
- Provide Magellan with the member's current demographic information, e.g., email address and phone number.
- See the section on [Before Services Begin](#).

What Magellan Will Do

Magellan's responsibility is to inform you of the member's eligibility based on the information provided to Magellan by the customer.*

****Checking eligibility does not guarantee claims payment. Claims payment depends on a variety of factors including but not limited to whether the service is covered, whether any applicable deductibles have been met, whether the member has benefits available or whether the insurer is the primary or secondary payer.***

SECTION 3: THE ROLE OF THE ORGANIZATIONAL OR FACILITY PROVIDER AND MAGELLAN

Appealing Care Management Decisions

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| Our Philosophy | We support the right of members or their providers to appeal or dispute adverse benefit determinations. |
| Our Policy | Applicable state and federal laws and accreditation standards govern Magellan’s appeal and dispute policies. |
| What You Need to Do | <p>Your responsibility is to:</p> <ul style="list-style-type: none">• Review the adverse benefit determination notice (non-certification/non-authorization letter) or explanation of benefit (EOB)/explanation of payment (EOP) notification for:<ul style="list-style-type: none">○ The specific reason(s) for the adverse determination,○ Appeal and dispute options available to you (e.g., you may or may not have the right to appeal on behalf of a member),○ Procedures and submission timeframe, and○ Specific documents required for submission in order to complete an appeal or dispute review.• Inform the patient/subscriber/legal guardian directly about the reason for the adverse determination, as well as the medically necessary level of care that Magellan is willing to authorize.• Follow the process described in the non-certification/non-authorization letter or EOB/EOP determination notice to submit an appeal.• Submit all the appeal or dispute information in a timely manner. |
| What Magellan Will Do | <p>Magellan’s responsibility is to:</p> <ul style="list-style-type: none">• Inform you in writing, in a clear and understandable manner, of the specific reasons for the adverse determination.• Identify specific information, documents, records, etc., needed to assist in an equitable dispute or appeal decision.• Thoroughly review all information submitted for an appeal or dispute.• Respond to appeals and disputes in a timely manner.• Notify you of any additional appeal or dispute options that may be available when an unfavorable appeal or dispute determination is rendered. |

SECTION 4: THE QUALITY PARTNERSHIP

Site Visits

Our Philosophy

Magellan believes that site visits are an important part of our quality improvement program. Magellan performs site visits:

- As a quality measure in selecting providers for our network,
- To communicate performance expectations and standards to providers,
- As an assessment of non-accredited organizations prior to initial credentialing and at recredentialing,
- As a component of a quality review, and
- To promote compliance with standards of regulatory entities and accrediting organizations.

Our Policy

Magellan conducts site visits of organizational providers:

- That are not currently accredited by a recognized accrediting agency*,
- To evaluate programmatic services, staffing, facilities, documentation, etc., or
- For further review of quality of care and service concerns.

**Acceptable recognized accreditation for organizational providers includes: The Joint Commission (TJC), American Osteopathic Association Healthcare Facilities Accreditation Program (HFAP), CARF International (CARF) [formerly Commission on Accreditation of Rehabilitation Facilities], Council on Accreditation (COA), Accreditation Association for Ambulatory Healthcare (AAAHC), National Integrated Accreditation for Healthcare Organizations (of DNV-GL) (NIAHO[®]), Center for Improvement in Healthcare Quality (CIHQ), Accreditation Commission for Healthcare, Inc. (ACHC) – Behavioral Health, and Community Health Accreditation Program (CHAP) .*

Site visit requirements for initial credentialing and recredentialing may be satisfied by a CMS site visit or a state licensure site visit when these requirements are equivalent to Magellan assessment standards.

What You Need to Do

Your responsibility is to:

- Cooperate with the quality reviewer's requests.
- Provide all necessary documents.
- Facilitate an on-site review, if requested.
- Collect your policy and procedure materials and forms, and have them in one location for ready access.

- Have a sample of blinded charts available for the reviewer to demonstrate that record-keeping practices are consistent with Magellan requirements.
- Have evidence of credentialing and primary source verification of clinical staff available for the reviewer.
- Make training logs and other evidence of required training available.
- Make available any specific treatment records or other documents requested by Magellan clinical staff. See the Organization Site Review Guide in [Appendix A](#) for additional information.

**What Magellan
Will Do**

Magellan’s responsibility is to:

- Conduct site visits for organization credentialing of non-accredited organizational providers and other organizations, as appropriate.
- Conduct site visits for quality-of-care issues, as appropriate.
- Provide timely, written communication regarding site visit results, including a description of strengths and opportunities for improvement noted by the reviewer.

