IBHP Provider Handbook Supplement

Revision log – updated October 1, 2024

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<tr><th>Date</th><th>Section</th><th colspan="2">Previous Content</th><th colspan="2">New Content</th></tr>
<tr><td rowspan="6">10/1/2024</td><td rowspan="6">The Role of the Provider and Magellan</td><td>Service Authorization Decision Timeframes</td><td>Authorization Turnaround Times</td><td>Service Authorization Decision Timeframes</td><td>Authorization Turnaround Times</td></tr>
<tr><td colspan="2">Behavioral Health: Preservice Authorization Review</td><td colspan="2">Behavioral Health: Preservice Authorization Review</td></tr>
<tr><td>Preservice: Inpatient (acute, subacute facilities and IMDs)</td><td>Notification of admission (NOA) is required to be submitted within 72 hours of admit. Magellan will provide a decision notice within one business day of receipt of a completed request.</td><td>Preservice: Inpatient (acute, subacute facilities and IMDs)</td><td>Notification of admission (NOA) is required to be submitted within 72 hours of admit. Magellan will provide a decision notice within three calendar days of receipt of a completed request.</td></tr>
<tr><td>Preservice: EPSDT requests</td><td>Magellan will review requests for services that fall under EPSDT for medical necessity within 14 business days of receipt of a completed request and medical history information</td><td>Preservice: ASAM levels of care 4.0, 3.7, & 3.5</td><td>Notification of admission (NOA) is required to be submitted within 24 hours of admit. Magellan will provide a decision notice within three calendar days of receipt of a completed request.</td></tr>
<tr><td>Preservice: ASAM levels of care 4.0, 3.7</td><td>Notification of admission (NOA) is required to be submitted within 24 hours of admit. Magellan will provide a decision notice within one business day of receipt of a completed request.</td><td>Preservice: PRTF or Residential Treatment Centers (RTC) & Partial Hospitalization Programs (PHP)</td><td>Magellan will provide the decision in five business days upon receipt of completed request.</td></tr>
<tr><td>Preservice: Standard</td><td>For standard authorization decisions, Magellan will provide the decision notice as expeditiously as the member’s health condition requires, not to</td><td>Preservice: Standard</td><td>For standard authorization decisions, Magellan will provide the decision notice as expeditiously as the member’s health condition requires, not to exceed</td></tr>
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Date	Section	Previous Content		New Content	
			exceed 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional calendar days if (1.) the member or the provider requests extension or (2.) Magellan justifies to the Idaho Department of Health and Welfare (IDHW) upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest.		14 calendar days following receipt of the request for service.
			Preservice: ASAM 3.5 and PRTF or Residential Treatment Centers (RTC)	For ASAM 3.5 and PRTF, Magellan will provide the decision in five business days upon receipt of completed request.	**Preservice: EPSDT requests**	**Magellan will review requests for services that fall under EPSDT for medical necessity within 14 business days of receipt of a completed request and medical history information.**
			Behavioral Health: Concurrent Review		Behavioral Health: Concurrent Review	
			Concurrent: Inpatient (acute, subacute facilities, IMDs)	Magellan will provide the decision notice within one business day upon the receipt of the completed request.	Concurrent: Inpatient (acute, subacute facilities, IMDs)	Magellan will provide the decision notice within **three calendar days** upon the receipt of the completed request.
			Concurrent:	Magellan will provide the decision notice within one business day upon the receipt of the completed request.	**Concurrent: ASAM levels of care 4.0, 3.7 & 3.5**	**Magellan will provide the decision notice within three calendar days upon the receipt of the completed request**
			Request for Extension	For any authorization request, a possible extension of up to 14 additional calendar days may be initiated if (1.) the member or the provider requests extension or (2.) Magellan justifies to the Idaho Department of Health and Welfare (IDHW) upon request	Concurrent: PRTF or Residential Treatment Centers (RTC) & Partial Hospitalization Programs (PHP)	Magellan will provide the decision notice within **five business days** upon the receipt of the completed request.
					Concurrent: Standard	**Magellan will provide the decision notice within 14 calendar days upon the receipt of the completed request.**
					Behavioral Health: Retrospective Review	
					Post Service (Retrospective) Review	**Magellan will provide the decision notice within 30 calendar days upon receipt of the completed request.**
					Behavioral Health: Expedited Review	
					Expedited Authorizations	**For cases in which a provider indicates, or Magellan determines, that following the standard timeframe could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function,**