SECTION 4: THE QUALITY PARTNERSHIP

Use of Seclusion and Restraints

Our Philosophy

Magellan believes the use of seclusion and restraints, both physical and chemical, is a last resort for maintaining the safety of patients, visitors, and treatment personnel, and should be utilized only in an emergency and when clearly indicated by a policy detailing specific criteria. Magellan supports the Centers for Medicare & Medicaid Services' manual on day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives which include a section on the use of seclusion and restraints entitled (CMS) *Standard: Seclusion and Restraint for Behavior Management* . (Standard 482.13(e) & (f)).

Our Policy

Magellan's contracted facilities must have written policies that include last resort indications for the use of seclusion or restraints, and specific monitoring parameters during the period of seclusion or restraint. Such measures are to be implemented when medically necessary, in the least restrictive manner by personnel specifically trained in safe and appropriate techniques, and discontinued at the earliest possible time. Seclusion and restraints are not to be used for disciplinary purposes or as a standing order. When there is a need to utilize seclusion or restraints, facilities will treat patients with the utmost dignity and respect and protect them from humiliation.

What You Need to Do

Your responsibility is to:

- Annually review and revise a policy or policies that include:
 - A mission statement and values for the safe and proper use of seclusion and restraints,
 - General and patient-specific prevention initiatives for reducing the use of seclusion and restraints,
 - Fostering appropriate staff knowledge, expertise and skills concerning the use of seclusion and restraints, and prescribing multiple measures to avoid inappropriate use, e.g., staff debriefing and education following each use of seclusion and restraints.
- Adhere to state and federal regulations regarding the use of restraint and seclusion.
- Review and consider utilizing *Guiding Principles on Restraint and Seclusion*, a joint document developed by the American Hospital Association and the National Association for Behavioral Healthcare to

help member organizations review their policies and procedures related to restraint and seclusion. (Click on <https://www.nabh.org/nabh-resources/> and scroll down to Publications.)

**What Magellan
Will Do**

Magellan’s responsibility is to:

- Inform you of patient safety issues and quality of care concerns.
- Support you with better practices information related to patient safety and the use of seclusion and restraints.
- Monitor your safety program.
- Provide guidance and collaborate with you in your efforts to address specific safety measures such as the use of seclusion and restraints.

SECTION 5: PROVIDER REIMBURSEMENT

Claims Filing Procedures

Our Philosophy

Magellan is committed to reimbursing our providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to facilitate prompt processing of their claims.

Magellan strongly encourages providers to submit claims electronically either through the Direct Submit process, through www.MagellanProvider.com (or the sites of Magellan's contracted vendors, if directed) or through a clearinghouse. Electronic claims filing improves efficiency and accuracy, and is less costly than submitting paper claims. You can find detailed information on electronic claims submission in [Appendix G - Claims Tips and Information](#).

Our Policy

Magellan reimburses organizational providers within prompt payment standards for inpatient and program services, according to member eligibility and benefit plans, contracted rates and reimbursement schedules.

What You Need to Do

Your responsibility is to:

- Contact Magellan prior to rendering care if the member's benefit plan requires certification/authorization for the service.
- Complete all required fields on the UB-04 (also CMS-1450) or CMS-1500 claim form accurately.
- Collect applicable copayments or coinsurance from members.
- Follow the detailed claim form completion standards found in the [Magellan National Provider Handbook Appendix](#).
- Submit claims for professional services delivered in conjunction with inpatient per diems as inclusive or exclusive, in accordance with the terms of your agreement with Magellan.
- Use standard code sets as established by the Centers for Medicare & Medicaid Services (CMS) for the specific claim form (UB-04 or CMS-1500) you are using. (You can find additional information under [Billing Codes and HIPAA Compliance](#).)
- Submit claims within 60 days of the provision of covered services or as set forth in your agreement with Magellan.
- Submit claims only for services rendered within the time span of the benefit certification/authorization.

- Submit claims with your non-discounted billed charge even if it is lower than the Magellan contracted rate.
- Contact Magellan for direction if authorized services need to be used after the certification/authorization has expired.
- Not bill the member 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.
- Call your Magellan Network contact if you are not certain which reimbursement rate applies to the member in your care.
- Call the customer service number indicated on the member's health benefit plan card for assistance if you are unsure of the Magellan Care Management Center managing the member's care.
- Review [Appendix G](#) - Claims Tips and Information.

**What Magellan
Will Do**

Magellan's responsibility is to:

- Provide verbal notice, send a benefit certification/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.
- Inform you of any reasons for administrative denials and action steps required to resolve the administrative denial.
- Send you or make available online an explanation of payment (EOP) or other notification for each claim submitted, including procedures for filing 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. The claim may deny for insufficient information, subject to applicable state and federal law.
- Regularly update the Universal Services List and HIPAA-compliant billing codes for behavioral services, posted on www.MagellanProvider.com.
- 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.
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

SECTION 5: PROVIDER REIMBURSEMENT

Billing Codes and HIPAA Compliance

Our Philosophy

We offer support to our providers by sharing information about recommended [HIPAA-compliant billing codes](#). Using these codes for both paper and electronic transactions benefits Magellan and our providers, resulting in prompt and accurate claims payment.

Our Policy

Providers must use standard code sets approved by the Centers for Medicare & Medicaid Services (CMS) for HIPAA compliance on both paper and electronic claims. Standard code sets include ICD-10-CM diagnosis codes, Current Procedural Terminology (CPT®) Fourth Edition codes and modifiers, HCPCS procedural codes with modifiers, revenue, Type of Bill, discharge status codes and Place of Service codes.

What You Need to Do

Your responsibility is to:

- Use the current version of ICD-10-CM codes (not DSM-5) on claim submissions. (See the CMS ICD-10 website at www.cms.gov/icd10 for additional information about ICD-10-CM.)
- Order ICD-10-CM manuals from the [American Medical Association](#) (AMA) website or by calling 1-800-621-8335, or order from Channel Publishing at 1-800-248-2882. You may order a CD-ROM of the complete listing from the United States Government Printing Office at: U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7594, or by calling the Ordering Office at 1-866-512-1800. See the CMS ICD-10 website at www.cms.gov/icd10 for information about obtaining ICD-10-CM codes.
- Use current CPT® Fourth Edition codes and modifiers to bill for professional services.
- Obtain copyrighted CPT® Fourth Edition codes and modifiers from the [American Medical Association](#).
- Obtain HCPCS codes from CMS at www.cms.hhs.gov.
- Use the industry-standard HIPAA-compliant code recommendations from the Magellan Universal Services list when billing for organization services. These codes are posted on www.MagellanProvider.com.
- Submit a license level modifier for the clinical professional rendering outpatient behavioral health service on behalf of an organization listed in [Appendix G](#) Billing Tips, number 14.
- Obtain your National Provider Identifier (NPI) for use in submitting HIPAA-standard electronic transactions or paper claim forms to

Magellan, and include this number on all claims submitted. To ensure accurate claims payment, we strongly encourage organizations to enumerate subparts at the site address level. Review the [NPI page](#) on our provider website for more information.

- Review the *Reimbursement* sections in this supplement and in the Magellan National Provider Handbook for additional claims submission information.

**What Magellan
Will Do**

Magellan’s responsibility is to:

- Post HIPAA-compliant codes on our provider website for standard services as they are approved and assigned by CMS and industry code-set owners.
- Inform you of how to find the current HIPAA-compliant code sets through CMS and the AMA.
- Identify coding gaps for services required by our customers, in conjunction with other behavioral health industry leaders, including the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).
- Request from CMS, and/or the code-set owners, assignment of appropriate coding for standard and public sector services, when gaps are identified.
- Share your NPI with health plans with which we coordinate your HIPAA-standard transactions.

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 the Centers for Medicare & Medicaid Services (CMS) and HIPAA compliance standards. Magellan offers an online claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. We provide both of these options on Magellan's website (or the sites of Magellan's contracted vendors, as directed) at no cost to our providers. In addition, we have several contracted clearinghouses through which both facility-based claims and professional claims can be submitted.

What You Need to Do

Your responsibility is to:

- Submit claims to Magellan, including those submitted on a UB-04 (also CMS-1450) or a CMS-1500, through a direct-submit upload process if you are able to transmit data in a HIPAA-compliant 837 format. To establish this process, go to our [EDI Testing Center](#) (at www.edi.MagellanProvider.com), create a unique username/password, download the Abbreviated Companion Guide, and upload a test file to run through HIPAA validation. You will need to 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 that you can submit actual claim files. If you have any questions or need assistance, contact EDI Support by email at EDISupport@MagellanHealth.com.
- If you do not have the ability to transmit data in a HIPAA-compliant 837 format and you need to electronically submit claims completed on a CMS-1500, consider the claims submission option available on Magellan's provider website (or the sites of Magellan's contracted vendors, as directed).
- Consider using the services of one of our [contracted clearinghouses](#) listed on www.MagellanProvider.com.

Note: You also can submit electronic claims to a non-approved clearinghouse, as long as your clearinghouse contacts one of the Magellan-approved clearinghouses to arrange to transmit the claims.

**What Magellan
Will Do**

Magellan's responsibility is to:

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

APPENDIX A

Organization Site Review Preparation Guide

Please have the documentation listed below available for the Magellan reviewer on the day of your review.