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<tr><td></td><td></td><td><table><tr><td></td><td>that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest.</td></tr></table></td><td><table><tr><td></td><td>Magellan must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. Magellan may extend the 72-hour time period by up to 14 calendar days if the member requests an extension or Magellan justifies to the IDHW a need for additional information and how the extension is in the member's interest.</td></tr><tr><td colspan="2">Behavioral Health: Timeframe Extensions</td></tr><tr><td>Request for Extension</td><td>For any authorization request, a possible extension of up to 14 additional calendar days may be initiated if (1.) the member or the provider requests extension or (2.) Magellan justifies to the Idaho Department of Health and Welfare (IDHW) upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest.</td></tr></table></td></tr>
<tr><td>6/28/2024</td><td>The Role of the Provider and Magellan</td><td>Screening for Other State Funding Eligibility

Magellan screens individuals not enrolled in Medicaid seeking Substance Use Disorder (SUD) or Mental Health services to determine whether the individual is fiscally eligible for services covered by alternative funding sources, and if the individual belongs to a priority population for SUD services. For eligibility screenings for alternative funding sources from Medicaid ("other state funding"), please contact Magellan at 1-855-202-0973. Individuals deemed eligible for other state funding must provide proof of a Medicaid denial within 30 days of eligibility to continue to access services paid for by other state funding</td><td>Screening for Other State Funding Eligibility

Magellan screens individuals not enrolled in Medicaid seeking Substance Use Disorder (SUD) or Mental Health services to determine whether the individual is fiscally eligible for services covered by alternative funding sources, and if the individual belongs to a priority population for SUD services. For eligibility screenings for alternative funding sources from Medicaid ("other state funding"), please contact Magellan at 1-855-202-0973. Individuals deemed eligible for other state funding must provide proof of a Medicaid denial within 30 days of eligibility to continue to access services paid for by other state funding. These</td></tr>
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			benefits are funded through the Idaho Department of Health and Welfare. Funding is limited and may only be used until funding has run out.
6/28/2024	The Role of the Provider and Magellan	Services Requiring Prior Authorization Service Paid Through Other Funding ** *Paid only through other state funding and not through Medicaid funds.	Services Requiring Prior Authorization Service Paid Through Other Funding ** *Paid only through other state funding and not through Medicaid funds. These benefits are funded through the Idaho Department of Health and Welfare. Funding is limited and may only be used until funding has run out.
6/28/2024	The Role of the Provider and Magellan	Care Management Overview Intensive Care Coordination Magellan's intensive care coordinators are supported by team members with extensive behavioral health expertise including psychiatrists, licensed mental health professionals, pharmacists, and recovery and family support navigators (peer support). ICC is guided by clinical practice guidelines, chronic care guidelines, and evidence-based clinical pathways to support quality and evidence-based decision-making.	Care Management Overview Intensive Care Coordination All of Magellan's intensive care coordinators are licensed clinicians. Magellan's intensive care coordinators are supported by team members with extensive behavioral health expertise including psychiatrists, licensed mental health professionals, pharmacists, and recovery and family support navigators (peer support). ICC is guided by clinical practice guidelines, chronic care guidelines, and evidence-based clinical pathways to support quality and evidence-based decision-making. Magellan care coordinators will: • Make contact with the member or the member's family or guardian at least every 30 days • Work with a youth's clinician to update the CANS at least every 90 days or more frequently if necessary.

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6/12/2024	Magellan's IBHP Provider Network	Network Provider Training These trainings include topics related to the delivery of benefits to members, reporting, billing, Magellan's systems and processes, and all state, and federal requirements.	Network Provider Training These trainings include topics related to the delivery of benefits to members, reporting, billing, Magellan's systems and processes, and all state, tribal, and federal requirements.