| <p>DOCUMENTS WE NEED COPIES OF The Magellan site reviewer will need copies of the following documents during the review:</p> | <p>DOCUMENTS TO SEE AND REVIEW The Magellan site reviewer will need to review the following documents during the review:</p> |
|--|---|
| <ol style="list-style-type: none"> 1. One of the following accreditations, with copy of feedback and any plan of correction if deficiencies were cited, if requested: <ol style="list-style-type: none"> a) Joint Commission (TJC) accreditation (inclusive of all sites contracted by Magellan), OR b) Healthcare Facilities Accreditation Program (HFAP), OR c) CARF International (CARF), OR d) Council on Accreditation (COA), OR e) Accreditation Association for Ambulatory Health Care (AAAHC), OR f) National Integrated Accreditation for Healthcare Organizations (of DNV-GL) (NIAHO®), OR g) Accreditation Commission for Healthcare (ACHC) – Behavioral Health, OR h) Center for Improvement in Healthcare Quality (CIHQ), OR i) Community Health Accreditation Program (CHAP) 2. State licensure/certification (all that apply) | <ol style="list-style-type: none"> 1. Organizational chart 2. Clinical documentation that outlines program content and structure 3. Referral source procedures and supporting documents, including both incoming and outgoing referrals 4. Quality management program documents, including description, plan, minutes, studies, satisfaction surveys, etc. 5. Policies, procedures for reporting critical incidents; logs of reporting 6. Utilization management (UM) procedures, supporting documents 7. Policies, procedures for member/patients’ rights; rights statement, evidence of distribution of same 8. Complaint policy, procedures, tracking logs 9. Policies, procedures regarding advance directives (if applicable) 10. Policies, procedures on confidentiality of member information, disclosure of information 11. Policies, procedures on treatment/case record documentation; sample of blinded records 12. Safety management policies, procedures including use of seclusion and restraint 13. Disaster plan; evacuation plan; fire marshal inspection certificate; record of drills, etc. 14. Job descriptions 15. Human resource policies, procedures related to hiring of professional staff and other staff providing direct services; includes verification of training, experience, license checks, reference checks, drug/alcohol testing supporting documents, etc. Sample of files 16. Policies, procedures related to credentials verification of licensed professional staff, including primary source verification procedures. Sample of credentials files 17. Supervision policy, procedures and supporting documents 18. Orientation, training, ongoing professional development program tracking |

APPENDIX B

What You Need to Know About Organization Credentialing and Contracting

Your time is valuable, and we are committed to making the process of getting you on board as efficient as possible. To that end, we have compiled a list of the most frequently asked questions we receive about organization credentialing and contracting. These are general guidelines. We invite you to visit us online at www.MagellanProvider.com for more information about Magellan and our provider networks. If you have specific questions, please contact your area contract manager.

What does an organization need to do to be considered an in-network provider with Magellan?

To be an in-network provider, the organization must be contracted with Magellan. The contracting process includes an assessment of each site specified in the agreement against Magellan's credentialing criteria.

What is credentialing?

Credentialing is the process Magellan uses to verify and periodically re-verify an organization's credentials (for all contracted sites) in accordance with credentialing criteria.

What does the organization credentialing process include?

The credentialing process includes:

- **Credentials Verification** – Magellan verifies your organization's licensure, accreditation, professional liability and general liability insurance coverage, and claims history, and Medicaid/Medicare program participation status and sanctions history. A Magellan site visit, or review of your CMS or state licensure site visit inspection, may be performed as a part of the assessment process.
- **Committee Review** – If your organization's credentials satisfy Magellan's standards, your organization's application is sent to a Regional Network and Credentialing Committee (RNCC) consisting of Magellan clinical staff and professional peers. The RNCC reviews applications subject to applicable state laws and our business needs. If your organization successfully completes the credentialing process and the programs and services are needed for members in your area, your organization will be accepted into the provider network pending execution of your organization's agreement.

How long does the credentialing process take?

Once all the required documents have been submitted, the credentialing process can typically be completed within 90 days. Site visits required for non-accredited organizations may lengthen the time.

Do individuals within the organization need to be credentialed in order to render services to Magellan members?

The organization must have a process to credential its practitioners. Practitioners who provide services to members must meet Magellan’s credentialing requirements for individual practitioners. If the organization can demonstrate that it performs verification of the credentials for its staff members, no credentialing of individual staff members by Magellan is required. If the organization cannot demonstrate that it performs the required verifications, the individual professional providers may not render outpatient services to Magellan members until Magellan credentials them. A separate professional group agreement with Magellan may be required in these instances.

How will our organization be notified if accepted into the Magellan networks?

Upon acceptance into the Magellan provider networks, your organization will receive a welcome letter along with your fully executed Facility and Program Participation Agreement or Network Provider Agreement, as applicable.

Will we be notified if our organization is not accepted into the Magellan provider networks?

In the event that your organization is not accepted into the Magellan provider networks, we will notify your organization in writing.

Once our organization completes the credentialing process, are the credentials good for the life of the contract?

No. As a condition of continued participation as a Magellan provider, we recredential organizational providers at least every three years. This process supports maintaining provider network quality. If your organization’s programs and services match our service needs in your area, your organization will continue as a Magellan provider.

What is the Magellan Facility and Program Participation Agreement?

Your Magellan Facility and Program Participation Agreement is the contract between your organization and Magellan to render behavioral healthcare services to members whose care is managed by Magellan. The contract sets forth the terms and conditions of your organization’s participation in the Magellan network as well as the terms and conditions applicable to Magellan. Newly contracted facilities may receive the Network Provider Agreement, but the same rules apply.

If we sign this Agreement, will each practitioner in the organization be eligible to see all members whose behavioral healthcare is managed by Magellan?

If your organization successfully completes the credentialing process AND if your practitioners’ specialties, licenses and training meet Magellan’s requirements, practitioners in your organization will be eligible to treat members, within their scope of practice, for the lines of business for which the organization is contracted.

For what Magellan plans is our organization contracted?

The plans for which your organization is contracted are identified by the reimbursement schedules included with your Agreement.

When does our contract become effective?

The effective date of your Magellan Facility and Program Participation Agreement, or Network Provider Agreement, appears on the first page of the Agreement. This date is the same as the date on the signature line used by Magellan to countersign and execute the Agreement unless a different start date has been agreed upon.

Where can I find out more about Magellan's policies and procedures?

You can access the Magellan National Provider Handbook, the state-specific and plan-specific supplements to the national handbook, Magellan Care Guidelines, Clinical Practice Guidelines, Professional Provider Selection Criteria for Individual Providers ([handbook appendix](#)), and many additional resources online at www.MagellanProvider.com.

APPENDIX C

Benefit Certification: Admission

If not approved for online Notice of Admission, facilities must call Magellan to certify admission following emergency care and stabilization services in an emergency department (also referred to as post-stabilization).

Please have the following information readily available when contacting Magellan to request admission benefit certification in order to prevent delays in the certification process:

Facility Contact Information

- Facility name and location if the facility is part of a wider system
- Name, title and contact information including telephone extension of the facility person contacting Magellan
- Name, credentials and contact information, including extension, of the facility's utilization review (UR) staff if the facility person contacting Magellan is not from the UR department

Member Information

- Name, date of birth, and health insurance ID
- Current member demographics, e.g., phone number, email address, etc.
- Location of member at time of request (in the emergency room [ER], admission area, or if already admitted – room number and name of floor or unit)
- Member's primary care provider (PCP) name and contact information (required for members with HMO and POS benefits)

Benefit Request Information

- Proposed admission date
- Admitting primary and secondary diagnoses
- Benefit request specifics – setting and acuity level:
 - Acute inpatient
 - Sub-acute inpatient (if requesting admission to behavioral health residential services)
 - Sub-acute outpatient services such as partial hospitalization or IOP
- Attending psychiatrist name and contact information
- Anticipated length of stay /discharge date
- Referring provider, as applicable

Clinical Information to Support Benefit Request

- How member presented (emergency or non-emergent intake)
- Presenting symptoms
- Risk assessment (suicidal/homicidal: ideation, threats, gestures, intent; self-abuse attempts/physical aggression)
- Psychiatric treatment prior to presenting at the facility (name of provider[s], last visit)
- Substance use disorder (SUD) treatment (substance use upon presenting, prior detoxification, most recent post-detoxification treatment)
- Medical history (hypertension, diabetes, stroke, COPD, heart failure, prior head injury, etc.)
- All current medications (psychiatric and medical)

Organizational and Facility Provider Handbook Supplement

- Results of diagnostics performed (vital signs, laboratory tests)
- Support system (family, residence stability in community, transportation issues)
- Plan of care upon admission (therapies, medications, anticipated discharge date and preliminary discharge plan)
- Identified social determinants of health

APPENDIX D

Benefit Certification: Continued Stay

Contact Magellan prior to the end of the current benefit certified/authorized period when anticipating a need for additional services.

Please have the following information readily available when contacting Magellan or when responding to our outreach to prevent delays in the certification process:

Benefit Request Information

- Updates to primary and secondary diagnoses (mental health and/or substance abuse)
- Benefit specifics – setting and acuity level for additional days/services:
 - Acute inpatient
 - Sub-acute inpatient (if requesting admission to behavioral health residential services)
 - Sub-acute outpatient services, such as partial hospitalization or IOP
- Anticipated length of stay /target discharge date

Clinical Information to Support Benefit Certification Request

- Progress of the member with plan of care
- Risk reduction
- Results of additional diagnostics performed (vital signs, laboratory tests)
- Changes in support system (family, residence stability in community, transportation issues)
- Plan for family and/or support system at discharge (provide date)
- Plan of care updates (therapies, medications, anticipated discharge date and preliminary discharge plan)
 - Post-discharge behavioral health provider
 - Post-discharge setting of care and acuity with details
 - Post-discharge appointment/intake date and time scheduled within seven days after the discharge date, with name of the participating provider **(required to receive an extension of authorization)**
- Social determinants of health impacting progress
- Best telephone number/contact information to reach member post discharge
- Collaboration with Magellan staff to connect member with our care management team to speak to member prior to discharge about services that may be available to the member in support of post-care assistance

Note: NCQA NATIONAL INDUSTRY STANDARD – If the discharge is to a non-inpatient level of care, the post-discharge appointment with a behavioral health provider must be within seven days after the discharge date. This is one of NCQA’s key HEDIS® (Healthcare Effectiveness Data and Information Set) follow-up standards for measurement of behavioral healthcare quality.