6/12/2024	Magellan's IBHP Provider Network	Contracting with Magellan
		
		New information added.
			Contracting with Magellan
			
			Licensed supervising practitioners may submit claims in their name for treatment services provided by non-credentialed practitioners within the group who are under the direct supervision of the licensed supervising practitioner as follows:
			
			Billing Codes/Modifiers/Requirements
			• Paraprofessionals must have services billed under the supervising practitioner.
			  ○ Providers bill the supervising NPI in Box 33.
			  ○ No rendering NPI should be billed and rendering provider identified by name only.
			• Claims should be billed with modifier U1 or UD for appropriate paraprofessional pricing.
			  ○ U1: Prescribers under supervision
			  ○ UD: Master's level provider operating under supervisory protocol

6/12/2024	Magellan's IBHP Provider Network	Indian Health Care Providers (ICHPs) Content Removed.	Indian Health Care Providers (ICHPs) Updated Tribal Appendix Coming soon…
6/12/2024	Magellan's IBHP Provider Network	Federally Qualified Health Centers (FQHCS) No previous content.	Federally Qualified Health Centers (FQHCS) Content added.

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6/12/2024	The Role of the Provider and Magellan	Federal Data Collection No previous content.	Federal Data Collection Content added.
6/12/2024	The Role of the Provider and Magellan	Screening for Other State Funding Eligibility No previous content.	Screening for Other State Funding Eligibility Content added.
6/12/2024	The Role of the Provider and Magellan Services Requiring Prior Authorization	Services Requiring Prior Authorization Intensive Home and Community Based Services - Multisystemic Therapy (MST) Multidimensional Family Therapy (MDFT) Functional Family Therapy (FFT) New information added.	Services Requiring Prior Authorization Intensive Home and Community Based Services - Multisystemic Therapy (MST) Multidimensional Family Therapy (MDFT) Functional Family Therapy (FFT) Family Program (FP) **Other funding excludes 638 funding.
6/12/2024	The Role of the Provider and Magellan	Medical Necessity Criteria All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Criteria are no more restrictive than those used in Idaho's Medicaid fee-for-service program.	Medical Necessity Criteria All guidelines meet federal, tribal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Criteria are no more restrictive than those used in Idaho's Medicaid fee-for-service program.
6/12/2024	The Role of the Provider and Magellan	Member Access to Care New information added.	Member Access to Care Establish policies and procedures for crisis management, prevention, and response, including, as appropriate, the prevention of escalation, intervention strategies and techniques, and the use of the least restrictive behavioral intervention and staff training. • Provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. Inform members about your hours of operation and how to reach you after hours

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			in case of an emergency. Each member's treatment plan must also include a crisis plan that informs the member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the members regarding what to do in an emergency.
6/12/2024	The Role of the Provider and Magellan	Advance Directives As appropriate, Magellan will inform adult members aged 18 and older about their rights to refuse, withhold, or withdraw medical and/or mental health treatment through advance directives. Magellan supports state, and federal regulations, which provide for adherence to a member's medical and/or mental health advance directive. ***What You Need to Do*** Your responsibility is to: • Understand state, and federal standards regarding advance directives. • Meet state and federal standards regarding advance directives. ***What Magellan Will Do*** Magellan's responsibility to you is to: • Meet state, tribal, and federal advance directive laws.	Advance Directives As appropriate, Magellan will inform adult members aged 18 and older about their rights to refuse, withhold, or withdraw medical and/or mental health treatment through advance directives. Magellan supports state, tribal, and federal regulations, which provide for adherence to a member's medical and/or mental health advance directive. ***What You Need to Do*** Your responsibility is to: • Understand state, tribal, and federal standards regarding advance directives. • Meet state and federal standards regarding advance directives. ***What Magellan Will Do*** Magellan's responsibility to you is to: • Meet state, tribal, and federal advance directive laws.
6/12/2024	The Quality Partnership	A Commitment to Quality ***What You Need to Do*** Your responsibility is to: • Understand federal, and Idaho state standards applicable to providers. • Comply with federal, tribal, and Idaho state laws, the provider agreement, and all other quality management requirements.	A Commitment to Quality ***What You Need to Do*** Your responsibility is to: • Understand federal, tribal, and Idaho state standards applicable to providers.