APPENDIX E

Benefit Certification: Discharge and Post-Discharge Continuity of Care

Contact Magellan or respond to Magellan’s outreach to you prior to or on the member’s discharge date to prevent delays in the certification process.

When a facility requests a discharge review, Magellan requires the following information:

Facility Discharge Plan for a Safe and Adequate Discharge

- Facilitate connection between your facility and the Magellan care management team to speak with member prior to discharge
- Details of seven-day post-discharge appointment/intake date and time, behavioral health provider name and contact information
- Best telephone number/contact information to reach the member post-discharge
- Additional discharge information may be required:
 - Psychiatric medications

Note: NCQA NATIONAL INDUSTRY STANDARD – If the discharge is to a non-inpatient level of care, the post-discharge appointment with a behavioral health provider must be within seven days after the discharge date. This is one of NCQA’s key HEDIS® follow-up standards for measurement of behavioral healthcare quality.

APPENDIX F

Frequently Asked Questions

| Question | Answer |
|--|--|
| How do I confirm that a member is covered? | Use our provider portal (or the sites of Magellan’s contracted vendors, as directed) to obtain member benefits and eligibility. If needed, you may contact Magellan for assistance by calling the number on the back of the member’s health benefit card. |
| When do I call for preauthorization? | Before the member is admitted or non-emergency services are rendered. |
| What do I do for an admission after business hours or on holidays? | <p>Use our provider portal (or the sites of Magellan’s contracted vendors, as directed) to obtain member benefits and eligibility. If needed, you may contact Magellan for assistance by calling the number on the back of the member’s health benefit card.</p> <p>Most benefit plans have a 24-hour access number that is usually the same as the number to call during business hours and can be found on the member’s health benefit plan card. If the plan does not have 24-hour access and asks you to call on the next business day, document the phone number you called, the date, time of day, a description of the voice message received and the name of the person calling for authorization, then place another call on the next business day.</p> |
| What preauthorization information is needed? | Refer to Appendix C of this Supplement. |
| Where do I find the Magellan Care Guidelines? | The Magellan Care Guidelines are available on Magellan’s provider website, www.MagellanProvider.com/mnc . |
| What do I do if an adverse incident occurs? | Contact the Magellan care manager managing the case right away. See additional information in the National Provider Handbook , Section 4: Adverse Outcome Reporting. |
| What do I do in emergency situations? | Manage the emergency in the most appropriate manner in order to protect the member. Then notify Magellan by calling the phone number on the member’s health benefit plan card. Most plans offer a 24-hour access phone number. If the plan does not have 24-hour access and instructs you to call on the next business day, document the phone |

| Question | Answer |
|---|--|
| | number you called, the date, time of day, a description of the voice message received and the name of person calling for authorization. Be sure to place another call on the next business day. |
| What is the timeline for physician-to-physician reviews? | Physician-to-physician reviews must occur within one business day of the request. |
| What does Magellan consider an adequate mental status exam? | A mental status exam must include the following: Appearance, level of consciousness, attitude, orientation, memory, cognitive functioning, attention, psychosis/perceptual disturbance, mood, affect, psychomotor activity, thought process, speech/language, thought content, insight and judgment, and assessment of dangerousness (to self, to others, or via functional impairments). |
| Do facilities need to use current diagnosis codes? | Yes. Facilities should use DSM-5 (the professional standard coding system for behavioral health) to determine the clinical diagnosis and the corresponding ICD-10–CM codes for billing purposes to satisfy HIPAA compliance requirements. (Use successor code sets when published on their effective dates.) |
| What is the appeal and dispute process? | Because the appeal and dispute processes vary depending on customer requirements and state laws, clinical or administrative non-authorization appeal procedures are outlined in the non-certification/non-authorization letter. |

APPENDIX G

Claims Tips and Information

1. Electronic claims filing is the most cost-effective way to receive reimbursement quickly. Magellan offers both an online claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. In addition, Magellan works with several clearinghouses (see details below).
2. Submit claims on the UB-04 (also CMS-1450) form for facility and program services. Submit professional services claims on the CMS-1500.
3. Complete all the fields on the claim form to prevent your claim from being delayed or returned. Guidelines for clean claim filing are provided in Section 5 of the [Magellan National Provider Handbook](#).
4. The Taxpayer Identification Number (TIN) submitted on the claim must be for the practice or location where the care was authorized and where the services were rendered. To notify Magellan of any change in TIN or address, sign in at www.MagellanProvider.com to edit your practice information/Form W-9, or notify Magellan's Provider Relations department in writing. Then submit the claim with the current information.
5. If the member self-refers, call the customer service number on the member's health benefit plan card prior to rendering services to verify the member's active coverage, your status in the Magellan network serving that member, and preauthorization requirements.
6. Contact Magellan for reauthorization if the type of service and/or primary diagnosis change after an authorization is given. Benefits are paid according to the primary diagnosis. The level of service and level of care authorized by Magellan must match the care billed.
7. A service may be preauthorized, yet payment denied for reasons including but not limited to:
 - Member plan benefits are exhausted
 - Eligibility/benefit coverage not in evidence
 - Coordination of benefits form not on file
 - Incorrect or incomplete information on the claim
 - Claim components such as CPT[®] codes, revenue codes or place of service differ from the authorization

The per diem rate includes the professional service pursuant to the terms of your agreement with Magellan.

8. Submit your claim to the correct address. The member's health plan benefit card and the authorization letter include the correct address for submission of your claim for the services provided to the member and a telephone number for questions about claims submission.
9. Contact your Magellan area contract manager or local provider service representative for assistance if your organization's claims payment does not match your organization's contracted rate and a Magellan customer service representative advises you that your claim has been paid correctly. As an alternative, you may submit a written appeal, including a copy of your organization's contract.
10. Call Magellan customer service before re-submitting a claim that has a paid status if there are no changes to the original claim submission. If there is a change to the original claim (e.g., CPT[®] code change or billed amount), then the claim must be resubmitted with a clear indication that this is a corrected billing.
11. Submit claims within 60 days of rendering service to meet Magellan's timely filing requirements or as specified by provider contract, regulatory amendment and/or state requirements. Depending upon the benefit plan, submitting a claim after the timely filing requirement may result in a denial of the claim.
12. Do not bill ancillary services, including history and physicals or services by an outside clinician (Ph.D., M.A., M.S.W., etc.) rendered in a participating facility separately from the per diem charge.
13. Bill for emergency room charges only if the member is **not** admitted. Per diems include emergency room charges when the member is admitted.
14. Submit claims using behavioral health codes:
 - a. Residential Treatment: submit on a UB-04 with
 - Revenue Codes 1001 - Residential Treatment, Psychiatric or
 - Revenue Codes 1002 - Residential Treatment, Chemical Dependency.
 - b. Intensive Outpatient (IOP) services: when submitted on a UB-04, use:
 - Revenue Code 0905 - IOP Psychiatric or
 - Revenue Code 0906 - IOP Chemical Dependency.
 - c. If you submit IOP claims with the CMS-1500 form, use the correct HCPCS Code (S9480 - Psychiatric IOP or H0015-Alcohol/Drug IOP).
 - d. Group therapy codes (CPT[®] or Revenue) do not accurately describe IOP and cannot be accepted.
 - e. Magellan requires (for organizational providers only) the following professional service modifier for each outpatient service claim line submitted, based on the license of the rendering provider, so that claims can be paid correctly on first submission:

- AF – Specialty Physician
- AG – Primary Physician
- AH – Clinical Psychologist or
- HP – Doctoral Level (Psychologist)
- AJ – Clinical Social Worker
- HO – Master’s Degree Level (Counselor)
- SA – Nurse Practitioner or
- TD – Registered Nurse
- HF – Substance Abuse Program (National Certified Addictions Counselor or State Substance Abuse Certifications).

Note: Select the code that best applies. Nurses and other professionals may only provide services and bill for CPT codes that fall within the scope of practice allowed by their professional training and state licensure.

Examples:

CMS-1500 Form: insert modifier in Field 24d under “Modifier” or

UB-04 (or CMS-1450) Form: insert modifier with CPT or HCPCS code in Field 44, e.g., “90791 AH”

- f. Public sector plans may have unique HIPAA modifiers. Find these at www.MagellanProvider.com/coding.
15. All attending physicians must submit name, NPI and taxonomy code on UB-04 claims and 837I transactions.
16. All ambulance/transportation claims (including POS 41 or 42) must include pick-up and drop-off locations.

APPENDIX G

Coordination of Benefits (COB) Procedures

Magellan coordinates benefits with other payers when a member is covered by two or more group health benefit plans. During benefit enrollment or whenever there is a change in coverage, members are required to provide information to each carrier if they have more than one benefit carrier.

To facilitate prompt claims processing, this information must be forwarded to Magellan along with other essential eligibility information. By verifying eligibility information prior to seeing members, providers help make sure that benefit updates and changes are completed, thereby avoiding claims processing delays. There are specific boxes on all claim forms that request coordination of benefits information.

When any of the following circumstances exist, Magellan generally investigates the possibility of primary coverage and other party liability (OPL) prior to paying the claim.