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		What Magellan Will Do Ensure that an appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations.	***Comply with federal, tribal, and Idaho state laws, the provider agreement, and all other quality management requirements. What Magellan Will Do*** Ensure that an appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal, tribal, and state regulations.
6/12/2024	The Quality Partnership	Options After Adverse Benefit Determination (ABD) – Appeal • Provide written notice to the member, member's authorized representative, or network provider with member's written consent to appeal, of the resolution of the appeal, which complies with all state and federal regulations and IDHW requirements and includes the results of the resolution process and the date it was completed. When the appeal is not resolved wholly in favor of the member or timely within the timeframes described above, the written notice will also include: ○ The right to request a State Fair Hearing, and how to do so. ○ The right to request to receive benefits while the hearing is pending, and how to do so. ○ Notice that the member may be held liable for the cost of those benefits if the hearing decision upholds Magellan's action.	Options After Adverse Benefit Determination (ABD) – Appeal • Provide written notice to the member, member's authorized representative, or network provider with member's written consent to appeal, of the resolution of the appeal, which complies with all state, tribal, and federal regulations and IDHW requirements and includes the results of the resolution process and the date it was completed. When the appeal is not resolved wholly in favor of the member or timely within the timeframes described above, the written notice will also include: ○ The right to request a State Fair Hearing, and how to do so. ○ The right to request to receive benefits while the hearing is pending, and how to do so. ○ Notice that the member may be held liable for the cost of those benefits if the hearing decision upholds Magellan's action.
6/12/2024	The Quality Partnership	Treatment Record Reviews ***Our Philosophy*** Magellan is committed to ensuring behavioral health record documentation meets federal and state regulations as well as IDHW and Magellan standards. As required by state law, accreditation standards, and/or contractual obligation, a treatment record review is one component of Magellan's oversight of the quality of its network providers. Treatment	Treatment Record Reviews ***Our Philosophy*** Magellan is committed to ensuring behavioral health record documentation meets federal, tribal, and state regulations as well as IDHW and Magellan standards. As required by state law, accreditation standards, and/or contractual obligation, a treatment record review is one component of Magellan's oversight of the quality of its network providers. Treatment

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		record review results are reported in the annual Quality Improvement Program evaluation for the purpose of identifying opportunities for improvement in network treatment record documentation and adherence to clinical practice guidelines. ***What You Need to Do*** To comply with this standard your responsibility is to: • Ensure that all entries and forms completed by staff in member records is legible, written in ink, and include the following: ○ The name of the person making the entry. ○ The signature of the person making the entry ○ The functional title, applicable educational degree and/or professional license of the person making the entry. ○ The full date of documentation. ○ Reviewed by the supervisor, if required. New Information Added.	record review results are reported in the annual Quality Improvement Program evaluation for the purpose of identifying opportunities for improvement in network treatment record documentation and adherence to clinical practice guidelines. ***What You Need to Do*** To comply with this standard your responsibility is to: • Ensure that all entries and forms completed by staff in member records is legible and include the following: ○ The name of the person making the entry. ○ The signature of the person making the entry (written in ink or electronic). ○ The functional title, applicable educational degree and/or professional license of the person making the entry. ○ The full date of documentation. ○ Reviewed by the supervisor, if required. • Follow industry-standard CMS and state recordkeeping and retention guidelines for electronic signatures. ○ CMS medical review guidelines for using an electronic signature require that systems and software products include protections against modification and providers should apply administrative safeguards that meet all standards and laws. The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information. • Ensure service/progress notes document the service/progress billed. Service/progress notes must

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		• Ensure service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered. • Provider's treatment record documentation must match all submitted claims and align with the service(s) billed on the claim (e.g., diagnosis, DOB, procedure code). • If a member misses an appointment, there is documentation indicating why the appointment was missed (if this is known) and what efforts were made to re-engage the member in treatment. ***What Magellan Will Do*** • Ensure that appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations. Substandard services are those that have or have the potential for a negative (adverse) impact on the member or services received.	reflect the service delivered and are the "paper trail" for services delivered. • Provider's treatment record documentation must match all submitted claims and align with the service(s) billed on the claim (e.g., diagnosis, DOB, procedure code). • If a member misses an appointment, there is documentation indicating why the appointment was missed (if this is known) and what efforts were made to re-engage the member in treatment and follow up with the member. ***What Magellan Will Do*** • Ensure that appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal, tribal, and state regulations. Substandard services are those that have or have the potential for a negative (adverse) impact on the member or services received.
6/12/2024	The Quality Partnership Critical Incident Reporting	Critical Incident Reporting ***What You Need to Do*** • Ensure all provider staff comply with state and/or federal regulations for mandated reporting of child or adult abuse, neglect, exploitation, and extortion.	Critical Incident Reporting ***What You Need to Do*** • Ensure all provider staff comply with state, tribal, and/or federal regulations for mandated reporting of child or adult abuse, neglect, exploitation, and extortion.
6/12/2024	The Quality Partnership	Fraud, Waste, and Abuse Magellan has developed and implemented a program to safeguard against the potential for, and promptly investigate reports of, suspected fraud, waste, and abuse (FWA) by employees, subcontractors, providers, and others with whom we do business. The program complies with all federal and state	Fraud, Waste, and Abuse Magellan has developed and implemented a program to safeguard against the potential for, and promptly investigate reports of, suspected fraud, waste, and abuse (FWA) by employees, subcontractors, providers, and others with whom we do business. The program complies with all

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		requirements regarding FWA including but not limited to IDAPA, Sections 1128, 1156, and 1902(a)(68) of the Social Security Act, and 42 CFR § 438.608, and serves to ensure that all providers are eligible for participation in the network, consistent with provider disclosure, screening, and enrollment requirements in 42 CFR §§ 455.100-107 and 42 CFR §§ 455.400-470. **Regulatory Reporting and Investigation of FWA** Magellan is contractually required to report all unverified allegations of FWA to the Medicaid Program Integrity Unit (MPIU) and cooperate with all appropriate state and federal agencies, including IDHW's MPIU, Medicaid Fraud Control Unit (MFCU), and the Department of Health and Human Services Office of Inspector General (DHHS OIG) in investigating FWA.	federal, tribal, and state requirements regarding FWA including but not limited to IDAPA, Sections 1128, 1156, and 1902(a)(68) of the Social Security Act, and 42 CFR § 438.608, and serves to ensure that all providers are eligible for participation in the network, consistent with provider disclosure, screening, and enrollment requirements in 42 CFR §§ 455.100-107 and 42 CFR §§ 455.400-470. **Regulatory Reporting and Investigation of FWA** Magellan is contractually required to report all unverified allegations of FWA to the Medicaid Program Integrity Unit (MPIU) and cooperate with all appropriate state, tribal, and federal agencies, including IDHW's MPIU, Medicaid Fraud Control Unit (MFCU), and the Department of Health and Human Services Office of Inspector General (DHHS OIG) in investigating FWA.
6/12/2024	Provider Reimbursement	Claims Submission ***Timely Claims Submission*** All claims for covered services provided to IBHP members must be received by Magellan within the days identified below. (Note: Timely filing is based on the services billed.) • Within **180 days** of the date of service, providers must submit claims for Medicaid services. • Within **60 days** of the date of service, providers must submit claims for non-Medicaid services/state-funded services for Substance Use Disorder (SUD), Adult Mental Health (AMH), and Children's Mental Health (CMH). • Exceptions: ○ Indian Health Services (IHS), Tribes and Tribal Organizations, and Urban Indian Organizations (collectively, I/T/U), must submit claims to Magellan within **365 days of the date of service**. ○ Providers submitting Medicare claims are given 365 days to submit claims for Magellan to	Claims Submission ***Timely Claims Submission*** All claims for covered services provided to IBHP members must be received by Magellan within the days identified below. (Note: Timely filing is based on the services billed.) • Within **180 days** of the date of service, providers must submit claims for Medicaid services. • Within **60 days** of the date of service, providers must submit claims for non-Medicaid services/state-funded services for Substance Use Disorder (SUD), Adult Mental Health (AMH), and Children's Mental Health (CMH). • Exceptions: ○ Indian Health Services (IHS), Tribes and Tribal Organizations, and Urban Indian Organizations (collectively, I/T/U), must submit claims to Magellan within **365 days of the date of service**.