- The claim is not an outpatient level of care.
- An explanation of benefits (EOB) from another health insurance carrier is attached to the claim.
- Other insurance information is printed in Box 9 A-D on the CMS-1500 claim form.
- Box 11D on the CMS-1500 is checked “yes.”
- Box 29 on the CMS-1500 indicates that a payment has already been made to the provider by a source other than Magellan.
- Box 50 and Boxes 58-61 on the UB-04 claim form indicate other insurance information.
- Any information on the claim or attached to the claim indicates the possibility of other insurance. (**Example:** *copy of an insurance card from another carrier, or letter from another insurance company.*)
- The claimant is 65 years of age or older.
- COB information is on file for other family members.
- The member's last name is different from the subscriber(s) listed on the claim.

Specific health plan contractual arrangements or state regulatory requirements may require that Magellan pay the claim first and then investigate the possibility of dual coverage. In most instances, however, Magellan will attempt to contact the member to clarify the situation prior to paying the claim. Claims falling within this description are considered “unclean” and are not subject to most prompt payment laws until the issue has been resolved. In these cases, providers and members are notified in writing that the claim will remain unpaid until further information is received from the member, and that if payment and/or nonpayment notice is not received within 120 days of the date of the EOB/EOP, providers may pursue payment from the primary carrier or the member.

APPENDIX G

Checklist for Submitting Electronic Transactions to Magellan

If you are a Magellan-contracted provider, you should already have obtained an MIS number/username from Magellan. This is found in the welcome letter sent to you from Magellan Network Services.

Please follow these steps in order to submit electronic transactions to Magellan:

Direct Claims Submission

- Initiate the direct submit process with Magellan and/or contact Magellan EDI Support.
- Download and review companion guides and FAQs.
- Complete the EDI survey.
- Magellan will review your completed survey, and if you meet the criteria for direct connect, we will give you access to start submitting test files. If you do not meet the qualifications, we will direct you to use one of our alternative electronic submission options.
- Once testing is complete, you will receive another email notifying you that you are able to send production files.

- Or -

Submission on Magellan's provider portal

- Go to www.MagellanProvider.com (or sites of Magellan's contracted vendors, as directed) and sign in with your secure username and password.
- Follow the prompts to submit a claim.

- Or -

Clearinghouse Submission

- Research [clearinghouses contracted with Magellan](#). Choose and enroll with a clearinghouse.
- After enrolling with a contracted clearinghouse, begin testing with your clearinghouse according to their instructions. Once testing is complete, you will be ready to send production files.
- Submit and/or receive electronic transactions.

Provider questions: Magellan's Provider Services Line, 1-800-788-4005.

Technical questions or support: EDISupport@MagellanHealth.com.

APPENDIX H

Organizational Provider Selection Criteria

Credentialing of Organizations

Administrative credentialing of organizations includes verification that the organization:

1. Is in good standing with state and federal licensing and regulatory agencies, as applicable;
2. Has no Medicare and/or Medicaid sanctions or exclusions from participation in federally funded healthcare programs;
3. Has current state licensure or certification in accordance with applicable state law;
4. Has appropriate current accreditation by The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Healthcare (AAAHC), CARF International (CARF) [formerly Commission on Accreditation of Rehabilitation Facilities], Council on Accreditation (COA), National Integrated Accreditation for Healthcare Organizations (of DNV-GL) (NIAHO®), and/or Accreditation Commission for Healthcare, Inc. (ACHC) – Behavioral Health.
 - a. If the organization does not hold such accreditation, an on-site review may be required; or
 - b. If Magellan has approved the state licensure or CMS criteria as meeting its standards, Magellan may substitute a Centers for Medicare & Medicaid Services (CMS) or state licensing/certification site review in lieu of the Magellan site visit when: 1) the CMS or state review is not greater than three years old at the time of verification; and 2) the site visit report is submitted to verify that the review was performed and has met Magellan standards, or a letter from CMS or the state agency is submitted that shows the organization was reviewed and inspection passed. Magellan may request supplemental information from the organization in addition to verification of the state or CMS site visit.
5. Is not subject to any contingencies or provisions placed on licensure and/or accreditation;
6. Meets Magellan minimum requirements for professional and general liability insurance coverage of \$1 million per occurrence and \$3 million aggregate (a variation to this requirement may apply if approved by Magellan);
7. Successfully completes Magellan requirements for malpractice claims history review;
8. Credentials its practitioners, including verification of licensed practitioners;
9. Completes and submits all required application materials and related documents, including any documentation of current accreditation;
10. Submits staff rosters, if requested by Magellan:
 - a. Staff rosters are to be submitted electronically and contain data fields, as defined by Magellan;
 - b. If a staff roster is requested and the organization is unable to comply with 10a above, an exception to the format may be made by Magellan, in its sole discretion.

All organizations are reviewed and approved by the appropriate Magellan Regional Network and Credentialing Committee (RNCC) prior to network participation and at recredentialing.