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		process as secondary. Ensure that the claim submitted to Magellan is submitted with the Medicare Explanation of Payment (EOP) or Explanation of Benefit (EOB) to complete the processing of the claim. ***If Magellan does not receive a claim within these timeframes, the claim will be denied for payment.*** Magellan will finalize clean claims within 30 calendar days of the date of receipt. Clean claims are defined as claims that can be processed without obtaining any additional information from the provider or from a third party. We strongly encourage all providers to submit claims to Magellan electronically – either one claim at a time via Availity Essentials, in bulk through EDI Direct Submit, or by enrolling with one of the claims clearinghouse vendors designated by Magellan. Call Magellan's Idaho provider line at 1-855-202-0983 for more information or visit the Getting Paid section of www.MagellanofIdaho.com (under *For Providers*).	○ Providers submitting Medicare claims are given 365 days to submit claims for Magellan to process as secondary. Ensure that the claim submitted to Magellan is submitted with the Medicare Explanation of Payment (EOP) or Explanation of Benefit (EOB) to complete the processing of the claim. ○ Additional time to file a claim may be granted on a case-by-case basis for Medicaid members who become retroactively eligible. ***If Magellan does not receive a claim within these timeframes, the claim will be denied for payment.*** Magellan will finalize clean claims within 30 calendar days of the date of receipt. Clean claims are defined as claims that can be processed without obtaining any additional information from the provider or from a third party. We strongly encourage all providers to submit claims to Magellan electronically – either one claim at a time via Availity Essentials, in bulk through EDI Direct Submit, or by enrolling with a claims clearinghouse vendor that has a trading partner agreement with Magellan. Call Magellan's Idaho provider line at 1-855-202-0983 for more information or visit the Getting Paid section of www.MagellanofIdaho.com (under *For Providers*).
6/12/2024	Provider Reimbursement	Claims Billing and Other Reminders ***Claims Resolution*** If you believe that Magellan has incorrectly processed or denied your claim, you may submit a **claim inquiry** to Magellan, for reconsideration of your claim. If supporting documentation is not required for Magellan to review your claim or supportive documentation is not available,	Claims Billing and Other Reminders ***Claims Resolution*** If you believe that Magellan has incorrectly processed or denied your claim, you may submit a **claim dispute** to Magellan, for reconsideration of your claim. If supporting documentation is not required for Magellan to review your claim or supportive documentation is not

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		providers may contact the Magellan Healthcare of Idaho provider line, at 1-855-202-0983, and speak to a customer service representative. If necessary, the customer service associate will submit a service request application (SRA) to Magellan's claims resolution team for further investigation. If you have documentation to support payment for your claim, you may submit an electronic claim appeal, with your supporting documentation, to Magellan via Availity Essentials. Without appropriate and complete documentation, your request will be denied and the original decisions upheld. Upon receipt of your claim appeal, Magellan will investigate the information presented and respond within 30 calendar days. Please be advised that a claim appeal is a request for a claim to be reviewed; it is not a guarantee of payment. **No claim appeal will be considered past 365 days** from the date on Magellan's explanation of benefits. It is the provider's responsibility to manage all denials and rejections and follow up with the appropriate resubmission or appeal mechanism outlined above. All decisions made regarding your request for reconsideration will be final and cannot be appealed.	available, providers may contact the Magellan Healthcare of Idaho provider line, at 1-855-202-0983, and speak to a customer service representative. If necessary, the customer service associate will submit a service request application (SRA) to Magellan's claims resolution team for further investigation. If you have documentation to support payment for your claim, you may submit an electronic claim dispute, with your supporting documentation, to Magellan via Availity Essentials. Without appropriate and complete documentation, your request will be denied and the original decisions upheld. Upon receipt of your claim dispute, Magellan will investigate the information presented and respond within 30 calendar days. Please be advised that a claim dispute is a request for a claim to be reviewed; it is not a guarantee of payment. **No claim dispute will be considered past 180 calendar days** from the date on Magellan's explanation of benefits. It is the provider's responsibility to manage all denials and rejections and follow up with the appropriate resubmission or dispute mechanism outlined above. All decisions made regarding your request for reconsideration will be final and cannot be appealed.
4/19/2024	Services Requiring Prior Authorization	Psychological / Neuropsychological Testing - "Prior authorization after threshold of 4 units per member per calendar year"	Psychological / Neuropsychological Testing - "Prior authorization after threshold of 14 units per member per calendar year"
4/19/2024	Services Requiring Prior Authorization	IOP - Intensive Outpatient Program/ASAM 2.1 • Medicaid Covered Service - "NO" • Prior Authorization or Notification of Admission - "NOA"	IOP - Intensive Outpatient Program/ASAM 2.1 • Medicaid Covered Service - "YES" • Prior Authorization or Notification of Admission - "No authorization requirement"